Streamlining the NHS.
No-brainer or nest of trip-wires?

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New initiatives to streamline our NHS have become so frequently mooted or implemented as to be an almost-constant backcloth to our national news.

Yet the vaunted benefits mostly bring disappointment. Why is that? A current example shows how we are disregarding some crucial underlying problems.

'Seek simplicity, then always distrust it'

– Alfred North Whitehead (1861-1947)

Our NHS healthcare traffic jams seem now ubiquitous: to speak to a GP receptionist, to see a specialist, to get a scan, receive hospital treatment, await an ambulance to get to hospital, to leave hospital with safe support … we can easily add to this elementary list.

This problem is not new but is accelerating and becoming ever more critical. That *something must be done!* has many different expressions from different sources. There is no shortage of suggestions, yet, most often, their early and apparent plausibility far exceeds their later purchase.

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A recent initiative announced in the media at the start of this new year, 2025, seems eminently sensible and practical. It has been agreed that GPs will now be able to refer patients for CT and MRI scans directly, rather than these only being available to hospital specialists. This empowerment of GPs thus cuts out the expense, delay and bureaucracy of often unnecessary/premature referrals to specialists. Patients will get their test quicker, GPs' to-and-fro bureaucracy is lessened, hospital doctors will not see 'unnecessary' patients.

Everybody wins … surely?

On first-pass analysis all this seems very clear, but further considerations disperse this surety.

For example, generally the more easily available something is, the more casually and indiscriminately it will be used – the more we will relegate our human effort, engagement or attention. This drift to profligacy is true with almost all our inventions. Our currently personally depleted general practice is probably very prone to this expedient default. Now CT and MRI scanners are extremely complex and expensive machines with high-skill and high-cost operating and maintenance requirements. How will the likely inevitable increase in demand be met? Where will the extra money and expert staffing come from? Other welfare services? Increased taxes?...

Some might argue that, apart from such resource and financial considerations, it must surely be a good thing for more people to have more investigations more easily – isn't that how we better detect and treat serious conditions earlier?

There is important truth in this, but it is partial and conditional. Low threshold investigation becomes more like screening, and then we must deal increasingly with 'false-positive' results: deviations from the normal which are ambiguous in nature and prognosis, and would not otherwise have been found – 'coincidentanomas'. The increased use of sophisticated scanners has already vastly expanded this whole confusing area of putative medicine – whether, when or how to go on investigating or intervening with anomalies that may, in any case, be stable (non-progressive) and dormant. Over-investigation can lead to over-diagnosis – slippery phantoms of real problems.

Amidst this new tide of high tech uncertainty some lives and health are certainly saved, but also much extra work and resources are required, and then, often, much fear and anxiety is generated in the patients so burdened with shadowy ambiguous portents. Iatrogenesis easily becomes a burgeoning risk in such territory…

Such complex predicaments and pluripotential knowledge need to be matched by equivalently sophisticated practitioners. The current proposals assume that GPs can take on this responsibility unproblematically. Really? Well, '*General Practitioners protect patients from hospitals, and hospitals from patients'* used to be an accurate aphorism of better practices, but struggles for any truth today.

The loss of this traditional capacity is responsible for many of our current NHS difficulties and avoidable inordinate expenses: it needs our fuller understanding.

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Before the serial 'modernising' NHS reforms of the last few decades it was a sine qua non of better general practice that any science of medical practice would, whenever possible, be embedded in, and delivered with, the art of personal understanding. This was largely achieved through the provision of personal continuity of care whenever this was a patient's preference and possible – personal knowledge and understanding were regarded as seminal.

There is much evidence to demonstrate that this erstwhile ethos of practice brings far more than reassuring comfort for patients and occupational satisfaction for doctors. Therapeutic benefits and diagnostic accuracy are both markedly (though not always)

increased. The former are due to the complexly healing and motivating possibilities of relationships. The latter is due to vagaries and irregularities in how human distress both presents and progresses … and thus how appositely we may apply our diagnoses.

This requires our deliberation on how variously we present our health problems and distress to others.

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Very often we ask for help with descriptions of very open-ended possibilities: 'I'm just not myself'; 'I've got no go in me'; 'I get these headaches/abdominal cramps/feelings of unsteadiness'; 'I just keep wanting to wee'; 'I've never felt so hopeless, doctor'; 'I feel sick all the time', 'My vision comes over all funny'… these are typical opening descriptions by patients: 'undifferentiated pathology'. Most of these will not be heralding serious or significant disease – they will, instead, be 'transient and trivial', or expressing some personal struggle or stress. But a few will be early portents of something far more serious. The distinction is often not easy. Who decides which is which? And how?

Until recent times it was usually a GP who made these discriminations. The reason they were especially enabled to do so lay not just in the breadth and depth of their medical knowledge, and the length of their experience, but also how they were likely to have personal knowledge and understanding of the individual they were dealing with. This rich weave of various kinds of knowledge could more accurately and speedily make the necessary decision. Their substantial medical knowledge could

better identify atypical presentations and rare serious illnesses; their personal knowledge led to a readier recognition of what was, or was not, characteristic of *this* person, or what the illness symptom might be expressing of their disequilibration, their life-predicament.

All the benefits of this have been clearly and repeatedly demonstrated by many years' research. Greater personal continuity of care is related not just to greater patient satisfaction, but to reductions in emergency referrals and admissions to hospital, routine referral for specialist assessment, urgent requests for ambulances, hazardous exacerbation of neglected chronic diseases, severe mental health breakdown and self-harm… Very strikingly, longevity is statistically related positively to such primacy given to personal continuity.

