Dear Editor

The NHS: we must be careful what we wish for

The recent BBC Panorama *Fixing the NHS: What Will it Take?* (24 March) missed an essential theme: the personal knowledge, bonds and understandings we all need to anchor and fuel much of our best healthcare.

Yes, the programme did effectively convene another important consensus – we need more investment in social care, IT/AI, buildings, recruitments and training … interviewed politicians, practitioners, patients and pundits all agreed. The slippery yet thorny question of how to pay for all this was skilfully not addressed.

So what else of importance was not talked about? It was an almost culturally-sanctioned neglect: it was how most of our frontline NHS consultations – those in primary and mental healthcare – are very largely *people-work*, 'pastoral healthcare', which consists of personally meaningful forms of comforting support, guidance and advice with patients (and other staff) – all of whom can become well-known. It was this kind of personal nexus that made possible the old adage: 'Family Doctors protect patients from hospitals, and hospitals from patients'. This now, alas, has feeble meaning.

Yet in my forty years as a GP I saw repeatedly how true this then was: with good personal continuity of care, delivered from small stable practices, we could offer far better personal access, monitoring, containment and discernment of diagnoses and interventions. With such metaphorical handholding our unnecessary referral and investigations rates were lower; patient and doctor satisfaction was much higher; anxious and bewildered demands on all the services was far less…

Those long observations are now solidly validated by much research from many sources.

All demonstrate that personal continuity of care delivered by familiar and trusted individuals has multiple positive outcomes – increases in diagnostic accuracy, therapeutic benefit, chronic disease containment, patient and staff satisfaction, staff stability; decreases in referrals, investigations, mismanagement, emergency services usage … and very considerably, the economic cost.

All desirable, surely? But these erstwhile benefits were delivered by much smaller GP surgeries who could operate more from personal interactions than the now-prevalent digital protocols with (often) unknown patients delivered by part-time, short-term GPs working in airport-like surgeries.

This is a predicament: our increasing investment in AI and IT – unless we are very careful – leads to a dominant proliferation of the remote, the impersonal and the algorithmically protocoled. Only in certain situations does this, in the longer term, increase efficiency and safety, and reduce costs. In many other situations the broader and longer consequences are quite the reverse. This is what is happening.

Such discernments are fundamental for the health and viability of the NHS. We need to learn from our history.

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Dr David Zigmond
Executive Committee, Doctors for the NHS