

**Bureaucratyrannohypoxia**  
**An open letter to Mental Health Services Director**

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Dear Paul

**My experience with an urgent psychiatric problem: an instructive example of current institutional complexity, rigidity and unresponsiveness.**

**Bureaucratyrannohypoxia**

In a recent phone call, I described briefly a fresh episode to you. It seemed (to me) a good example of the rising tide of depersonalised, procedural complexity. This burgeoning is burdensome: obstructive to sensible, sensitive, attachment-respectful care. It is often confusing, frustrating and disheartening for professionals, patients and possibly (even) managers. It is very expensive.

Before time submerges memory, I want to record this episode, and some of my thoughts about it. The episode is one of many: I choose just one, for focus and dissection.

My detail is very deliberate: please take your time.

### **1. The Prelude**

Early one afternoon (in June 2010) I am telephoned by the mother of a 39-year-old woman. The mother herself is clearly fearful and distressed by convergent difficulties gathering around her daughter: "Ellie is crying all the time ... she won't eat and yesterday got drunk (again) ... she was doing so well until she foolishly and briefly tried to get back together with Omar (ex-partner) ... Just one night, but she accidentally got pregnant ... She was shocked and realised it was a terrible mistake. She had a Termination, but when Omar found out, he 'went mental' with rage and broke her arm so badly she had to have complicated operations, and now cannot use it ... She can't look after her little boy (Sam, age 4), so my sister is looking after him ... Ellie says her life is so useless and painful, she'd rather not have it ... I've got a disabled husband: I can't stay with her ... She doesn't want to go into

hospital, she's had bad experiences there ... Can you help us, Doctor? ..."

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Ellie joined my GP list three months ago. I had seen her twice for routine appointments. She told me she was a 'refugee' from an acrimoniously broken relationship with Omar, and had moved across London to create both distance and defensible space. My more psychiatric questions clarified a pattern of several years' fluctuating Reactive Depression and spasmodic alcoholic consolation. She told me of her failed attempts to make a durable, loving bond with a man. Each ended with a variety of hurt, abuse, betrayal and derogation. It needed little prompting for her to talk of the developmental roots of this: her descriptions of a charismatic, powerful but sarcastic and alcoholically violent father; a cravenly collusive and melancholically abstracted mother. Her manner was naïve, warm, submissively apologetic, distressed and affecting. She was tearfully and copiously grateful for my interest in her current dilemma and its history, both recent and ancient. I realised how important quality and continuity of personal care would be for her. While re-prescribing her established anti-depressants, I communicated this to her: as her GP I offered her both periodic anchorage and guided-support across her Sea of Troubles. I talked with her of possible help from longer-term Counselling and Alcohol Services. We conjured and glimpsed future possible scenarios from a rebuilt life. She left me, both times, with a moist-eyed smile and a proffered, warm, firm handshake.

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My urgent visit to her revealed rapid disintegration. Having retreated into her bed and nightclothes, her chaotic and spasmodic speech was rent further by anguished sobbing. Her physical needs and safety were provided by her mother, now buckling under the heavy contagion of distress. Despite the intense level of emotional disturbance, I was able to establish sufficient recognition, communication and alliance with Ellie to calm and contain them both. I held her hand, to gently push out a fragile bridge to the small island in Ellie that could think and speak clearly. We established that she was so

overwhelmed by her life-events, and her distress, that she could no longer competently care for herself and would need supervised care, until recovery. I told them I would try to arrange this for her, at home. I then returned to my surgery, to record a diagnostic formulation that would be required from the Mental Health Team(s).

'Acute Severe Schizoaffective Reaction/ Agitated Reactive Depression (choose either). Risk to Self only (probably undeliberate). Co-operative/ motivated to help. Previous binge-drinking. Needing immediate supervised care (at home, if possible). Complex and chronic emotional/ family/ relationship problems: will need much reconstructive psych. work later.'

That would do.

## **2 Complex Times: The Institutional Response 2010**

On arriving back at my surgery I ring my Community Mental Health Team for contact details and procedural advice. I am given these, and contact the Crisis Team Manager, after much delay, via a Paging Service. The eventual telephone contact is one of a unilateral pro-forma interrogation (of me), rather than any kind of colleagueial dialogue. Her questions are formulaic, and I have the sense that the questioner is guided more by institutional rules than relevant experience. At the end of her questions she tells me that a member of her Team would be able to visit at an unspecified time within the next four hours and that it is essential that I am present, for the safety of her staff. I tell her that Ellie is forlorn and passively imploded: she is a possible hazard only to herself, not imminently and only indirectly. Also this institutional safeguard takes no account of my other work: I have a busy Practice to run.

