

Eric – diagnosis may be sometimes necessary; it is rarely sufficient

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I did my medical training in the 1960s. I have now worked as an NHS practitioner for more than 40 years: as a psychiatrist, psychotherapist and GP. The length and breadth of this work has led to my guiding maxim: 'Healthcare is a humanity guided by science'. Such subtle simplicity seems increasingly homeless and at risk. My recent writings and efforts stand against the tide.

Summary

Diagnostically centred, schematic and managed healthcare has brought great benefit to the treatment of structural physical diseases. With other kinds of dis-ease its results are often much more problematic, even destructive. Current trends render this a growing problem. A true and recent story of an eternally grief-stricken elderly man serves as a cautionary and explanatory example.

Introduction

Diagnoses – when well placed – have muscular leverage: they form the core-knowledge of most of our dramatically successful treatments for structural physical illnesses. Yet diagnoses have limitations of view; they can only offer descriptive clusters of commonality – what is *generally* true, the generic. They cannot tell us about the unique world of *this* individual *now*.

For this reason the generic diagnosis often fares poorly in healthcare realms where *individual* understanding, meaning and experience hold the key to therapeutic engagement. It is proposed here that most psychiatry, therapeutic psychology and medical encounters with functional complaints are all better addressed by a more idiomorphic approach; that the cost of not doing so is high.

Why is this important? What can happen? The following true story, about Eric, explains and illustrates.

This account is an extract from a long letter to a director of a mental health trust. The letter is written to document, and then catalyse, thought and debate about the increasingly inordinate use of the medical model – how this is leading to a complex fragmentation, and then destructive

depersonalisation, of healthcare. Alarming this is happening especially in areas where quality and continuity of human contact and individual understanding is most important.

The story of Eric, and its inherent missed and miscommunications are a small but powerful example of a grave and accelerating problem. The letter could have been written to any similar NHS trust. The discerned problems are now so widespread and insidious as to best be considered *cultural*.

The wide and complex sources of this culture are beyond the scope of this article. Yet we can begin a remedial response. Any limitation or reversal of damage must come from a counter-cultural ethos: I call this 'holistic compassionate care' (HCC). Some essential and guiding features of HCC are itemised in the box overleaf.



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Holistic, compassionate care: a summary

- Personal healthcare is a humanity guided by science.
- This humanity is an ethos and an art.
- Holistic, compassionate care (HCC) requires mindful titration of art and science in ever-changing situations.
- This titration works like a carburettor: balancing opposing elements (petrol: science v air: art) in ever-changing mixtures to serve the needs of the whole (engine: person).
- Too much or too little of any one element causes suboptimal functioning and, eventually, no function at all.
- HCC is potentially important in all our encounters with human distress or dysfunction, yet always differently.
- HCC is particularly important in situations where there is not a quick and decisive physical treatment – hence general practice, psychology and psychiatry are especially vulnerable to its loss. Similarly the care of older people.
- HCC often deals with issues that are personal, inexplicit and have symbolic meaning. Science has no access to such ‘metacommunication’.
- HCC is often potent, but subtle and fragile. It is easily damaged or destroyed. Its ‘habitat’ needs protection.
- HCC is currently seriously damaged and impaired by an excess of ‘science’ and corresponding impoverishment of ‘art’. [This is much like the carburettor delivering a ‘too rich’ mixture: the engine will have difficulties with fuel consumption, environmental pollution, power; smooth-running and starting. Healthcare analogies are obvious.]
- Thus more of something ‘good’ may, in fact, be worse.
- Schematisation is the opposing principle to holism. Thus, for example, excessive category-based management will displace attachment-based personal understanding. Examples of current changes adding to this inadvertent damage: in General Practice – the loss of smaller, friendlier practices and personal lists for GPs, QOF-based remuneration; in Psychiatry – increasing subdivisions of medically-modelled care pathways and Clinical-Academic Groups; in Psychology – very similar: especially in excessive, diagnostically schematised CBT/IAPTS pathways.
- Wisdom = knowledge x reflection x experience x imagination.
- Systems that replace clinical wisdom with managerial solidarity generate very serious problems.

