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Dear Dr Dratcu

**Dr Frankenstein's Reprise: Industrialisation of personal healthcare: adverse effects of sequestered psychiatric in-patient services**

I am writing to you as a long-serving GP with a long but now increasingly consternated interest and experience in Mental Health. For many years I have accumulated both dismay from, and interest in, the riddle of our increasing personal disconnection in healthcare.

This letter is very long: this reflects not just the length of my observation and reflection, but also the protean complexity and multivalence of our tasks. Crucially, I believe it is our expedient oblivion and then short-circuiting of these essential subtleties that has led to many of our current errors. So this long missive is a small act of correction.

Yet though this letter may be unusually demanding, I hope it will be equally rewarding through attention. It is one of several I have written about areas of endangered or eroded personal care. For several years I have worked in a system where mental health services have become more humanly disconnected despite, apparently, good administrative coherence. Patients' experiences of psychiatric admissions provide clear examples of this.<sup>1</sup> The first part of this letter portrays the problems I encounter. Later I provide some little-discussed explanations and finally my ideas about the now very difficult restoration.

It is important that I first clarify that this letter is *not* a personal or professional criticism of you or any of your staff, though it *is* a critique of the system we are operating and the culture it leads to. All the difficulties I describe may

include, but extend far beyond, any individual practitioner. Though addressed to you, I am intending communication to be stimulated more widely.

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First, let me tell you something of the background to this letter, and outline a more general view of our mutual problems: for many stymies we have in psychiatry, including your territory of acute admissions, are a constituent of this larger, ailing, puzzled jigsaw.

I am one of your local GPs. I am working in an NHS that is increasingly troubled by its own designs: by generating a more and more industrial-type system of rigidly boundaried fragments, defined by administratively categorised specialisations. The costs of the resulting human disconnection are high, but its subtlety also leads to expedient ignorance: over-systematised and depersonalised care has developed its own life and momentum: sleep-walking like a *Frankenstein's Monster* among the perplexed and vulnerable.

My concern about such healthcare misindustrialisation extends to all more pastoral areas of healthcare – those where the charismatic blessings of rapidly successful technology-based cure is unlikely: this constitutes much of mental health services and General Practice. I have been recently engaging with colleagues in these areas to stimulate creative debate. Amidst these wider concerns and efforts, the activities of sequestered In-Patient psychiatry continue to provide me regularly with graphic examples of the consequences of our healthcare follies. I have written previously to other mental health executives detailing some of my own and patients' experiences: I urge you to read them.<sup>1</sup>

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Second, let me introduce myself. I am a veteran inner-city GP servicing a small practice in Bermondsey, your catchment area. In the first half of my career I did much qualitative research into healthcare human connections;

what is therapeutic and what not, then why and how.<sup>2</sup> In more recent years this interest has become bound to my consternation that modern systems of diagnosis-centred management, in their attempt to confer precision and efficiency, are often overused and then become *countertherapeutic*.<sup>3</sup> This is obviously the reverse of what is intended, and further attempts to rectify the problems with similar methods will compound and compact the human disconnection. This is the corrosive paradox and conundrum we have generated throughout pastoral healthcare. This letter is part of my mission to widen and broaden thought and discussion.

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Now I would like to return to our problems with acute psychiatric admissions.

I am currently caring for four patients who, in the last year, describe urgent in-patient psychiatric care at the Maudsley Hospital. Their individual stories converge with similar experiences of care: the emergent themes – of being cared for with impoverished personal understanding at times of intense vulnerability – are growing with our current accelerated systemisation.<sup>3,4</sup> Increasingly we have a system ill-equipped to offer havens of comfort, containment and personal understanding to enable natural processes of healing and recovery. Instead the overwhelmed, the dis-integrated, the disequibrated – the acutely mentally ill – are hurried between relays of assessment and risk management teams: staff who usually have no prior or subsequent relationship with the patient.<sup>5</sup> All of this may make much sense to management. It does not for patients: for their inchoate agitations or utterances of distress – and then the personal understandings of meaning necessary to heal such breakdown – require a rapport involving personal continuity, patience and imagination: these are unlikely to survive on a conveyor-belt of short-term objectification. No kind of institutional or academic cleverness can substitute for personally evolved healing relationships.<sup>6</sup>

My argument here is separate from, though may be amplified by, those of scarcity of resources. There is, currently, a media conveyed interest in the lack of acute psychiatric beds.<sup>7</sup> This may also be a serious problem, but different to what I am addressing: my four patients were all 'lucky' to be promptly admitted to a local unit (The Maudsley Hospital). My questions here are not about funding or procurement, but the *nature* of such care. My view here is that in mental health it is often the failure or disruption of human bonds that sicken, and it is through certain kinds of careful human bonds and understandings that we heal.<sup>8</sup> Technical language and procedures may sometimes help such humanities, but rarely should they displace them.

