

Our Post-Covid NHS:

whither our withered personal continuity of care?

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What is the value, and future, of personal continuity of healthcare? The current global Covid-19 pandemic has led, for now, to a near-total eclipse of these questions. But what will we see when this eclipse has passed?

A clinical vignette from 1978 is an ancient reminder of what, in all likelihood, we are losing.

Introduction

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At the time of writing the attention and efforts of the world's healthcare are almost entirely locked-on to epidemiology and public health systems: data; testing, tracing and tracking; logistics; triaging; quarantining by decree; formulaic intensive care (where possible)... Considerations or exchanges of personal meaning, narrative or experience have become, for now, irrelevant distractions to our survival-moded services. A storm-endangered boat has no time for its imperilled inhabitants' more obscure memories, meanings or affects. As in wartime, we must pare down to functional essentials.

Yet what may be essential to a wartime civic organisation and economy may not then be suited to our post-war Welfare. This truth seemed evident to the 1945 UK electorate when they mandated an Attlee rather than a Churchill government.

Why and how is this relevant to our current NHS? Well, our services are now, and rightly for now, thoroughly geared-up to a mixture of expert-hierarchy and systems mass-management, all facilitated by the rapid deployment and expansion of post-millennial IT and its social media. For example, the remote but instant and socially-distanced email, Zoom or smartphone video call in general practice has almost entirely replaced the (now) cumbersome, space-demanding, more virus-hazarded, face-to-face consultation sort with a known doctor – the familiar milieu of traditional personal continuity of care.

All this is, for now, certainly understandable and advisable. But what about the future? There are many who think that, in healthcare, the more automated and generic systems and the more IT, the better. In many ways this kind of thinking has gathered to dictate the cultural tide, throughout UK Welfare, for the last thirty years. Our Covid-crisis has merely – legitimately for now – accelerated this process. But we must beware: a heedless progression down this route will discard, probably irretrievably, much of value.

What is discarded? And what is its value?

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Last week I came across a long-forgotten, never-published article written forty-two years ago, in 1978. *One Man's Therapy is Another Man's Sickness. A Doctor's Dilemma* was written at the end of the first of my forty years as a GP Principal. I had already by then also worked in Psychiatry and Psychotherapy. The described interchange I had with Dorothy (not her real name) was fairly typical of the better consultations our more sophisticated (in my view) GPs and psychiatrists could then sometimes manage. The (hour) long interview I refer to was something I made readily available to interested patients, on request, for four decades.

The kinds of questions and understandings this previous eraed article pursues were, at that time, common fare for discussion among many of my peers and mentors. The then-influential – yet historically evanescent – Balint movement seemed, to me, the quintessence of this kind of personally-attuned, bespoke, continuity of care. There were other luminaries: Szasz, Laing and Illich – then current healthcare critics and

philosophers – excited much of our discussion. After the millennium these kind of discourses became increasingly rare among practitioners. Now, for many, they are probably redundant or incomprehensible.

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The long-term fate of Dorothy after 1978, and its possible relationship to the event then described, is worth an outlined retrospective view.

Dorothy continued, intermittently and opportunistically, her wish to talk with me about the kind of issues emerging in *One Man's Therapy is Another Man's Sickness* for many years. Sometimes this was a brief, yet significant, exchange while consulting about a more medically defined matter. Occasionally she would request a long appointment for more deliberated focus. This led to an excellent rapport with our practice counsellor. Importantly, the choice and initiative were always hers.

Remarkably, a little after 1978, Dorothy conceived and bore her only child, in her very late forties – even more remarkable then than now. Subsequently, through the many transitions and challenges from middle to old age, she would share with me, and my small-practice colleagues, her relatively benign health problems, predicaments and growing understandings.

Dorothy and her husband, Alf, settled into a seemingly quiet, affectionately ironic yet loyally appreciative and active old age. In 2014, when both were aged 82, Alf rapidly declined and died from a previously unsuspected malignancy. Dorothy bore her grief with loving, candid stoicism. Her own death three months later followed an

uncannily similar course: a kind of sweet tragedy of shock, serendipity and symmetry.

When Dorothy died, I felt a kind of gratified sadness that I came to recognise as a blessed windfall from such long, professionally-framed and exchanged intimacy. The influences and interweavings erstwhile GPs had with others' lives was rarely heroic, dramatic or magically brilliant, yet it was both humbling and immensely enriching through its very personal identifications and investments. This relic from 1978, for all its callowness, samples and celebrates that world.