The letter

(Names have been changed to protect confidentiality)

The complete and original letter can be found at www.marco-learningssystem.com/pages/david-zigmond/eric.htm

1977–2010

As a GP for more than 30 years in the same practice, I have had medical responsibility for thousands of people. Eric was one of my few ‘old-timers’ I’d had almost no contact with. I knew what he looked like: a tall, increasingly stooped, bespectacled man, now in his early 70s, who had always dressed with neat, quiet formality and who carried a mien of discrete compliance, of well-mannered appeasement. I remembered several glimpses – spread over many years – of his visits to other practitioners. Paradoxically, I had another route of acquaintance with him that was more detailed – though more abstract – through the post: letters from specialists over many decades. Hazy memories of these were crystallised into the terminology of his disease-register and medical notes summary: ‘mature-onset diabetes’ and a ‘long history of major, relapsing depression’. I remembered old letters from the 1960s: the days of outer-city mental hospitals, ‘modern’ tricyclic anti-depressants and courses of ECT. More recent letters had better news: containment and quiescence of his symptoms and punctilious compliance with prescriptions, plans and attendance. I sensed stable fragility well attended to: I had no need to intervene or understand further: if at peace, do not disturb.

* * *

2011–2012

An urgent phone call. The receptionist, Sue, correctly recognises raw and intelligent fear in the unknown woman’s voice. Sue is intelligent, in response. It is not a ‘good time’ for phone calls, but she puts the call through immediately. Sue has an unschooled instinct for real distress, and thus accurate precedence.

‘Doctor, I’m Dora, Eric’s niece ... I’ve known him all my life ... I’ve never seen him as bad as this, so ‘down’ ... since last week I can’t get him to eat, or talk, or take care of himself ... I can’t really get normal conversation from him ... he’s said frightening things: all quiet and intense – about his life ending, or ending his life – I can’t really tell ... I can’t leave him like this, but I live out of London and have young children to get back to ... I don’t know what do, doctor, can you help? ...’

* * *

Within an hour, Eric and Dora are sitting with me. Eric’s deflation, hopelessness and anguish are painfully and immediately apparent: his slow movement, enfeebled voice, depleted gaze and burdened gait all convey intense and incarcerated despair. Words – delicately baited – may later amplify or explain. Dora’s presence and prescience are what I had imagined from our brief telephone contact: unintrusively engaged, lovingly watchful, fearful of tragic catastrophe.

I sense in Eric some fresh personal trauma causing this dramatic collapse: some kind of rupture; an internal haemorrhage of hope and faith. I need his words to explain: they are like frightened small fish sheltering in the darkened deep. I have to be still awhile, and patient. His words begin to surface; I lean forward, gently, to catch them:

'They've told Nancy that I can't see her anymore, that I've got to go somewhere else ... but I don't want to go somewhere else ... I just want to go back to see Nancy ...'

The words almost collapse at the back of his throat and are exhaled plaintively and weakly, as if he is dying. They choke to a halt with inhaled, silent sobs.

Dora is calmer, now she is sharing this enervated burden. I turn to look at her. She returns a knowing gaze. She does: she starts to explain:

'Uncle Eric has been seeing Nancy (a social worker) at the Clifton (Community Mental Health Centre) for about eight years. He's been told he has to stop. Nancy says it's due to some sort of reorganisation: that the managers have told Nancy that what she's doing isn't what's most suitable for him: that they'll find him somewhere else ... But I know how much my uncle has been helped by Nancy: he only sees her for about twenty minutes, every few weeks. But he trusts her, and she's been kind and really got to understand him over a long time. I think that's why he's been so well for these last years ... After everything that happened to him when he was young, taking Nancy away from him now seems so cruel ...'

I realise I am dealing with broken vital connections, and a still-active volcanic personal ancient history, of which I know nothing. I must understand the essence of Eric's world, and story, very quickly.