Such are the diagnostic and therapeutic advantages bestowed by personally invested and longer-term healthcare bonds that erstwhile GPs could provide. Those doctors, working in smaller units with patients and staff they knew well, could more readily distinguish the serious from the trivial, the personal from the organic, the watch-and-waitable from the emergency-referred. For example, if Dr X knows a patient and their current predicament well they might, after examination, say, 'I don't think your headaches/stomach cramps/muscle twitching/dizzy spells are due to anything serious. It's most likely due to an overspilling of the stress from your divorce/redundancy/son's criminal charges etc… Come and see me again next week, but sooner if anything gets worse.'

Such skilled and accurately attuned containment used to be much easier when a stably anchored and anchoring GP could, and did, offer this kind of flexible and easy

access. Any subsequent errors of assessment could be promptly identified and corrected. Knowing this, both doctors and patients could be less anxious; any inevitable initial uncertainty and ambiguity of undifferentiated pathology could be tolerated with (relative) safety – follow-up was clear, accessible, certain and soon. Expensive scans and hospital investigations could wait…

But this is now not the modus operandi of most current GPs. Doctors working in ever-larger practices, usually very part-time, on short-term contracts, often from several sites, will have very meagre personal familiarity or knowledge of either patients or colleagues. They are most unlikely to be able to offer the kind of vigilant flexible containment, support and guidance – the safety net – portrayed above by Dr X. What, instead, can such a transiently engaged current doctor do? Well, even though they will probably not see the patient again they can, at least, reduce culpability and risk: they can arrange extensive investigations and/or referrals…

This is a common consequence of a system whose unmanageable pressure of work is both a symptom and cause of the breakdown of continuity of care. Yet the argument is often made that such GP personal continuity is an expensive and unnecessary luxury that is a distraction from the 'real work', which can be expeditiously distilled to a relay of mass-managed practitioners and procedures.

But this depersonalised procedural relay is much more expensive than what Dr X could do so readily. And it also adds greatly to the demands, cost and strain of hospital services. And then patients' uncontained illness-anxiety is often ignited and unleashed…

Facilitating sophisticated investigations without a firm bedrock of personal and pastoral healthcare confers very mixed blessings…

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The folly of this oversight has been amplified by several related initiatives in recent years to 'relieve' GPs of their cardinal frontline role. Like much populist politics these have easy appeal by apparently offering simple solutions to complex problems. So, if GPs are too few and too busy to do their work properly then why not relieve them of much of their broadly-based primary diagnostic functions and instead get them to concentrate on complex cases and managerial/supervisory tasks?

Hence the idea of First Contact Practitioners (FCPs), who would substitute for doctors in making initial assessments and diagnoses. The FCP *Unterdoctors* can be pharmacists, physiotherapists, occupational therapists, dieticians … all of whom have some working background in healthcare. Physician Associates (PAs) – more worryingly – may have had only a two-year university crammer course. All, though, can be more quickly trained and cheaply paid than doctors. This bargain-package funding is called the Additional Roles Reimbursement Scheme (ARRS).

To the unwary this may seem like an Occam's Razor, but such a 'solution' will prove more of a populist folly and myth. The myth is that medical practice is merely a system of atomised facts that can be precisely itemised, navigated by algorithms, and managed by procedures. While this has some useful, yet always partial, truth in hospital medicine, it is far less apposite in the far-more chimeric and humanly vagaried world of primary and mental healthcare.

The follies come and accumulate from this reductionism. FCPs, and especially PAs, will be guided by prescribed algorithms rather than any deep knowledge, long experience or familiarity with the patient. Knowing this, they will practise defensively – adhering rigidly to management-defined pro forma, then being unable to cut to the chase. So this inventive discrimination – so essential to sustainable medical practice – becomes fearfully distanced, denied or passed on.

Very little of this will help the GPs who are meant to supervise all this and will now have even less contact and familiarity with the patients concerned. Increasingly those siloed doctors will be referred only those patients who the non-doctor FCPs deem more complex or serious. But, as we have seen, this discrimination itself often requires significant knowledge and skill: most serious conditions start off seeming trivial or commonplace. How to cannily identify the often-camouflaged dangerous, yet also *not* over-investigate or over-react to the vastly greater flow of minor and self-limiting complaints … that is something erstwhile family doctors were pre-eminently well-suited for. All this was respected and secured in the NHS until the serial reforms began in the 1990s. In many international studies the NHS was then regarded as the most efficient, safe, equitable and best-value-for-money health system worldwide. This was largely due to a nexus of family doctors who, by often knowing as much about their patients as they did about illnesses, could manage and deliver their personally accessible first-contact service 'protecting patients from hospitals, and hospitals from patients'.

Yes, there was then also some enormous variation in standards, and some egregiously bad practice. But despite these, the old system – based on personal continuity with a

familiar practitioner – yielded a much more stable workforce with excellent morale and motivation: that was why it was able to perform so well.

There is a paradox here that is often missed: to be expert at identifying and dealing with the serious, practitioners also need immense experience, too, with the 'transient and trivial': that is how we best learn about not only the natural histories and masquerades of many complaints, but the many layers and presentations of the always-somehow-unique people who come to us. To deprive GPs of their 'front-door' function deprives them of the experience, wisdom and gratification that come from this more vernacular medical practice.

Seeing mostly patients that they don't know, who are priorly designated and referred by some form of First Contact Practitioner, will turn GPs' work increasingly depersonalised, dull and bureaucratic.

Patients are hardly likely to be safer or happier.

GP recruitment will fall. Doctors will increasingly leave. Those that remain will be even more scanner-sighted, but humankind-blind.

Ah, but then we can replace them with more Physician Associates…

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> *'Men reform a thing by removing the reality from it, and then do not know what to do with the unreality that is left.'*

– GL Chesterton, *Generally Speaking* (1928)

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