I, certainly, as I face my own old age, both mourn and fear the loss of such roles and capacities from our national life: I would value that kind of professional human connection for myself.

One Man's Therapy is Another Man's Sickness

October 1978. Inner London General Practice

The old man departs slowly, clutching his expected prescription for winter bronchitis. I reach forward over my desk and press a button. It is a repeated, so now almost mindless conditioned, reflex. There is a harsh rasping noise in the waiting room, signalling to the fifteenth patient that I am ready for our brief encounter. I pick up the worn, overpacked envelope on the top of the pile. Faded ink writing tells me her name is Dorothy Newman, aged 46. The thickness of her folder shows me she has had much to complain about; I am hoping our meeting will be lighter than the weight of her records suggests.

Dorothy makes a rather timid and hesitant entrance to the consulting room. She stalls uncomfortably between door and chair in a way that conveys to me that she is frightened to make an approach and has doubts about her right to consult me. I am feeling rather tired

and punch-drunk from the day's collage of patients, phone calls and requests, but manage to raise a welcoming if patriarchal 'Come and sit down'.

My first images and impressions of Dorothy are those of neatness, order and acquiescence. She tiredly, yet anxiously, launches into an account of her migrainous headaches and episodic nausea. As one part of my mind listens to her story, as any doctor would do, the bulk of my attention is now focusing on the unconscious language of her body and the intonation of her voice. I imagine that many of my old medical school teachers would be uncomprehending of the way I have already decided that her problems are most unlikely to need further medical effort of a conventionally diagnostic or therapeutic kind. Immediately I am struck with the way Dorothy presents rather than what she actually presents with. While talking of her distress I see her mouth smiles fixedly in a kind of grimace. Her eyes reflect a hurt and sadness and her voice sags with the same kind of pained stoicism. Her arms and back are rigid and unmoving. The left hand is tightly curled in a fist around a handkerchief as if to make an encircled knot of concealed feeling. I imagine this hand as a physical metaphor of her mind; that her conscious and public self tightly surrounds and suppresses a very different secret self.

I ask some routine medical questions, more to structure my initial rapport with her than to initiate a new medical manoeuvre. I perceive the brief physical examination as another conventional ritual to establish a safe base. Through this she seems a little less tense and I sense that she may now wish, or be able, to change the language of our communication. The following dialogue evolves. It is similar to many I attempt, though more successful and succinct than some:

Dr I'm pretty sure that these are a return of migraine headaches, like you've been having for years. Your sickness, too, is the same sort of thing. I think it's your insides getting tightened up. Do you know why this happens to you?

Dorothy The other doctor says it just happens. He said some people are just prone.

Dr Hmm. I don't think anything "just happens". I don't have any better medicine for you, but if you could understand what is "just happening" to you, perhaps you could help yourself get rid of these symptoms. If you tell me a little about yourself we might get some clues as to why your body tightens up in this way.

Dorothy If you think it would help.

Dr I can never guarantee that, but it might. Perhaps what I notice about you might also help you to understand what is happening to you...

Dorothy Yes, often I get so anxious and caught in my own world that I don't know what I must look like to other people. Funny, that...

Dr We're all a bit like that. But I sense that you feel you always have to please people – I mean, even as you're talking to me of unpleasant and distressing things you smile, as if *you* are having to look after *me* ... but I imagine that under the smile you must feel quite different...

Dorothy Yes. Often I feel I could scream and shout and go berserk. But I never do. I'm really a very quiet person, doctor ... does that make any sense?

Dr Yes, it does. Well, I guess you're "really" both. The outside you is really quiet and the inside you is really screaming. They're both you ... we all have clashing bits in us...

Dorothy Oh, yes. But you can't go around just showing your strong feelings.

Dr I agree with that, not all the time anyway! But I imagine it's more of a problem than that. Perhaps the screaming inside you is because you store up so many feelings that the pressure becomes unbearable...

Dorothy Mm ... I don't believe in burdening people. People have their own problems. They don't really want to listen.

Dr Not even those closest to you?

Dorothy No, not really. I keep most of it inside, even with them.

Dr It seems to me that it's very necessary for you to control your feelings overmuch. Do you know what you would be afraid of if you didn't?

Dorothy People wouldn't stand it.

Dr Stand what?

