

Form Devouring Essence: When brokered services tend broken hearts

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Our healthcare rhetoric of data and systems has largely destroyed our capacity to make the kind of personal bonds that understand and heal human dissonance. Stephen and his plight serve to illustrate and explore this.

1. A Prologuing Parable

'What would you like, Dali?' says Ali, from behind the Pizza Bar.

The Dalai Lama squints and marvels at the long list of offered combinations.

'I want One with Everything!' he replies, throwing his arms wide in rapture, to suggest Infinity.

Preparation takes Ali some time and the box is made up specially, the largest he has ever used.

To pay for it the Dalai Lama gives Ali the largest banknote he can procure and then waits, patiently at first.

'Can I have my change, Ali?' he asks eventually.

Ali sighs softly and shakes his lowered head slowly, with muted sorrow and disappointment: 'Oh! Dali! You, of all people, should know not to ask for this; that all Change must come from Within.'

– The Tibetan Book of the Dudes

7th century BC, upgraded and rebranded version, 2014

2. Form devouring essence

Stephen's origins fifty years ago were chaotic and prophetic: an accidental conception by a young, brief and impulsive coupling. The unreceptive conceiver hurried to expediently jettison their conception: father rapidly for oblivion; mother bridled until Stephen's birth, then passing him to her own parents for care.

Stephen's early childhood was thus repaired and reprieved for a few, and the most, secure years of his life. Mother then met another partner and thought the omens were now right to start a more deliberate family. Through

contention, then acrimony, then litigation between mother and her own parents, Stephen was removed from his grandparental loving home and returned to his parental and capricious source. Fate was not kind to any of the converged players in this new Act: mother never had another live birth, and stepfather's geniality of promise turned to a sullen resentment of envious disappointment. The knot tightened and darkness gathered: indifference turned to sarcasm, slashing words conflated with beating fists and bodily shakings. Stephen shook, retroflected and planned escape. For her own security, mother colluded with power. Stephen left home age fifteen looking for some predictable and protective influence. He soon joined the Army.

Stephen never really found the peace or inclusion he craved. In his early adult life he lost himself in sports, macho banter, the consoling hazes of alcohol, drugs and thence to sexual deliria, with little-known partners. A brief marriage first absorbed such continuing assaults, then listed, capsized and sank, leaving a vengefully confused ex-wife adrift, huddling for comfort and buoyancy with their two sons. Stephen's growing awareness of how he was, in many ways, re-enacting his own abject beginnings was more than he could bear: he sought further escape through the only routes he knew – from the comforts that drew in his nemesis ...

In his forties Stephen's life is slowing and he is beginning to see more clearly the pattern of his personal carnage. He tries to rebuild, but finds that this is akin to footholding sliding shale.

By his late forties his old defences are in terminal decline. His distress can no longer be distracted or buttressed and far exceeds his vocabulary. His signalling becomes urgent, intense, scrambled and uncontained. Dread, rage, guilt, fear, grief, shame, contrition all jostle to inhabit his confused and alienated loneliness. His offered quanta of anguish are inchoate and polymorphous: insomnia, panics, overwhelming physical symptoms – without – signs for the doctors, the sense that his mind and body are sometimes exploding and other times imploding and then colonised by others, consoling or persecuting superstition, bleak and suicidal despair, his fear of harming those that venture care or closeness: all are presented to A&E

departments, Walk-In Centres, Out of Hours call centres, thence to Psychiatric Services and, finally, his new GP, me.

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Stephen enters my room and my life for the first time seeming turbulent and adrift. I fine-tune the signals: I think I discern a mistrustful yearning for affection, inclusion and reassurance. An unbidden image fleets my mind: of a storm-tossed, mast-broken caique limping into the shelter of a small harbour. All of this is communicated to me wordlessly and will-lessly: I have intuition for his story – history – but this is not yet tethered by details. When disclosed, such details coalesce to warn of the difficulty of our task: we will need to offer Stephen several capacious and flexible containers – hearts, minds and diaries – to quieten, nourish, and heal him. Now, forty-five years after the disintegration of his brief exposure to wholesome family life, Stephen will need the best kind of family surrogacy our Welfare Services can muster. Such belated balm for his ancient wounds will not cure him, but slowly, from outside-in, it may awaken Faith, Hope and Charity* – *Agape* – the heart of healing.

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Who will provide such supportive and guiding scaffolding? As his GP I can play a small yet important part, but I will need much help, particularly from psychiatric services. Yet here, where I am needing easy access to a bridge, I look out instead to a chasm: there is no ‘family’ to receive him, just a succession of placements.

To reify the metaphor: in one year Stephen was seen by many boundarised and separate Teams. Specifically: Hospital Liaison (3), Emergency Psychiatric, Home Treatment, In-patient, Community Mental Health for Mood Disturbance, Community Mental Health for Psychosis (his protean disturbance made distinctions only administratively meaningful), Psychology: Cognitive Behaviour Therapy, Psychology: Behaviour Activation Therapy.

Very significantly Stephen does not know the name of any of the Teams and cannot recall the names of any of their practitioners.

