

**Missed and Miscommunications:
Personal disconnections in Psychological
Healthcare**

A letter for embattled colleagues

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Throughout our most important, difficult and intimate relationships we must be able to listen carefully to what we do not want to hear – without this much is jeopardised. This is true, too, in many of our healing encounters – often these require our best attempts to creatively contain dissonance.

Introduction

Healthcare as an ethos of personally wellfared (well fared) networks is being rapidly displaced by healthcare as a managed jigsaw of procedural activities. Healthcare communication follows suit and becomes reduced to varieties of data-exchange or instruction. Freer forms of dialogue become impoverished, often discouraged: many kinds of creative and healing opportunities are lost. This, of course, can be deleterious to patient care. What is less frequently scrutinised is the injury all this may cause to practitioners' morale and relationships. This narratively framed letter shows what has happened.

Prologue: The tale and the dilemma

The letter at the centre of this article was written to a fractious colleague in response to a chain of events that symptomatise the commonplace in current NHS Healthcare: such has become a new blight on the quality of care for patients, and the morale and culture of humanly meaningful connection between practitioners.

To make sense of the letter, it is necessary to set the stage and stage the sets.

My own stage is a small inner-city General Practice, my professional home for thirty-five years. For twenty years I worked together with a succession of practice-based Counsellors and Psychologists to provide prompt, bespoke and responsive psychological healthcare. This was a quietly seamless service that naturally expressed much informal feedback of good experience, longer-term benefit and personal appreciation. These were frequently evident between professionals as well as patients. Measurement and statistics were then not attempted or even considered: this small practice knew its patients well and any failure to engage with, or benefit from, what was offered could be easily recognised and (usually) understood. Such was this quiet, low-key patient-centred service. With rare exceptions, it was addressed with a discrete respect and affection by staff and patients alike.

A few years ago plans were mooted to industrialise, standardise and collectivise such psychological healthcare. The new generation of Services

would be delivered by unifying diagnostic criteria, facilitated by extensive and intensive questionnaires and psychometry – hence would come diagnostic accuracy, quantitative research and future funding. Standardised training would be increased to replace variformity seen as unpredictable, possibly hazardous.

As I heard of these plans I felt disquiet: I feared the loss of personal bonds, vernacular understanding and imaginative dialogue as a basis of psychological healing. In my mind's ear I heard the trampling of all this by the march of a new cadre of clamorous scientism. The beckoning talk was of *Brave New World*, but I heard 1984. The actual year of my first premonitions was 2004.

Eight years later I am struggling to retain my ethos and territory for personal continuity of care. While government slogans talk of individual choice and respect, my experiences and communications are increasingly those of centralised control and depersonalised, corporate hegemony. I joke of being a reincarnated kulak trying to survive the USSR's Farm Collectivisation Programme: my banter thinly veils my dread.

Over the next few years I try to alert various planners, managers and practitioners to my prophecy. Their responses range from hostile avoidance to courteous commiseration – I never manage to incite substantial revolt among the reformers. My predictions prove accurate; an unconsoling endorsement of my judgement. There is subsequently evidence aplenty of the mounting loss of therapeutic personal connection and understanding. As procedures, documentation and waiting times become longer, I hear of patients increasingly never attending, dropping out and describing didactically structured sessions that had little personal meaning for them. Interestingly, such inconvenient truths are often 'lost' in published data. In previous times such dislocations were comparatively rare, but would be discussed with intelligent and easy informality between colleagues. Not now.

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Onto this stage Eddie steps with apologetic hesitancy. Eddie is in his early 60s, his physical frame is hobbled by the arthritic ravages from many decades as a road-worker, his attire is of drab poverty, his mien of a hard life in which he had to appease others. His tousled hair is darkened-white but it frames a surprisingly young face with a sad, soft beseeching gaze.

Previously my encounters with Eddie had been courteous but impersonal in their scope and content. Eddie now has booked himself a Long Appointment with me: I realise he has something unprecedented and important to share. He does: he tells me of distressing reawakenings of mostly forgotten ancient memories, from his childhood. The trigger for this was a recent visit to a hospital: while limping slowly up a long corridor he had a sudden shock of recognition – an area where he was sternly instructed to wait. It was 1955. In the adjacent ward his much loved but little known father lay dying.

The story Eddie reels in from his flashback is complex, unusual, poignant and tragic in its consequences. I now understand more of his restricted life – his leaving school at thirteen, his lifelong self-doubt and self-deprecation, his difficulty in making confident friendships, his fear of wanting love from a woman. I had sensed this in his gaze before: now I see the hinterland.