Within 15 minutes I have deciphered much: I am simultaneously gratified by understanding and disturbed by what I have understood.

* * *

Eric was the youngest of five boys in a traditional, poor London docker's family. His mother, in her forties when he was born, ailed throughout Eric's infancy and died when he was three. He was cared for by a younger sister of his dead mother, Aunt Ada, until the onset of the Blitz. By the time his neighbourhood was shattered and ablaze, he and his four brothers and father had all dispersed, separately, away from London: Eric and three brothers were evacuated to families throughout the Home Counties, the oldest brother and father joined the Merchant Navy, hoping to stay together. They did not; father perished in an attack on the Arctic Convoy.

Eric's wartime childhood as an evacuee was abject, grief-struck and fearful. He was moved several times to

different families for reasons dictated to him, but little understood by him. His experiences of care were various – kindness, affection, hostility, cruelty, indifference – but never predictable, dependable or within his control. He could not understand the difference between death, separation, abandonment or punishment. He learned to survive by appeasement, submission, invisibility. His memories of his mother and Aunt Ada brought grief that was rarely consoled: he learned, too, to appear to be brave.

At the end of the war, at the age of 11, he returned to his orphaned family of older brothers, in the resuscitated ruins of London's Docklands. Eric's brothers were kindly and protective with Eric, though tougher than he: they had had long-enough and robust mothering. For his sense of protection and belonging, he followed his Band of Brothers to work in the Docks, soon after leaving school.

Eric's brothers and a few of his more thoughtful workmates were his social and family life, for several decades: he never made sexual relationships with women – a dangerous and painful yearning, a Bridge Too Far.

‘To be known to another, with intimacy and volition, is one of the most powerful balms for human distress’

Eric's depressive breakdowns, in his thirties and forties, were possibly related to fresh abandonments: by his brothers who left him, each to move away from the Docklands to spawn their own families. By his fifties his 'family' consisted of his now distant, elderly, often ailing, brothers and a few retiring, soon-to-vanish, fellow dockers.

As his livelihood, companionship and brothers died, this vulnerable, inarticulately yearning, self-deprecating elderly man feared the waning of his solitary life, unknown and unwitnessed. Nancy had recognised this with discrete intuition, and for several years provided the kind of family surrogacy that provides humble but deep affiliation and palliation, yet has no official designation. Nancy, it seems, was guided by a basic tenet of care: that to be known to another, with intimacy and volition, is one of the most powerful balms for human distress. With evident sense and sensitivity Nancy had – with necessary professional safeguards and boundaries – contained and symbolically cradled this eternally grieving, unmothered old man. Nancy's humbly potent humanity, though, had invidious flaws: it is undesignated and unmeasurable; not part of a recognised generic care pathway. Ipso facto, Nancy should not be doing this work: Eric should go elsewhere, to a place of prescribed and recognised 'treatments'.

The consequences of this 'rationalised management'? An avoidably, yet now primitively disturbed and distressed elderly man – whose life I now fear for. What will I do?

* * *

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What I can. My attentions to, and on behalf of, Eric have been multifarious, and for many months. My more direct endeavours have been akin, I imagine, to Nancy's – to compassionately contain, respond and guide: to comfort, palliate and help him reclaim some hope for his increasingly meagre life. Due to his feelings of unsafety now, with the mental health teams, I have been seeing him every two weeks: I accept I may need to do this indefinitely. I am sadly aware that there are now few GPs who would take this initiative, or accept this responsibility. What would happen to Eric elsewhere?

How, with apparent good intent, do we deliver such miscarriages and perversions of care?

I have directed my attention more widely, too. I have wanted to understand and define the institutional misperceptions and misconceptions: how, with apparent good intent, do we deliver such miscarriages and perversions of care? I have had to be resilient and assiduous in my (re)search, motivated not only by Eric's individual and affecting predicament, but also an increasing number of other patients describing similar dislocations of human understanding by specialist services.

