All is Therapy; All is Diagnosis

Unmapped and perishing latitudes of healthcare

David Zigmond

Advances in medical science have steadily made biomechanical diagnoses and treatments more precise and effective. But this has been achieved, often, by a narrowing of focus so that much human context and meaning becomes unperceived and unconceived. Authentic vignettes from the author's experience – over several decades – illustrate the process and consequences.

'*You don't really understand human nature unless you know why a child on a merry-go-round will wave at its parents every time around – and why the parents will always wave back.'*

Bill Tammeus, American Journalist (1945-)

1950s. Richness in austerity

The austerity Britain of my childhood sighed wearily: a murky, exhausted wake from the long convulsions of World War II. My surrounding childhood world drew breath amidst a wary stability and peace: many grieved and more were haunted. Less obvious were the wordlessly yet powerfully disturbed: the guilt of the survivors, the partially-sighted resentments of those who sensed infidelities in their absence. My parents – resourceful and uncomplaining people – had their more particular trials and sorrows: my father for a late-war injury which crippled his mobility (and possibly his male self-esteem) for his remaining decades; my mother, much earlier, from her mortally-shattered family who all perished (from 'natural' causes) in her childhood, exposing her as an orphan to the perils of a Depression-ravaged inter-War Britain.

Doctors Paul and Margaret, I think, rapidly sensed and apprised such things even before they knew much of the detail. I remember, as a small boy, feeling protected by their discrete warmth, knowledge and kindness.

Doctors Paul and Margaret were a married couple, our near-neighbours, and together ran a small General Practice from their home. Margaret's consulting room was next to the reception and waiting area. To see Paul we took a few steps outside to a converted garage, where he sat at a handsomely plain and robust oak desk – utility furniture that had served in their thousands throughout the War. The house's domestic hinterland became familiar to me, too: my parents became friendly with Paul and Margaret, I became part of a street-gaggle with their sons.

This interweaving of professional-vocational-locality-domestic-family was, I think, typical of much life – and General Practice – of the time. Amongst better practitioners it led to an unselfconscious integration, an innominate

holism, well before common attempts were made to distil, commodify or brand such notions. I think now that Paul and Margaret had a natural understanding – a sense and sensibility – of the unspoken spectres and meanings behind the presented distress or anxiety. Amidst my mists of memory I cannot define clearly the exact times or childhood decisions that led to my later vocations. Yet I think these early experiences, of this couple's benign aura, had a strong inductive influence: even then my innocently receptive eye and mind somehow discerned what I could formulate only much later: that their converged knowledge of the personal and the impersonal could contain, comfort and heal. My early proclivity to such understanding was born of intuition: the vocabulary of scholarship, to describe or explain, would take many more years.

2010s. A small Practice: a bridged island

'The All is alive' – Thales of Miletus (624-527 BC)

Pam knocks gently, knowing my signs of incipient late afternoon gruff fatigue. Her entrance is welcome: she comes revitalising me with hot tea. Pam has been afternoon receptionist in our small practice for a decade. Her middle age experience and deportment are sparkled by youthful gleams and warmly ironic humour. I greet and test her with a long moan of mock-theatrical self-pity conveying the suffering I so self-effacingly endure for others: I, a broken, groaning dying soldier on the carnaged Crimean battlefield; she, the consoling, saintly Florence Nightingale, The Lady with the Tea. Pam's smile is complex: amusement, commiseration, contrition, teasing tolerance and palliation. I do not need to say much: she understands my need for bantered, boundaried, fleeting tenderness. She heals me a little: it has been a long and difficult day. Her tea and resonance may be almost wordless, but they are powerful: like a life-affirming force-field these help contain and sustain me. Such is well-fared welfare; a benign relay – now I am restored to do the same for others.

Pam waits a few seconds for the first signs of my revival, then refreshed attention. Her expression has solemned and now conveys earnest request.

'What now?!' I ask, part question, part peremptory and pre-emptive retort. 'I thought you'd come just to refuel me … It's been a really difficult day.' I add, now more sharply, to scotch any further demands.

'It's Ruby…' Pam persists: she is kind to me, but resilient too. 'I think you should see her today … I've said you will and asked her to wait: she initially didn't want to, but now she will…'

My exasperation is tinged with hostility; I sigh conspicuously: 'But why today, of all days?!' more a warning than a question.

Pam is unerringly calm: 'Because she looks terrible … she's never been right since Robert (her husband) died so quickly of that cancer, just after Christmas … she's always been quiet and shy, but now she's really gone into herself … She comes regularly, every month, for her usual prescriptions. Before she'd chat a little, but now she hardly looks at us … and today I was quite shocked: she's not just withdrawn – she looks really ill: pale and frail … She's all on her own and hates asking for help … Yes, I think you should see her today, while she's here…'

In this small practice people's faces, voices and stories are seen, remembered and recognised. Receptionists accrue percipient and vernacular understandings of patients and their lives. So when longer and good bonds evolve, so do dialogues rich in personal investment.