Eddie's sensitivity far exceeds his vocabulary. He will need much imaginative guided support to enable him to reclaim his remaining and limited life. I need much help, to help him to do this. I contact Psychological Services in writing, giving them a pithy but full outline of the therapeutic challenge and asking them to contact me for fuller discussion. They do not do this: instead, without other contact, they send him a fat envelope filled with long, detailed questionnaires to 'objectively' define his problem, diagnosis and its severity. There are numerous other prolix documents informing him of the administrative nature and duties of the service, its complaints procedure, and what he should do if he feels suicidal. Eddie is semi-literate and has only just begun speaking personally, for the first time in his life. He feels intimidated, exposed and ashamed by the contents of the envelope: he comes to see me – tremulous, tearful and afraid of reprimand – for protected safety of passage. With difficulty I eventually manage to make phone contact with the C-in-C at HQ.

The centralised Manager for Psychological Services now agrees to speak to me directly, and I outline what has happened. I am sharp in my insistence that Eddie should not be required to provide them with intrusive and unnecessary (for him) data before he is personally engaged.

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Eddie's eventual session with Sam, the Psychologist, was thus much primed and expedited by me. Two weeks later Eddie describes, in his limited words, a benign encounter with Sam. But Eddie's encouragement from Sam did not endure the length of their session, for Eddie was told he would henceforth be sent to the Snowden Centre, for possible group therapy. He would be put on a waiting list, and they would send him an appointment for their own assessment. Eddie has spent his life waiting for others and appeasing them: his faltering courage in finding his voice for the first time in his life is fragile – I fear its casual extinction.

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Three weeks later Eddie tells me has heard nothing from the Snowden Centre. I had suggested he call them to enquire, but they had not responded to his Ansafoone request. He describes all this with a kind of dejected fatalism while looking down and away from me. Again, I fear losing his fragile hope and connection.

Clearly, I have been unsuccessful in getting Psychological Services to provide Eddie with the timely, personally responsive guided support I think he needs. I will try to engage and enlist Sam, to see if he can exert some leverage within his own organisation.

Such attempts at judicious transmitted influence have become much more difficult within the current NHS. Healthcare workers now understand and frame their work according to prescribed schedules, protocols and contracts: these are monitored by managers, who are themselves answerable to their

employing Trusts. Sam seems, to me, a likeable and diligent man, but in many ways a product of this sequestered healthcare. Tellingly, unlike my colleagues from less managed times, I have been unable to get to know him well.

I try, with polite firmness, to tell Sam of the likely damage to Eddie of avoidable uncertainties, delays or interruption in this initial and fragile therapeutic engagement and containment: Eddie's (probably) once-in-a-lifetime opportunity.

Despite what I thought was a friendly and courteous start, Sam rapidly flares. His voice sharpens and rises to warn me off – I have become an intruder and a trespasser. What is, for me, the pursuit of holistic personal care seems, for Sam, an alien threat or interference. My attempt to expand dialogue is angrily cut off.

What to do? Advance or retreat?

What would you do, reader?

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I retreated awhile. I thought for several weeks and then wrote this letter*.

Herewith:

The letter

Dear Colleague

Missed and Miscommunications: Psychological Services and Primary Care

My long delay in composing this long letter already presages much of its message.

After our recent ensnared communications, I have needed much time to reflect. I think the precipitated problems are of a new kind, increasing and extending far

beyond either of us: the complexity and importance of all this merits much thought. My multilayered response follows, and with it the letter's length and long incubation. I hope you will read it in kind.

I am writing to you, first, to apologise and conciliate. Later, if you are interested, I offer an extended view of the background: the healthcare 'stage' on which all this is acted out. For our difficulties also represent broader cultural and historical currents: a *Zeitgeist*. Our missed and miscommunications are thus not just a private matter. They are also microequivalents, harbingers and echoes of much larger-scale dissonances and difficulties in which we are all now immersed. Culturally these are important, yet – *because* they are cultural – often avoided. Such wider relevance presents a fruitful opportunity to share this tale and conundrum: I want to raise the level of awareness and creative debate. I am therefore conveying this letter to other professionals I think may be interested.

Depersonalised institutions; frayed communications

But first my attention to you: I am sorry that you have been upset by any of my communications. As you know, interprofessional personal contacts are now sparser and less collegial than I am used to: I think this is both a symptom and cause – in part, at least – of our mounting difficulties. These I was first unaware of, then surprised by.

To reel back: when I last phoned you, a few weeks ago, I was calling for a friendly 'Hello' and, possibly, to briefly talk about problematic patient waiting/induction times, both generally and specifically at the Snowden Clinic: I was fearful that a distressed and disconsolate man was lost in an ever more complex and remote system. This has become a widespread problem in the current care of the mentally distressed. Regarding this, I do not – and have never – considered you personally responsible for any of these larger administratively obstructive shibboleths or dislocations: we are all in this together, and these frustrations will need our communal recognition and understanding. In our conversation, you indicated (mostly indirectly, I thought) your experience and feelings of being harassed and criticised by me: I attempted to reassure that any described discontents (from either patients or myself) are *not* personal: they are most often complexly cultural and institutional. Yet I had little forewarning of the strength of your reaction, so my attempt to reassure you was – I think – mistimed and ineffectual. I am certainly sorry if you have felt personally attacked or derogated. I have always intended, instead, to carefully focus expressions of vigilance or

dissent. It is important to reiterate that these almost always address complex institutionalised healthcare tangles: yet clearly, if these are not discerned, they can compromise our best individual endeavours and working relationships: our milieu becomes us.

