Introduction

This anthology covers many writings from my first forty-five years in medical practice. It is intended to be the first of a series: other volumes will follow at similar intervals.

The long period covered is reflected in the length of the book. This may be problematic and I have considered several options – for example, a much briefer selection, or a division of volumes by assigning eras or categories. But such easier accessibility incurs losses: not only the *Gestalt* of the evolution of ideas, but also the interconnectedness of expanding and propagating perspectives: *Holism*. For the patient reader, therefore, I hope this large whole will bring more than the sum of its many parts.

But other readers have many different preferences and proclivities. I accept that many may wish for shorter works with less elaborate framing. For them I have divided this long anthology into three separate books: *The Psychoecology of Gladys Parlett, From Family to Factory* and *Bureaucratyrannohypoxia*.

For those who choose this longer compendium, you may sense that it was very carefully written, but lumpily gestated, in clusters of activity, over many years. It is probably best read in a similar manner. Only a reader of exceptional stamina and resolve will attempt to ingest it in a steady, linear fashion. Instead, I suggest approaching it as a *Meze*: a large, varied platter to be sampled, savoured, contemplated and enjoyed according to the reader's changing inclination and appetite. To guide the reader's choices I have employed devices which I explain later.

From the beginning of my medical work I have always had interests beyond the biomechanical. Fifty years ago I thought this hinterland was often unwisely disregarded: this is even more so now. My long explorations of this

hinterland have invoked a medley of heart, soul, relationships, intuition, semiotics, imagination, intellect (philosophical *v* pragmatic intelligence) and meaning. Many would name this medley 'holism', but I am wary: I do not want to differentiate or offer yet another brand or package. Yet, whatever we call these things, they are substantial – if elusive – essences of our humanity. Throughout my writings I argue that our incorporation of such essences into our many practical tasks constitutes the imperilled *art* of Medicine. I wish to explore with you, too, two important primary principles. Firstly, how these elements – of humanity, art and healing – are not themselves directly measurable or manageable. Secondly, and consequently, we can never successfully proceduralise or industrialise them. Later articles consider how the attempt to do so leads to perverse results.

My **Acknowledgements** are many, and I have separately sectioned these.

The number and variety of articles is now very large. This can seem confusing and overwhelming. To mitigate this I have dated the articles and written a very brief synopsis of each. These are found in the **Contents** section.

To break up the great steppes of text I have introduced pictures to refresh, contrast, amplify, parody, clarify or puzzle. To encourage the mind to retrace and linger, I have used the journalistic device of highlighting evocative or seminal passages.

The sequence of writings is mostly chronological: the exceptions are explained. To further aid navigation and digestibility I have divided the anthology into three sections.

Section One is titled *What can go right*. I start by exploring the limits of the biomechanical approach, and then the very different skills and perspectives we may develop to offset these limits.

The earlier writings in this section are from another era and were written for then respectable, now deceased, mainline medical journals. They have a formality and quaint courteous style that I later abandoned. Those with an interest in history, anthropology or archaeology will find here a trove of recorded relics: Doctors' White Coats, Residents' Messes, Physician Superintendents, Mental Hospitals and babies home-delivered by GPs: the curious reader will find more. Can writing from this very different era now be seriously relevant? Indeed: I think that these earlier articles contain messages and challenges that are now even more urgent. Also remarkable and very pertinent is this: equivalent mainstream journals now would not publish such articles: the writing would be deemed to have inadequate data, evidence basis and academic references. Is such strictness of convention progress? I leave that question with the reader.

I open Section One with an **Overture**: *All is Therapy: All is Diagnosis*. This is a very recent article and I have deliberately placed it to immediately precede the earliest in this anthology. Such juxtaposition of the two ends of a professional lifetime's writing – separated by nearly forty years – highlights not just individual change, but social ones, too. The chosen contemporary article – the herald to its ancestors – is itself a kind of viewing-platform for history: it describes three episodes from my own sixty-year experiences with doctors – as a child in the 1950s, being a doctor now, and going to the doctor now, for my own healthchecks. These autobiographical vignettes thus serve as historical snapshots: they sample, at different places and times, what is happening to human relationships and meaning in healthcare. Section One offers many other engagements with these Leitmotifs.

Intermezzo is not primarily about healthcare but a brief encounter with some of our richer human complexity: often such are decisive but unspoken aspects of our fate. Shimmering chimera are often vital subtexts to our health, yet our

schematised healthcare has become increasingly illiterate of such subtext. This growing discrepancy is addressed in later writings.

Section Two is titled *What has gone wrong*. Round about the Millennium I had a belated awakening: I slowly discerned the institutional changes that were gathering throughout our Welfare services, and then the depersonalising consequences. In many ways this depersonalisation can be seen as what happens when we attempt to short-circuit or eschew certain kinds of understanding. What are these? They are for the same kinds of human variety and complexity that are poorly served by biomechanics and quantifiable science – the kinds of understanding I was developing as a younger practitioner: Section One of this anthology.

Section One thus starts by considering healthcare blessings we may confer on one another if we develop our capacities for resonance, imagination and creative tolerance of ambiguity. Section Two then describes the curses we unleash if we neglect or proscribe these capacities.

These later, post-Millennium, essays can also be seen as broader profiles: of what can go wrong in technologically advanced societies when we do not know how and when to constrain manipulative and managerial thinking, language and activity.

Even in the one decade these later articles were written, computer use has increased massively. Section Two surveys not only the burgeoning follies that come from attempts to industrialise and commodify healthcare; I also wish to portray how these are fuelled and amplified by insentient computer use. I believe this has accreted to perilous proportions, yet remains little discussed. For this reason I have used a later article – *Where in the World are You?* – to introduce the otherwise time-ordered pieces collaging our many guises of unintended human disconnection.

Section Three carries the mission and title of *What we may do*: my missives to newspapers, journals, politicians and colleagues. These sample recent efforts to galvanise and broaden thought and debate. Generally the letters to colleagues are longer and more detailed. Those to newspapers are necessarily brief, pithy and skeletal. The long submission to the Health Secretary – *Five Executive Follies* – serves as both an extended critique and then summary of the problems of the 3Cs in healthcare: Competition, Commissioning and Commodification.

Sections Two and Three thus have much description and analysis of the difficult relationship between individuals and institutions. I have therefore had to use some technical and institutional terms, though I have tried to reduce these to a minimum. To further aid the reader there is a **Glossary** of key terms.

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The **style of writing and format** require some introductory comment.

My longer articles and letters often include stories or descriptions of events to illustrate, clarify or reify theory. I believe this kind of interpersonal 'biopsy' can be much more effective than its conventional scarcity would suggest. Human experience is primary; theories and systems, however effective they might be, are secondary and artefactual. In our increasingly virtual world we are apt to forget this important principle. My narratives may be a reminder.

Personal identifications are disguised, but the stories, descriptions and dialogues are as accurate as this human can make them.

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Lastly some **notes about language**. Firstly a minor point. I tend to use a generic 'he', rather than the now almost conventional 'he/she' as the latter looks/sounds cumbersome/ugly, to me.

Secondly, a more major point, for me: I like rich, polyvalent, carefully expressive language, as this not only communicates complex realities better, it makes it more possible for us to perceive them. Restricted and impoverished language does the reverse. The *science* of medicine can function with a plain, if arcane, prosaic vocabulary: the *art* of medicine needs always to expand this. My language therefore aspires to both the poetic and precise. In an amply humanised healthcare we need wide, connected spans of mental life and language.

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