The young manager is curt and adamant: Team Policy is not negotiable. We are at an impasse: it is impossible for me to comply. I now fractiously ask if she has any ideas as to how I may get Ellie urgently cared for, at home. She brightens with a nascent possibility: if I send Ellie to St Thomas' A&E Department after 6 pm, she will be seen by the OOH Emergency Psychiatric Team there, and they will assess her, and my suggestion.

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After 6 pm I manage to contact the Duty Psychiatrist after much searching via the Hospital Switchboard. I tell him the outline of the current crisis and some selected antecedents. He is sympathetic in manner and pragmatic in plan. I do not tell him of my freshly-exited impasse with the Crisis Team, lest this somehow invalidates my request. He cordially suggests I send Ellie to A&E, where someone from the Emergency Team will assess her. A much briefer but much more dialogic and helpful phone call, this. I express my relief and gratitude.

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I now call Ellie: her mother answers, fatigued and expectant. I outline the plan. She responds with realistic despondency and deferral: "Ellie's now exhausted and asleep ... She's in no state to go to hospital and wait around for someone to ask her lots of questions. Can I take her tomorrow, after she's had a night's sleep?" This deferral makes sense to me, though I simultaneously sense my unfair frustration with their lack of 'compliance' to The System.

I call back the hospital Duty Psychiatrist and tell him of these developments. She will arrive the next morning at A&E. I will fax a letter with some helpful background and my reasons for recommending Home Treatment, by the Emergency Team who can assess her in A&E.

No, he says. Do not send a letter as this will be received within ordinary working hours, deemed a procedurally incorrect GP referral, returned to me with the instruction to re-contact the Crisis Team and start again. However, if I get the patient and mother to attend A&E, and make no mention of all our prior communications, it would be treated as a fresh self-referral and not sent back to me. As co-conspirator, he is inventive and supportive: he knows The System. Such stealth and deceit is essential to procure what I know is necessary for Ellie. And to return home that night. It has taken me 2½ hours.

The time later taken by Staff in A&E, and later by the Home Treatment Team, merely to assess and decide, would be much longer.

### **3. Simpler Times: The Institutional Response 1970s-80s**

From the early 1970s I have had several decades working in, and then alongside, psychiatric services (the latter as a Principal GP). The response I now describe is drawn from many similar incidents in this earlier period, in which I was either active, or witness to. It is typical of the better practice of the time. The scenario is thus a fictitious graft of those old experiences onto my more recent problem with Ellie.

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After seeing Ellie at home, I immediately phone Dr G, the Consultant Psychiatrist at Highmount Mental Hospital. Dr G is aged about 50, and has been a consultant there for ten years. He has got to know many of the GPs on his patch and is interested in, and respectful of, the very different psychological qualities, styles and abilities that the different practitioners bring to the encounters with complex emotional distress. We have had warm and efficient problem-exchanges several times over five years. I sense he has a good sense of my human and professional strengths, deficits and (I secretly hope) vulnerabilities.

When I call Highmount I am initially put through to Linda, his secretary. She has a bright, alert and friendly manner and is clearly interested in her work. We immediately recognise the other's voice: we have a short bantering diversion, the kind of safe familiarity that keeps morale and relationships buoyant in turbulent waters. I tell Linda about my patient Ellie, in outline, and what I am hoping Dr G will arrange. She tells me that Dr G is busy on the Wards, and that he will call me in an hour.

Dr G calls me as arranged. It is calming and reassuring to hear his voice. Linda has briefly briefed him, and he invites me to tell him what else I think is most salient. His few questions are intelligently chosen, from long and wide experience. He understands a complex situation with graceful and subtle

speed. My conversation with him has lasted only five minutes, but it is full and consummate.

He will get Ellie visited in the next couple of hours, he says. He's not sure who will go, either himself or his trusty, long-affiliated CPN, Patrick. Either Patrick or Dr G will call me the next morning and let me know what they have decided and implemented.

Dr G makes his expected second call to me. He had visited and spoken to Ellie and her mother for about half an hour: it was harrowing, affecting contact, and the time taken matched what he needed to know, as well as the sufferers' near-exhausted emotional resources. They had all agreed to try caring for her at home, unless she deteriorated. Patrick would visit daily, and would also liaise with Social Services. Dr G would revisit later in the week. The usual medications were specified and prescribed. Another short but full colleagueial dialogue: concise, companionable, accommodating, flexible and satisfying.