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I used to work both in, and with, psychiatric services that offered mental healthcare based on far greater personal continuity and thus understanding. Because of this, the previous services were more economically viable, too: a psychiatrist and his team who have developed a trusting, nuanced and personally understanding rapport with a patient are likely to have far greater therapeutic leverage and success than a rapid carousel of centrally-directed strangers, however well trained. But this is what we have now: the attempt to model such pastoral care on airports, surgical techniques or car factories leads to the abject disconnected 'care' described by my four patients.<sup>9</sup>

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We cannot recreate the past, yet with intelligent analysis it has much to teach us. My early career experiences in now-vanished, better Mental Hospitals taught me much about the subtle values of longer-term personal bonds and understandings; of flexible and intelligent capacities for containment and asylum; and – conversely – the folly of sharp, excessive packaging – our expedient resort to rigid diagnoses and institutional care pathways. Such early lessons in thoughtful eclecticism guided and enriched my working lifetime, had decades of enthusiastic agreement among my peers and are supported by much historic documentation.<sup>10</sup> Sadly and importantly such

lessons are increasingly lost or disregarded – this is one definition of *cultural change*.<sup>11</sup>

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So, how can we transpose or transplant these lessons to our current situation? Here are some notions, caveats and suggestions to help us reconfigure mental health services in a way that restores my working maxim: *Healthcare is a humanity guided by science. That humanity is an art and an ethos.*

**In Principle**, we need to understand:

- How and why have we brought about these difficulties? I think much can be explained by a little discussed, but seminally important, shift of axioms in teaching and academia throughout mental healthcare. We have abandoned the previous equilibrium between *phenomenology* (a description and clustering of how things *are*, or appear) and *semiotics* (what things might *mean*).
- Phenomenology is more compatible with objective and scientific discourse and understanding. Semiotics is necessary for imaginative human understanding. So, phenomenology is more concerned with treatment: healing must draw largely from semiotics. A balance and easy exchange between the two is necessary for *holism*. Compassionate care is mostly impossible without holism.
- Partly due to the rise of computers, and then the seductive (often treacherous) opportunities to industrialise mental healthcare, there has been an increasingly demanding rhetoric to displace semiotics (an unmeasurable art) by phenomology (a measurable proto-science, though often speciously so).
- Without intelligent discrimination this can easily lead to the follies of *scientism*: to services whose zealous attempts to make a science of manipulation is often at the expense of the art of individual understanding.
- We need to return to a *personal* continuity of care – sometimes over long periods. This can provide much better individual understanding and

thence to humanly nuanced diagnosis and therapeutic influences. (The exceptions to this are always instructive and interesting.)

- Personal continuity of care is more an understanding and arrangement between consenting adults than a procedure decided by a Central Directorate.
- Nevertheless personal continuity – even when desired, optimal and unproblematic – must always be ‘safety-netted’ by background administrative and institutional continuity.
- Generally, when working well, personal continuity of care should be a pre-eminent and anchoring principle.

**In Practice** this means:

- Bringing back Consultant General Psychiatrists who would be responsible for running a team (these used to be called ‘Firms’ and typically consisted of the Consultant, one or two grades of trainees, a Psychiatric Social Worker, Community Psychiatric Nurse, Clinical Psychologist, Occupational Therapist and then his in-patient Ward Staff).<sup>12</sup>
- This Consultant Psychiatrist would be responsible for a geographical area and therefore would get to know families, streets, local myths and rumour, GPs, Social Workers, Health Visitors and District Nurses.<sup>13</sup>
- By having their own core-staff and in-patient Ward, the Psychiatrist, and the more long-serving members of the team, are then able to provide a much more personally-knowledged and engaged service.
- This locality-based, consultant-led team would provide the bulk of widely ranging psychiatric help for most patients who need it. The team would be responsible for the whole span of most patients’ likely care: out-patient clinics, home visits (assessment, monitoring and therapeutic), day-patient and in-patient care.<sup>14</sup>
- For very refractory or unusual cases there would be tertiary centres to refer to.<sup>15</sup>
- This consultant and their team would then have the advantage of personal knowledge and understanding to make dextrous and effective decisions.