Dorothy Oh, people wouldn't like me if they knew ... I mean, sometimes I think I'm really selfish and horrible, that if people knew what I was really like they wouldn't ... I don't know.

Dr You started off looking to me very angry and tense. I think you look sad now...

Dorothy I get frightened that I'm not good enough. I go around trying to be nice to people and please them but feeling all sort of angry or bitter at the same time.

Dr And the sadness?

Dorothy Sometimes I feel very lonely; cut off ... like nobody can understand. I'm like that even with John [her husband]. I don't think he'd understand anyway. He's very good to me

really, so I feel guilty about what I feel sometimes. I mean, I do love him so why should I feel like that? It's not fair on him ... or natural either.

Dr It seems that to be "fair" to people you have to deny a whole side of yourself which comes out anyway in your body, now in the form of sick headaches...

Dorothy It's funny you should say that... You're probably right because I've noticed that I get the headaches whenever I'm all churned up and hiding ... I feel better now just talking about it.

Dr I think that is an important point. That you feel better when you express yourself and worse when you hide yourself. Perhaps a deeper problem is your feeling that people won't be able to tolerate you being angry or needy. Do you have any idea of what made you like that?

Dorothy I think it must have started with my mother. She had a rare disease and was crippled. My father wasn't there so I had to look after her. I loved her, of course, but then sometimes I used to get, you know, bitter. But I couldn't do anything about it ... I mean it wouldn't have been fair to upset her, she had so much to cope with...

A longer interview I arranged that week confirmed what I thought and felt about her problems. Dorothy spent her childhood and adolescence anticipating and responding to her mother's needs and feelings but discounting and swallowing her own, and this has served as a kind of template from which all her later relationships have been modelled. Of course, such a pattern of passivity and self-effacement becomes strongly reinforced by her significant others who would probably describe her as 'a conscientious worker', 'such a *nice* woman', or 'a wonderful wife to John'. But the price for such outer charm and compliance is her inner and inverse impulse to rage and rebellion that she can only express by her incapacity and unconscious body language.

I do not regard Dorothy's symptoms as an illness that I can take away. Her migraine and nausea do not 'just happen'. They represent the tight, angry, scared, hurting part of her. Early in her life it seems that Doris had decided that such hurts and resentments must be borne inwardly. Her symptoms now are her clandestine signalling system indicating that all is not well in her life and relationships. Her conscious self may well decide that certain feelings can be denied, parried or 'got over', but at a deeper level her feelings will continue to operate, disturbing her sleep, her bodily functions or the equanimity of her persona. Her 'illness' then is not what she *has*, but what she *is*; an expression of something central to her, not the possession of something alien.

Dorothy is like many people, possibly the majority, who come to the doctor. What can I do for her or with her? I am sceptical about peddling her further or newer medical treatments. Her lengthy records attest to the impotence of such methods. If one hurting or tight part of her is suppressed by medicines it seems that another part continues the signalling. I am aware that most of the medical tools I have at my disposal derive from a model and ideology that believes in driving problems underground rather than bringing them to the surface where they may be shared, worked-through and outgrown.

Would a psychiatrist help her? I have my doubts. Psychiatrists generally seem at their most efficient in the containment and suppression of socially dangerous or embarrassing behaviour. That is hardly Dorothy's problem. On the contrary, I think Dorothy would probably lose her migraines and sickness if she allowed herself to be *more* socially dangerous or embarrassing. Yet if the psychiatrist has a (very common) medical bias he is likely to add to her passivity and faulty self-image by telling her that her problems are due to some sort of 'mental illness' that can only be countered by *his* correct and prescribed behaviour; giving him a 'full history' and showing reliability in further tablet-taking and hospital attendance: 'patient compliance'. All this, perversely, confirms her myth that she must go on fulfilling

others' expectations in order to find some peace or security. I know, too, that even psychodynamically- orientated psychiatrists can feed into this same system, albeit by more subtle and subliminal routes. Psychotherapy by prescription rather than request can, paradoxically, accentuate a person's feelings of passivity, helplessness and lack of identity. In spite of his few or soft words and interpretive skills the therapist may become yet another person defining Dorothy; in this case the 'expert' might 'know' her unconscious.