Over many months I have made numerous phone calls to various psychiatric teams. I have had to be patient, persistent and assertive to generate substantial dialogue. Face-to-face contact has been harder, success had been sporadic yet labour-intensive.

This Odyssey has two parallel paths – of seeking exploratory dialogue with Psychiatric Services while securing restitution of care for Eric. Both are long and difficult. This following description thus attempts salience, not completeness.

* * *

I spoke initially to Nancy, then to both the clinical manager and the consultant psychiatrist at the mental health team. With all three there was a layered carapace to their responses. First, wary bewilderment: why would a GP want to enter their territory with such energy of concern and enquiry? Then institutional deflection and edict: 'The team has assessed and decided ...'. 'The care pathway, directed by agreed trust protocol ...' and other armoured phrases of unpeopled authority. With skill and patience I was able to get to the cramped and uncomfortable person trapped behind the armour. Nancy seemed wary, weary, circumspect then relieved in her brief confiding:

I'm sorry, Doctor ... of course, I'm especially sorry that poor Eric is having to go through any of this ... I'm sorry that I can't do the helpful work I know and like ... I'm sorry you're having to deal with the fall-out of all this ... But I can't do anything – you know how it is with Management these days: I can't say too much...

The others, with less direct knowledge of Eric, went through the same process of deflection, dissemblance, then confidence and dispirited contrition.

Again, my tricky choreographic riddle: how to maintain respectful colleagueial relationships, while indicating clearly and strongly my wide-ranging disagreements with their policies and decisions?

My clarity and resolve – and anxious concern – were refuelled unhappily; by the accuracy of my predictions: Eric's abject misery became so uncontained that he was admitted to a psychiatric unit. Given his early experiences of care by strangers and the nature of current admission centres, his likely reaction was also easily predicted: iatrogenic damage was deepened. The cost to NHS resources is considerable; to human welfare much greater.

* * *

In my effort to keep Eric's distress closer to drama than tragedy, I contacted you in your role of clinical director for the mental health trust. Your response was prompt, concerned and pragmatic: you delegated one of your experienced and senior deputies, Dr Y, who would communicate with me.

Dr Y did contact me in a way that was remarkably unremarkable: he sent me a long email.

Remarkable? Unremarkable? Which?

The e-mail combines immediacy and precision of signal with remoteness of human contact: no face, no voice, no location, no touch. Yet it is increasingly used automatically, even in such humanly-demanding situations; it has become a part of our culture. But is such signalling communication? If so, what kind? What for?

Dr Y's email was polite in taking control. It proceeded like an instruction manual, assuming that I needed his executive explanation, guidance and help. Some anomalies made this most improbable. He started by acknowledging that his reply was mostly based on his perusal of electronic records: he had never met Eric, *'but I do have a lot of experience with such patients'*. As if I do not?

Proceeding to address me like a silent Tannoy system, Dr Y then raised the possible therapeutic options of various psychotherapies for Eric. This line of thought seemed (to me) to assume a common simplistic notion of 'psychotherapy' as a sequestered, distilled, specialist activity that has to be designated and delivered systematically. Eric (and I would say most people I see who are distressed) do not want or need that kind of schematised activity. They do, however, want contacts that are psychotherapeutic: contacts that develop trust, hope, understanding, meaning, structure and safety. Nancy had been doing this with Eric, very appositely, for years. I could see this clearly within minutes of talking to Eric. Even Sue, my receptionist, rapidly intuited much the same. Yet various managers of specialist services could not, or would not allow themselves, to see this. Why? My theory: because Nancy's unschooled and undesignated therapeutic contact lay outside currently prescribed

algorithms and care pathways: that which is not prescribed now becomes proscribed.