While doctors' interchanges often segue rapidly to the technical, the task-focused and the managerial, the receptionist's encounters may linger more freely and naturally.

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Pam is right.

She ushers Ruby in with patient and tender vigilance. Ruby is weak, pale, sallow and almost extinguished of life-spirit. She crosses the room as if

impeded by a dense and invisible gas. Despite this torpor she manages her usual self-abnegation – now it is almost inaudible: 'I did ask Pam not to bother you, doctor … I know you've got a lot to do…' Her voice is enfeebled and leaden, her gaze unfocused, dull and lifeless. She is short of breath.

Soon after I am technically categorising and recording. 'Severe Reactive Depression/Impacted Grief. Probably Anaemia. ? GI bleeding ? Self-neglect and diet ? Other. Mild Heart Failure.' The medical train is on its tracks. It might not have been if Pam had not looked and thought and cared as she does. Much does not conveniently present as we wish: I must value and protect my receptionists as my social antennae.

I am wondering, too, how could Pam have made this bond of affectionate observation in a now commoner and much larger practice, with its airport-like forms of human processing and (dis)connection? There, I might get home sooner; but what would happen to Ruby?

2010s. A larger Practice: impoverishment in plenty

'Seek knowledge, even if it be in China' – Muhammad

Soon after the new Millennium I sensed my mortality more sharply. I submitted to conventional sense and decided to register with a GP. I, too, will eventually need more than easy (self) prescription for transient complaints: age begins to perish our seals of denial.

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I sought and found a small single-handed Practice with a trail of good repute. Dr F was a likeable, courteous, thoughtful Frenchman; laconic humour spiced an understated compassion. I did not see him much, but each time I did I sensed a growth of joint interest, memory and understanding. Five years ago I was sorrowed by what he told me: he was leaving his work in the NHS and his life in the UK. He had become increasingly frustrated and demoralised by the progressive loss of personal satisfactions, meaning and connections in his work.

He was emigrating to mainland China, to work as a Family Doctor, to reclaim an ethos, a modus vivendum, he increasingly missed. I think my expression signalled perplexity or incredulity, for he rapidly offered bridging explanations: his wife is Chinese, he had spent years learning the language.

I had not needed him much but had sensed a deep affinity, were I to need to need him. I felt a gentle pang of sadness; I was grieving for a receding attachment I had never really tested, but which I felt had been quietly there.

We shared a warmly farewelling handshake. I briefly thanked him for his friendly and competent contacts with me; I would be sad not to see him again. His look shared this light, sweet flutter of melancholy and he nodded to signal his confluence: 'Of course, there are many people I shall miss, but I think you understand why I am leaving…'

I did and I do.

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In more recent times my awareness of my blessings has become both stouter and more tremorous: my gratitude for my particular good health is reluctantly laced with a darkening sorrow: for our universal transience – our eventual and inevitable fragility and extinction. I try to be pragmatic; I can offset this a little. I will submit to the nationally vaunted programmes to monitor and control physical risk-factors: horizoned Black Riders of mortality.

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I attend this re-staffed and managed health centre. A young desultorily expressioned receptionist is looking fixedly at a display on a computer screen. I softly cough to signal my presence, but she is a receptionist who is not receptive. Aware of my waiting presence she attempts to rapidly offload me: 'Over there. Check-in is with the computer', she jerks her head to indicate its direction, keeping unbroken contact with her own computer task.

The computer interrogates and briefs me with brief staccato instructions. When satisfied with my identity and appointment it emits a soft chiming sound to tell me that I am temporarily dismissed and where to go while awaiting further instructions.

I sit in a waiting area that has rows of stackable plastic chairs all facing a wall in which there is a large viewing hatch beyond which the (non) reception staff sit. Above the hatch is a horizontally long, thin, electronic screen across which an endless procession of bannered messages loop to inform, mollify, instruct or warn: 'Feeling down? Find out about our Counselling Services … Problems with alcohol consumption? … Are you at risk of HIV? Other sexually transmitted disease? … Has your child had its MMR vaccinations? … Stopping smoking will be the one decision you'll never regret … One consultation is for one patient with one problem …None of our staff will tolerate any form of rudeness, threat or aggression of any kind. Offending patients are immediately removed from our list …'. I am aware of the insidious, silent hegemony of such devices; legal civilian nerve-gases to secure compliance and docility.

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There is a louder, sharper chime, to alert attention. Eyes are raised to the screen to be briefed and instructed. My name appears alongside which consulting room I should go to.

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I am seeing the Practice Nurse for some routine blood tests. I have never seen her before. She is looking at a computer as I enter the room, I think to brief her about my 'personal' data. 'Good morning', I say, cheerily, I think. She makes a brief, low, rear-throat sound in acknowledgement. This is wordless and her attention remains with her screen. 'I don't have a request form, but I have come for blood tests: Renal-function, Lipid Profile, Uric Acid and HbAIC'. I say this overtly to inform, but I also have my curiosity about her curiosity, or

lack of it: will she enquire about my likely knowledge of such things, and the source of it? She does not.