Dorothy's age and background are different from mine, but I empathise with her. I too have had the nausea and migraines as the inevitable penalty for 'keeping it all inside'. The differences are partly those of casting. I attempted to get patients to love me by the doomed endeavour of trying to be perfectly and ceaselessly accommodating, whereas she courts her husband and family with such sops. There are other important differences: she has a suggestibility and deference to doctors and other authority figures that I have struggled to abandon. She does not yet know about the subtle relativity and capriciousness of medicine and psychiatry. If I send her to a hospital two miles north, she is likely to be labelled as having an 'affective illness' and be given even more tablets. If she attends the clinic one mile east, she will be mysteriously engulfed into an intensive system of transference-based Kleinian-flavoured psychoanalytic psychotherapy. These patterns of practice reflect as much a diagnosis of the institutions as their patients.

The psychiatrists and physicians that she might see all have their own models, theories and skills. Most dangerously we are all liable to believe we are right. She is therefore unlikely to become aware of the alternatives if she consults any one doctor. I too have my predilections and convictions about the nature of such problems but I hope I am aware that they are *my* preferences and projections. It may be important for Dorothy to know that. Although I recognise it as an important pursuit, I have become wary of models that confidently vaunt an 'objective' or 'scientific' approach to emotional and behavioural problems; so often there is a hidden agenda or a covert ideology. I make an exception to this where there is the rare likelihood of treatable brain-disease or gross social disruption. My own training and outlook

have now been influenced by a wide variety of methods and techniques. So much of what I have learned has seemed a kind of wisdom or help when first encountered, but later I have seen it turned into a kind of therapeutic imperialism by the zeal of the helper who needs to be needed. I am aware of this possibility in myself and must constantly monitor it.

Dorothy's problem, as I see it, resonates both with my own experience and what I like to regard as my special skills; I must be wary not to use her for my own edification or advertisement.

While in my surgery I am a General Practitioner, not a psychotherapist. So competent execution of physical diagnosis and therapy is clearly and unarguably within my realm. But what about the kind of problem that Dorothy brings? Should I merely prescribe medicine to attempt symptomatic suppression? At the other extreme, should I try to change the kind of person that Dorothy is? In my view both of these have radical dangers. The first perpetuates and colludes with her assumption that she must remain confused, impotent, pained and dependent on doctors and people who 'know best' what is 'wrong with' her and what is 'good for' her. The second assumes that it is both possible and ethical to change Dorothy. That lies outside both the scope and nature of my (unspoken) contract with her. Even if I had the power to bring about such changes in her, it would be unethical without certain important precautions; her pattern of responses and defences may cause her distress, but it is also a *modus vivendum*, a way of belonging and being in the world with her family and intimates. Could I really foresee the kind of repercussions a change in Dorothy would have upon them? To effect such a change from my own convictions is probably more the nature of politics than therapy. It may be that the most I can do is to find a 'common language' that makes sense of her experience, both to her and to me.

So what do I convey to Dorothy in my later, long interview with her? I tell her that what I feed back to her is my perception. It is not 'true' or 'false' but may be more or less useful to her depending on how she feels about it. Some of what I say she may wish to swallow and assimilate. Some of what I offer will be alien and useless and she should not take it. I

indicate that I can only respond to her as I am with all my own preconceptions, biases and predilections. All doctors and therapists (and people!) are the same when dealing with the inner world of another; we are all driven by temperament which we rationalise by theory or ideology.

I discuss with her how I see different kinds of psychologists, therapists and psychiatrists going about their work of understanding and relieving distress; perhaps she will feel that she can find some help among them. I hope that she will see that there is no easy answer that can be guaranteed; a realisation that I have only achieved after much confusion, disillusionment, time and searching. Even if there were only one kind of understanding to her problems she would still find growth beyond her present impasse frightening and often tedious. Giving up old structures and patterns is as hard as the exploration and mastery of the new. I, too, know all this from personal experience. I do not elaborate on it with Dorothy, but I let her know. Is she ready or willing to explore these new avenues? The initial response seems favourable to me but only she can answer; it is essential that the initiative and definition comes from Dorothy herself. It is inevitable that each of us must journey through life and be confronted with our own impasses, conflicts and dilemmas. Whether we remain stuck or grow beyond areas of pain and difficulty is for each of us to determine. Which Dorothy does is not my responsibility though it does arouse my compassion and concern. The decision is hers and I can only enlighten and help it with the resources I have to offer. Therapy may be good medicine to take, but it is often bad medicine to give, for the giving may be more for the donor than the recipient.

I wish her bon voyage. It is her journey, but she may need some help along the way. If my work – my contact with her – can facilitate that, then I am well pleased.

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