For example, a psychiatrist with long experience of a patient is much more able to quickly and accurately evaluate a difficult and unstable situation and, say, admit the patient, or have the CPN visit regularly or get them an urgent Day Centre place, supervised by an OT. (This was much of my experience in the setting of large Mental Hospitals in early 1970s. Care was – comparatively – much more efficient, person-centred and seamlessly initiated and integrated. Holism was not explicitly talked about, but easily enacted. Staff conflict, tension and sickness was much less and morale much higher: people *liked* their work.)<sup>9</sup>

- It is, therefore, not just patients who will benefit. Work satisfaction is much greater when personal investment is more valued and attachments last long enough to bear fruit that can be witnessed and savoured. Staff who derive warmth and satisfaction from their difficult tasks will work much better. This has benefits for both management and the economy.<sup>11</sup>
- The dismantling of administrative barriers to more holistic and personal healthcare is needed throughout the NHS where pastoral care is elemental. For example, there are strong arguments for reinstating GP personal lists and hospital General Physicians.<sup>16</sup>
- The kind of Consultant Psychiatrist that I envision re-establishing resembles also the better old kind of General Practitioner in terms of their breadth of skill, accumulation of personal knowledge and long-term vernacular commitment. They would thus be more experienced, and thus older, on appointment. Their professional influences would derive as much from vocational education as hegemonic training.<sup>17</sup> This raises further issues about medical recruitment, training *v* education, and the design and finance of career structures: all need further complex analysis.<sup>18</sup>

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I do hope you will read this letter with something of the thought and spirit that has gone into it. I certainly do not expect a long written reply, but I would like to begin some informal discussions. I am also inviting this from our Mental Healthcare Commissioners and Medical Director.

With best wishes

David Zigmond (GP)

**Post-scripted appendix: Early reply from Dr Dratcu**

6 November 2013

Dear Dr Zigmond

It was a pleasure talking to you on the telephone. I am honoured that you have decided to share your thoughts with me. I am also very pleased to see that you have such wide and longstanding interest in, and understanding of, the ever changing framework within which mental health services operate, and the implications of this to our patients.

You have written a very detailed document and I apologise for not addressing it point by point. May I nonetheless start by saying that many of the concerns you have raised are exactly the same that I and a significant numbers of my colleagues frequently entertain about developments in mental healthcare provision within the NHS. We are all aware of the fragmentation of mental health services in recent years and its pitfalls. We are also aware of the challenges that many management-driven approaches may engender in our interaction with our patients. In an age where IT and databases increasingly encompass everything we do, there is indeed a risk that all this may culminate in what you describe as "increasing personal disconnection and industrialisation of healthcare".

These are clearly broad issues that go far beyond mental healthcare alone, and for which we are unlikely to have easy answers. With your permission, and as we discussed on the telephone, the best course of action for me at the moment is to divulge your message to my colleagues.

Kind regards

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## Notes and references

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<sup>1</sup> In this long letter I have not included a description or analysis of individual accounts that have provided me with grist and motivation. Similar stories can be found in earlier writings, which I have numerically referenced and are easily accessible via my Home Page. This applies also to related and cited healthcare themes.

Previous letters to senior colleagues might interest you. They are:

- *Eric: Another victim of Hypertrophic Obstructive Management Coagulopathy: A letter to the Medical Director, South London and Maudsley NHS Trust* (2012)
- *Bureaucratyrannohypoxia: An open letter to Mental Health Services Director* (2010)

The particular patients who talked with me of their depersonalised and unattuned in-patient experiences are willing to talk to you and other responsible healthcare workers.

<sup>2</sup> My interest in this has spanned a long career. See, for example:

- *Three Types of Encounter in the Healing Arts: Dialogue, Dialectic and Didacticism* (1987)
- *The Front Door of Psychotherapy: Aspects from General Medical Practice* (1989)
- *Why Would Anyone Use an Unproven Therapy? Treasures in the Mist* (2010)

<sup>3</sup> See, for example:

- *Idiomorphism: the Lost Continent. How diagnosis displaces personal understanding* (2011)
- *Institutional atrocities: The malign vacuum from industrialised healthcare* (2013)

<sup>4</sup> *Continuity of Care: Of course, but whose? A Sleight of Slogans: Letter to Family Doctor Association* (2012)

<sup>5</sup> *If you want good personal healthcare, see a Vet. Caveats for holistic healthcare Part II* (2012)

<sup>6</sup> *Sense and Sensibility: The danger of Specialisms to holistic, psychological care* (2011)

<sup>7</sup> Dr Martin Baggaley recently talked to the media about the loss of psychiatric in-patient beds. He was there talking of *quantity*: my concerns here are *qualitative* and different, though they may be parallel.