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Dr Y's long and tendentious email concluded, with a kind of magisterial authority, by instructing me about this man he had never met: 'Overall, the type of all-embracing care that secondary care tends to offer can often entrench such personality characteristics'. What does this mean? Like most general statements about human experience, motivation or fate, this is a notion that is bound to be true, sometimes. But an opposite proposition is also sometimes true. The art and wisdom of practice comes from the creative and pragmatic editing and synthesis of such partial truths. So, Dr Y's statement, which may sometimes be usefully true, is now rendered hazardous by its introduction as 'Overall', which implies hegemony, like a Monarch reigning 'over all'. This is not pedantry: a crucial and difficult part of our work in mental health is to always look for exceptions to our predicated patterns. Without skilful handling of these paradoxes, important misunderstandings will be frequent. Eric is a stark example of this, and how it happens. Dr Y's long and didactic email seemed heedless of this. He paid no attention to the personal nature of Eric or my engagement with him: Eric will need some kind of innominate, but bespoke, humanely imaginative containment until the end of his life. This is not rare, yet is rarely acknowledged. Over many years of working with the mentally distressed, I see that this kind of innominate approach has been crucial. How do we assure space and resources for such unpackaged, difficult-to-measure-yet-made-to-measure, free-form compassionate contact with others? In the longer term, in contrast, I have found the currently vaunted time-limited, designated packages of care to be of evanescent interest and shallow effect.

What I wanted and needed from Dr Y was some sophistication of dialogue. What I got was a default-type of e-mail: now so ubiquitous as to be a new convention. In this culture – of screen-before-person – practitioners are now deluged by an inassimilable quantity of such signals. Few get read with good attention; even fewer intelligently discussed. Yet, if we look closely, we can see anomalies and absurdities which few would intend. This happened here: with Dr Y, myself and Eric.

* * *

If we distance ourselves and look with an alien, intelligent eye, what do we see? In a highly complex arena of mental distress, where individual understanding must be key to

any success, a delegated manager electronically transmits abstracted judgements and decisions. He has spoken to neither the patient, nor either of the most involved practitioners, both of whom are highly experienced, competent and intelligent. He is addressing one of them now, but does not draw on their knowledge and experience of their work or the patient. His view is, rather, distilled from absent persons' computerised records, and then submitted to 'authoritative' patterns of generic recommendations (to which there must always be many exceptions). The role of this sequestered manager is not to engage in a mutually informative dialogue with those involved. Instead, he 'posts' a long, monologous electronic signal, with intent to instruct and command. A related image occurs to me: of an air traffic officer in a control tower. He is looking into a screen at symbolic representations of distant aircraft, to which he sends vectoring instructions. I have little doubt that this may be the best format for air traffic control. But electronically mediated remote control for mentally distressed humans? What kind of psychiatry does this lead to?

We have here sampled what is coming.

For many years I worked in and alongside mental health services where such formulaic management hardly existed, but intelligent colleagueal personal contact was abundant, welcome, even enjoyed. In all the places I worked, until recently, I witnessed the likes of Eric receiving flexible and humane care: schematic designation might have been comparatively meagre, but the human understanding and its quiet satisfactions much greater.

* * *

I have been striving to reconnect with – maybe even begin to regenerate – this older, more humanly-earthed professional culture. Due to my frustrations with this I contact you. But due to your business (I imagine) you delegate my request for dialogue to a trusted lieutenant, Dr Y. He, quite unintentionally (I believe) then rapidly re-enacts the bulk of my problems and discontent with NHS Institutions: he resorts to a device which short-circuits any personal contact, understanding or complexity: without further ado he transmits a didactic e-mail, defining reality to me, and for me. I don't mind this approach if I am enquiring about train times, but I want to talk about Eric. I am reminded of a Woody Allen aphorism: '*Confidence is what you have before you have understood the problem*'.

Dr Y's rapid acting-out of my critique amused me as an exquisitely timed though inadvertent parody; but it simultaneously dismayed me with further evidence of the ubiquity of the problem. Yet I have hope. Firstly, that you have read this long-journeyed and thought-marinated marathon letter with good attention. Then, most importantly, I hope that dialogue will be broadened and deepened, between us and beyond us. Lastly, I hope you do not answer this with a formulaic email!

David Zigmond, Principal GP, Bermondsey