This anomie does not daunt the sharply missioned (now commissioned) Teams – for all, it seems, have an agenda to ‘cure’ him or, at least, to ensure brisk progress along a relayed ‘Recovery Pathway’. This process, it seems, attempts to short-circuit more primal, powerful needs: these, through personal attachments, can create individual understanding and thence a growing, deepening capacity to create positive meaning and gratifying bonds.

Over many years an underlying principle – now increasingly disregarded – has become clear to me: that desired change comes often by an indirect route. Symptoms then dissolve not through direct countervailance, assault or ablation – what some like to confidently call ‘management’ – but by certain kinds of attuned and resonant apposition; the deliberate fostering and protection of certain kinds of *relationship*. Such constitute the inductions of *healing*, which contrast with the conductions of *treatment*. As a young psychiatrist in the 1970s I was engaged with many such personal projects. It was humbling and unglamourised work, but had quiet, slow, deep satisfactions. It was impossible to standardise and very difficult to measure, so we did not. This did not matter then because, in healthcare, we had not yet entered a world so tightly managed and systemised. The recently emergent healthcare realms have subsequently attempted to subsume all human problems and activities to standardised codes, procedures, quantifiable data and generically packaged Care Pathways. These ensure computer-compatibility, but there is a costly undertow: Technototalitarianism.

In my early years of practice the difficult work of looking after Stephens was much more possible: I had around me a colleagueial extended ‘family’ for synergy and support. Often these people got to know both the patient and myself, sometimes over many years; we developed a well-fared web of personal familiarity: welfare.

Such longer, personal, confluent contact has become almost extinct. My contact now is usually once-only with a sharply-boundaried, specifically-tasked duty-desk worker or Team Leader. Like Stephen, I feel my family has gone. My work has become homeless.

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For the last decade, since the disintegration of my colleagueial family, I have been trying to understand the riddle of our increasing personal disconnection in healthcare. This is happening both in spite of, and because of, our mandates for 'efficiency': our increasingly resourced, ratcheted and managed systemisation. How and why have we created a culture that is less able to care for Stephen than forty years ago? What do we need to reclaim?

3. Re-anchoring essence

I think much can be explained by a little discussed, but seminally important, shift of axioms in planning, teaching and academia throughout pastoral and mental healthcare. We have abandoned the previous flexible equilibrium between *phenomenology* (a description and clustering of how things *are*, or appear) and *semiotics* (a speculation of what things might *mean*).

The significance of this needs a little elaboration. Phenomenology is more compatible with objective and scientific discourse and explanation. In contrast, semiotics is necessary for imaginative human understanding. So, phenomenology is more concerned with treatment, while healing must draw largely from semiotics. It is the thoughtful balance and dextrous exchange between the two that makes *holism* possible. The art of medical practice and compassionate care are mostly impossible without the broad, flexible intelligence of holism.

In the last dozen years there have been influences destructive to the fragile habitat of such holism. This is largely due to an accelerated coupling of computer use to projects aiming to standardise and industrialise all healthcare. This leads ineluctably to a reductionist healthcare rhetoric: to

displace semiotics (an unmeasurable art) by phenomenology (in mental and pastoral health a proto-science, easily and speciously overdeveloped).

Such projects can readily turn to follies. Indiscriminate and overzealous attempts to forge a science of manipulation will risk extinguishing the art of understanding. This becomes much more likely as our NHS services are designed to be brokered – this is now implemented by such devices as autarkic and competing Trusts, Commodifying Commissioners, Payment by Results and competitive tendering. The consequent follies thus turn what should be artful science into a cult of *scientism*: hermetic systems of technical language and data which develop like monoculture farming and become inimical to wider questions and dialogue. Commercial and organisational interests almost always will be allured by such streamlined production and tamper-proof packaging. Hence form devours essence.

What we are losing are anchoring principles: *Healthcare is a humanity guided by science. That humanity is an art and an ethos.* How do we retrieve them? We must re-establish the more fragile art of healing alongside the now oligarchic science of treatment. We must create head and heart-space for the rich vicissitudes of human bonds and understandings. We must understand and respect the fact that the heart of many of our most precious experiences and activities cannot be directly codified and measured: they require conservation of different kinds of language and thought. When we have seriously understood these we might dare to take our hand off the ratchet and our foot off the accelerator. We might then care for one another in more natural, imaginative and wholesome ways: with more sense and sensibility.

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Men reform a thing by removing the reality from it, and then do not know what to do with the unreality that is left.

– G K Chesterton (1928), *Generally Speaking*

Note

* *Faith, Hope* and *Charity* were the names given to three obsolescent RAF Gloster Gladiator fighter biplanes that were the only aerial defences of Malta at a crucial stage in early World War Two. Due to the skill and heroic resolve of the pilots, these three old planes warded off the vastly more numerous and modern attacking Italian Air Force. Malta occupied a pivotal position for massive opposed forces: the surrender of air-supremacy would have changed world history radically. This remarkable respite created a hiatus sufficient to shift the balance. The full significance of *Faith, Hope* and *Charity* only became clear much later: timely small acts and events can have exponential consequences. Likewise, healing also often needs opportunistic hiatuses into which faith, hope and charity may be both transmitted and take root.

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