Despite these now ubiquitous frustrations, I want to acknowledge with you my respect for your diligent and caring work, and the good energy and intent you bring to it. I am sorry if you have felt personally sullied in my attempts to a broader critique. If so, then I may have failed to clarify this important distinction: for that I am sorry.

Disjunctive professionals: disconnected patients

(i) *Macrocosm*

I here want to broaden the picture: it is important to me that you understand some of my difficulties, too. For the professional dilemmas I face behind all this are difficult and, for the kind of practitioner I am, inescapable. Throughout a long working lifetime I have striven to plant and nourish convivial, appreciative and respectful relationships with my many and varied NHS colleagues. Until very recently I did this – for several decades – with much pleasure and very few exceptions. The principles and practice guiding my ethos have been of holistic and personal continuity of care, and these were rarely stymied by any greater managerial or industrial design. All this has rapidly changed: my ethos and working eco-systems are now often obviously countermanded. An easily-accessed and friendly colleagueial network has become fragmented into boundaried, often defensive and competitive shards – usually hermetically managed, only open to formal diplomatic channels.

I am aware of a grim personal paradox: the best kind of individually attuned and invested care – which enlightened and warmed me as a young practitioner, and which I will cleave to til the end of my working days – is most unlikely to be offered to me when I am older and vulnerable. This current tendency, to hierarchically obedient and generically schematised healthcare, has unwittingly degraded and impoverished many subtle and humanising blessings. In previous decades these came with styles of care that value quality and continuity of personal contact, when possible, as central to our most therapeutic influence. We have a sharp contrast to this now: our increasing thralldom to fissioning Trusts, administratively based Specialties, committee-designated care pathways and algorithms – and from all these the mind-asphyxiating, grudgingly-glanced

galaxies of administrative documentation – these are some of the (inadvertent) generators of our growing healthcare malaise and anomie.

Your employer, IAPTS*, though a relatively new device of psychoadministration, runs similar risks to many other (inadvertent) victims and perpetrators of this over-schematised healthcare alienation. IAPTS is among many others I witness, and attempt to counter with shared mindfulness. Examples from the broader NHS stage: the designed demise of smaller, more personal GP practices; the extinction of the General Physician; the abolition of GP personal patient lists; the dispersal of Hospital Nursing Schools training to Universities; the electronic devices to parry human contact or enquiry; the division of psychological and psychiatric services into multiple, bounded medical-type teams. All of these have (inadvertently) led to a destruction of personal types of contact, knowledge and understanding.

The cumulative effects of these have brought me mounting dismay. In my areas of interest (General Practice, Psychiatry and Psychology) these seem most grievous. Most of my thoughtful peers have agreed with me, but have taken earliest retirement; fatigued and dispirited from the dehumanised forced-march. I have chosen to be (am?) more wilfully and obstinately engaged and outspoken. Interestingly, some of my old cohorts, now in the safer shadows, off the stage, watch me and have become regretfully emboldened: 'I now wish I'd stayed and fought ... but then, I felt too tired and had little chance of success ... I suppose I'm now best out of it.'

Obstinacy, folly, egotism? Courage, integrity, percipience? Probably all. With this impure compound of motivations I shall continue my (probably doomed) mission until my vocational energies begin to fade: I think (and hope) I shall recognise that time. After that – long after, I hope – I shall pray that I am tended by a renaissance of practitioners who are encouraged to understand and value such holistic and personal continuity of care. The prognosis for this is poor.

(ii) *Microcosm*

From the welter of these personally impersonal themes, I want to return to the spawning microcosm of all this: our joint work, relationship and communications. I reiterate that I value these, despite the maelstrom of larger cultural forces and clashes to which we are all exposed. I am not cavalier about 'collateral damage': I am remorseful and thoughtful when it happens. I shall

always try to reduce it, but remain resolved to facilitate (sometimes provoke) thought and discussion about seminal themes, especially the value of continuity of holistic/personal care, and the destructive effects of its unnecessary loss.

To change a culture is a daunting task, many would say impossible. In this principled folly/vocation, I must have resolve and stamina for my myriad exchanges and encounters. But I must sometimes balance these with restraint: I then need to take care not to be perceived to personally wound or derogate. Where I have failed to find this right balance with you, I am very sorry. As so often, we struggle to find better ways to combine macrocosm and microcosm: courage to engage the big picture, yet sensitivity to those that inhabit it: us! When I do this better, with others, I am nourished and deepened.

With best wishes

David Zigmond

* The letter has been slightly shortened. Locally or personally identifying features have been removed or disguised: it is the general themes that are important, not the identifiable particulars.

**IAPTS = Increased Access to Psychological Treatment Services is the UK's centrally designed and managed service, referred to in this article and letter.*

Interested? Many articles exploring similar themes are available via <http://davidzigmond.org.uk>

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