

GPs' demoralisation is due to our loss of human connection

A recent headline 'Thousands of GPs "plan to quit"' (*Guardian*, 20.1.16) heralded an accurate description of NHS GPs' plummeting morale, resilience and commitment. The journalists' analysis then correctly identified our many problems: ever-increasing workload and stresses from ever-greater expectations of services, then rising litigation; all expressed in a population whose increasing longevity is bound to increase comorbidities.

Yet all economically similar countries are facing these inescapable problems. What is particularly problematic for the UK, though, is how we have pursued 'efficiency' to deal with them. In brief, we have attempted to manage our healthcare as if it is a competitive manufacturing industry. This change in service paradigm is essential to understanding our current predicament. The *Guardian's* otherwise excellent reports hardly explored the basis of this shift. This short piece fills in some gaps.

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From the 1990s each successive government has increased GPs' 'must do' lists: myriad QOFs, goals and targets, audits, appraisals, inspections, prescribed care pathways ... and then competitive commissioning of services. Each of these 'must do' tasks may be well intended by planners but subtracts from the autonomous headspace and heartspace of practitioners: these spaces are the harbours for our personal interest and imagination – the springs of our best vocational spirit and pastoral healthcare.

General Practice was never the most glamorous or charismatic of medical specialties, but for many decades its better forms commanded much vocational loyalty and enduring personal contentment. The basis for such quiet and stable satisfaction lay in its human relationships: GPs' consultations took place almost entirely between the doctor and patient, and could then sensitively extend to the patient's primary relationships. Forty years ago this was aptly called 'family doctoring'. Other agencies were little involved, and then usually only by invitation. Because there was so little intrusion or

management from elsewhere, personal understandings, and then affections, could flourish.

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Such human engagements have been changed utterly by the NHS being subject to commercial commodification, industrialisation and then computerisation. Governing agencies now have a fearsome pre-eminence in the consulting room, directing an endless stream of prompts and imperatives. The increasingly fatigued and stressed GP becomes torn between his need to obey governance and the wish to create good human sense and connection with *this* person *now*. Increasing our mandatory tasks of obedience and administration has crippled our better human capacities and responses.

The headspace and heartspace that was available to previous generations of GPs helped us make human and personal sense not only with and for our patients, but also ourselves and then our wider colleagueial network. We have lost all of these: our profession has become humanity-famined.

The current nadir in General Practice is inevitable. The now factory-like culture of our NHS is like an over-disciplined family driven by parental ambition. Early compliance may be easy; what comes later is very different.

We need to reclaim much of the personally scaled and personally contended. We have much to undo.

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