<sup>8</sup> *Mother, Magic or Medicine? The Psychology of the Placebo* (1984)

Thirty years ago this article expressed a kind of imaginative, yet disciplined, *intersubjective* analysis often pursued by thoughtful practitioners. This kind of thought has become nearly extinct in the last twenty years. In my view this is largely due to our indiscriminate use of electronic informatics. This has

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generated an unwise and uncompromising rhetoric of *objectification*, whose language is data. Unmindfully unleashed, such data have a similar relationship to human imagination and relationships as swarms of locusts have to human habitats and crops – see *Words and Numbers: Servants or Masters? Caveats for holistic healthcare Part 1* (2012).

<sup>9</sup> I documented this change in culture, and its human casualties in *Psychiatry: Love's Labour's Lost. The pursuit of The Plan and the eclipse of the personal* (2010)

<sup>10</sup> I have many documents to itemise and date these changes. Two of them I have contextualised in:

- *Language is not just data: it is a custodian of our humanity* (2013)
- *Physis: healing, growth and the hub of personal continuity of care*  
*A thirty-nine (39) year delayed follow-up correspondence with Sally* (2013)

<sup>11</sup> *Institutional atrocities: The malign vacuum from industrialised healthcare* (2013)

<sup>12</sup> My earliest experiences in Psychiatry – in an old Victorian Mental Hospital in the early 1970s – provided an excellent (comparatively) personal service of this kind. Its positive influence has been indelible for me. See *Psychiatry: Love's Labour's Lost. The pursuit of The Plan and the eclipse of the personal* (2010)

<sup>13</sup> The conception of the old general psychiatric team could be redesigned. Obviously they would not operate from a large Mental Hospital. Smaller, more numerous In-Patient units would be close to Day Centres, Out-Patients etc, ideally within easy walking distance. Geographical proximity and easy personal contact with colleagues lead to much better colleagueial understanding and relationships – see *Eric: Another victim of Hypertrophic Obstructive Management Coagulopathy* (2012).

<sup>14</sup> These reincarnated General Psychiatrists would function much like the better GPs of this earlier period: they guide and care for many different kinds of patients over long periods, will often delegate to known colleagues but retain an overarching interest, personal knowledge and responsibility.

This kind of sense of caring containment was mostly more therapeutic for patients: work satisfaction for the professionals was commensurate with this.

<sup>15</sup> This worked well in the 1970s. Only a small fraction of more puzzling and refractory cases would be sent to a tertiary centre (eg for Severe and Uncontained Psychosis, Eating Disorder or for long-term Psychotherapy). This is paralleled elsewhere in the NHS: see note 16.

<sup>16</sup> See my examples at the end of *Five Executive Follies: How commodification imperils compassion in personal healthcare* (2011)

There is a parallel argument to reinstate the erstwhile kind of General Physician who would provide the vast bulk of hospital-based secondary medical care. They (as before) would only refer on a small fraction of more complex work. Currently, older people are often under multiple medical specialists, each for a fairly common condition. Very often patients cannot name the speciality, even less the specialist: there are all kinds of losses here –

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of personal bonds and understandings that are essential to comfort and healing; to speedy, accurate professional judgements that come from personal familiarity; of efficiency that comes from uncomplex administration; of efficiency that comes from good work satisfactions from satisfying personal bonds.

General Practice, since the abolition of Personal Lists and the accretion and demise of small Practices, has very similar problems.

<sup>17</sup> Consultants many years ago were usually less formally trained but more informally educated. They were older and thus had longer and wider experience. This may have been less neatly compact for managers but produced many unsystematic blessings.

See *No Country for Old Men: The Rise of Managerialism and the New Cultural Vacuum* (2009)

<sup>18</sup> There is a welter of problems in all this. What are the alternatives to the current severe academic meritocracy to gateway Medical Schools? How can we best encourage education (learning by enquiry) without losing the hard essentials of training (assurance by instruction)? If (as I would argue) Psychiatric Consultants should have longer and wider prior experience of healthcare and life, how would we encourage this without loss, to them, of money or motivation?

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