#### **4 Comparisons, contrasts and comments**

These different scenarios will be familiar to all older Practitioners who have retained memory and interest. Likewise, I believe, my frustrations and critique. The following brief comments are fairly random. Some problems I identify may have become insoluble: I hope I am wrong.

- A. The old system of Consultant General Psychiatrist-managed small teams covering In-Patients, Out-Patients, Domiciliary Visiting and (even) Long-Stay wards was much more intelligently responsive, interpersonally continuous and economically-efficient. (I would accept that only better Consultant-teams from that era support my argument.)
- B. Senior Psychiatrists in that earlier period were, when appointed, usually both more widely experienced and older than is now the case: Consultant Psychiatrists typically started their tenure aged about 40 years, having worked for many years as Physicians or General Practitioners, before turning to Psychiatry.

The equivalent today is a Practitioner almost ten years younger, with often very little medical experience. Furthermore, the psychiatric experience they have had is likely to expose them more to academic or managerial meetings, and far less to the complexities of longer-term understanding and response to individual anguish. The contemporary Consultant is thus likely to be algorithmically well-trained, but interpersonally (and Clinically) sparsely experienced and educated. This statement does not reflect the innate calibre of the practitioners, rather the consequences of the systems that train and employ them. The economics and design of training and services are now subsumed excessively to the Medical Model and a derivative Commissioning Economy. These tend to confer specious order and authority to situations poorly understood or engaged with. It is easy to understand the allure of thinking and language that seems to provide such speedy definition and clarity. In my view it usually requires considerable clinical experience to develop a subtle understanding of the limitations of the Medical Model, in order to be able to selectively and competently discard it; to make way for the more creatively empathic and imaginative aspects of growth and healing.

- C. 'Assessments' and 'Treatments' are often administered by inexperienced Multi-Disciplinary Team Practitioners, who are themselves programmed, strictured and structured by algorithms, guidelines or diktats from NICE, relevant Trusts, etc. These commissarial imperatives are themselves navigated almost entirely via the Medical Model and the Commissioning Economy.

I have an endless stream of examples of inexperienced MDT workers conducting lengthy, formulaic assessments, leaving an indigestible, long trail of bureaucracy and documentation. Amidst such dogged (sometimes zealous) compliance to The System, the patient feels exhausted, overpowered and unheard. This pattern is conveyed to me regularly. Paradoxically, the inflexible overuse of the Medical Model seems more likely with younger Clinical Psychologists, OTs, Social

Workers, RMNs, etc, perhaps because they are prone to use the model anxiously and defensively. Spectres of Medical incompetence or negligence are so much easier to tame or side-step after lengthy and substantial Clinical experience. In my view these kind of Practitioners should revert to auxiliary, complementary or supportive roles in relationship to the Principal Psychiatric Practitioner ('PPP' = Consultant or Deputy) who would then be freer to 'cut to the chase'. In the previous era, when the PPP delegated to other Practitioners with skill and sensitivity, then administration and bureaucracy was light and dextrous and staff morale was much higher. People mostly did what they were good at, and felt safer and more valued.

**D. Unanswerable questions? Impossible options?**

In order to reclaim and regrow some of the departing skills and wisdom (I would designate them as 'Holistic', 'Psychodynamic' or 'Humanistic'), we need to undo many recent 'advances' (which I suggest are not). Among the many conundrae, some involve training and staffing: how can we selectively undo rapid specialist training and encourage might-be psychiatrists to be immersed as (say) Physicians or GPs for several years first? Could consultant status be strengthened but delayed for several years? How could applicants happily accept this as part of an unengineered and gentle acquisition of wisdom, for the benefit of themselves, their therapeutic eco-systems, their patients? Can this possibly fit alongside the near ubiquitous streamlining and acceleration of NHS Professional career pathways? Likewise, could we dismantle current MDTs and get the non-PPP psychiatric-care workers to reclaim, and re-energise, with pride and cooperation, traditional but more limited roles, once valued but now atrophied from disuse?

No easy answers to such questions, even if desired. No Reset button.

The work of all in Public Welfare has become increasingly in thrall to doctrines and mindsets from Health and Safety, corporate, competitive industry and policing. The resulting Bureaucratyrannohypoxia has coalesced to a Culture that ensnares and suffocates us all. The fragile but rich influences

of healing, humanism and holism are now almost extinguished. Likewise the better kind of confederate socialism that used to contain the NHS. How can we resuscitate and rehabilitate these?

Such questions are crucial far beyond our local responsibilities or individual career spans. I hope this open letter will provide some spark and fuel for our further thought and discussion. I look forward to both.

With best wishes.

Yours sincerely

David Zigmond

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