Instead, without looking, she hurls a question across the room. The question is imperative, stark and unredefinable. The voice is loud, rhetorical and with the guttural, gravelly menace that only impatiently direct Ulster citizens can convey to otherwise benign utterances. 'WHICH ARM?' is the sudden and unframed question. My unprepared then panicked perception back-somersaults to somewhere in the late-1970s' Northern Ireland: I think I am going to be taken out and shot.

I wince briefly, offer my exposed left arm and then regain sufficient composure to have bland but cordial contact with Nurse Q. As my blood flows I become quietly amused by my images: historical memory-shards, relics of harboured hatreds. Now rapidly recovered I ask whether she is from Northern Ireland. Yes, she says, she was brought up and trained in Londonderry, but her secondary home and family have been here, in London, for many years.

She does not ask me about my probable medical knowledge, or anything else about me. She smiles, as if into a mist, when I leave.

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I phone the surgery to make an appointment to see the new (for me) GP to discuss my blood tests. I am put on hold while waiting to speak to a receptionist. This administrative hiatus is filled by an expedient plug by and for the practice: a softly, even seductively, authoritative female robotic voice begins to inform me of extra clinics and services that may be offered by the practice, which services can be competently dealt with by Nursing Staff, and what to do about Out of Hours requirements. In these two minutes I have not yet heard threats or ultimata to the deviants or misbehaved: I am relieved. Another voice cuts in: the real voice of a live Receptionist. I make my requests clear, succinct and practical and follow these with some questions about the new order: she replies in kind. 'Dr NP (the new Principal) has expanded the

practice and is very busy, so it's easier for you to see one of the part-time Assistants. I'll book you to see Dr A: she's very nice…'

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I come to see Dr A. I do not now expect anyone to recognise or greet me in the practice beforehand. The computer and I, now better acquainted, perform our brief chimed procedure and I go to the waiting area to discern my name from the bannered attempts to crop-spray my mind and conduct.

A more commanding chime now beckons my encounter with Dr A. As I enter she turns a brief, warm but tiredly unfocused smile toward me with a simultaneous 'Hello'. She signals to a chair at the corner of her flimsily veneered, already chipped, new desk before turning away again, back to the computer: the anchor-post for her consultation-consciousness. As she is scrolling down my laboratory results, I can see my non-medical details which remain constant at the top of the changing screen contents. My name is preceded by 'Doctor'.

She turns back to me and offers another jading smile. She asks me how I am: I sense this is mostly a courtesy, but also to ensure I do not have another major agenda before she can start on the one she has decided. I do not have one, so now she is free to quickly move us both onto the problem she has identified and dissected.

'Well, I've looked at your recent blood tests … they're all fine except your sugar, so that's one we have to talk about, because officially you're now a diabetic…'

She goes on to automatically convey structured questions, information and advice about my diet, lifestyle, monitoring regimes and possible future medications. This, I can see, is a generic didactic package she applies to all mild diabetic-risk patients. She has been professionally mannered and clear in her delivery: but it is a delivery and not a dialogue. Fascinatingly (for me) she has learned nothing about me as a person: what kind of life and relationships

I have had, what I hope for, what I fear, what brings me joy, what brings me dread – what is likely to sicken me, what to heal me.

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Yet within her frame she is a competent didactic teacher, her messages are well-rehearsed and well formed. She pauses to see if I understand: I do. I am thoroughly cognisant of what she is telling me: imaginative observation would quickly indicate this. At the end of this auto-piloted freight run she slows a little to tie up this parcel with a faintly simpered, liberal, school-mistress voice: 'Well, I think that's as much as we need to say today – quite a lot, isn't it? – is that ok?' This is a statement and prescription from her, not really a question for me. She tilts her head a little while beaming an unknowing yet coquettish smile: her sweetening and concealment of control is the outer packaging.

She never asks about me being a doctor, and I (partly now for experimental reasons) do not tell her. She shows no curiosity about my personal or occupational life. Dr A acts a role of the agreeably impersonal: I think that she does not know that she does not know me – and can then proceed with her job as if this is of no consequence to either of us.

At present this is, arguably, enough: I do not yet have the kind of dis-ease, disease, dependence or infirmity which requires the kind of personal understandings that can contain, comfort and heal. If I live long enough, I will.

Yes, Dr A's advice is sound, and her prescribed medications far more precise and powerful than anything that was available to my 1950s doctors. Yes *treatment* is usually much better, but what about *care*? Here there is no such commensurate progress, often the reverse. I know that when my health and life begin to ineluctably unravel, like Ruby, I will want *personal* and personal-*continuity* of care from practitioners with that ethos and vocation: people like Doctors Paul and Margaret.

But in a healthcare world increasingly designed, commissioned, commodified, commercialised and managed by others very different from them, and remote from me, how is this possible? What, instead, will happen?

The portents are already visible, if only we will look.

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Healthcare is a humanity guided by science.

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'*The danger of the past was that men became slaves. The danger of the future is that men become robots.*' – Erich Fromm, *The Sane Society*, 1955