

Six Suicides and One Homicide

The catastrophe of jettisoned personal containment in healthcare

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Care and treatment are different though synergistic. The increasing trend to executise treatment over care destroys this critical complementarity. The consequences show us how important are such balances.

*Life is full of infinite absurdities, which, strangely enough,
do not even need to appear plausible, since they are true.*
– Luigi Pirandello, *Six Characters in Search of an Author* (1921)

A recent news item (*Today*, Radio 4, 29/11/14) flared briefly, then disappeared behind fresher shocks: six suicides and one homicide in the acutely mentally ill within the previous few months. The deaths were newsworthy because they were very possibly preventable: requested psychiatric inpatient beds could not be found for these evidently distressed and disturbed people. An evolutionary explanation was offered: that this was consequent to successive closures of inpatient units; the result of decades of rhetorical precedence given to ‘care in the community’. Then the crucial question: are such ‘progressive’ policies safe?

Clearly, conflation of care and preventable death is a sure recipe for a vigorous, if evanescent, headlines. Yet in matters of complex welfare, such headlines are merely attention to the iceberg’s tip. What lies beneath may be less evidently dramatic, but is more enduring and extensive. This much larger residue is the damage and attrition we live with.

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Forty years ago I had a contentious discussion with my supervising Consultant Psychiatrist, Dr W. She had recently read a speculative paper on the future of NHS Psychiatry. “Places like this [Mental Hospital] will be obsolete: not needed. With our gathering research, better training, psychopharmaceutical advances and more defined Care Pathways, we will be able to treat it all in the community ...” She swept her hand expansively to indicate both the whole Ward and vast Victorian edifice beyond: “... All this will not be here.”

Despite my youth I balked at her vision and enthusiasm for this Brave New World: “I don’t think that most of the kind of Psychiatry that I have seen here can ever have the requisite diagnostic precision or therapeutic leverage to make that broadly possible. It seems to me inevitable, yet also fortunate, that such ensnared and encoded unhappiness often yields only partially to our

medically-modelled diagnoses and treatments. I think that however clever we think we or our systems are, a lot of people will go on needing much protected space and time to heal and recover ... Yes, 'asylum' might be a good word for that kind of human activity as well as this kind of place ...". I swept my hand in emulation of her gesture: the same building, but a very different construction of meaning. "Also, some people may not be able to substantially heal and recover: what about them?"

I thought this question was worth pursuing, but Dr W's astringent retort tugged in a different direction: "You are remarkably young to have so little faith or optimism and yet so many opinions. It will be interesting to see how long you can survive ... Well, meanwhile we've both got a lot of work to do..."

I wanted to persist, but Dr W's depleted tolerance was clearly signalled. My submission was diplomatic: my speech was guillotined, but my thoughts continued to flow, then crystallize. From these early experiences I was rapidly learning the importance in my work of personal attachment and containment – how crucial these were for healing and palliation.

My commitment grew, to harbour and nourish these imperilled humanities.

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Forty years later I am working as a small-practice inner-city GP. My precociously dissonant prophecy has become an evident, familiar and now seriously impacted Welfare problem. For while the service burgeons and vaunts its many speciality-based treatments, it has become largely impoverished in the humbler, yet often more important, tasks of humane containment and care. So, while I can more readily procure for my patients specialist assessments and prescribed treatment packages, it is almost impossible to get care that is personally invested, skilled and responsive: the kind that understands and values personal relationships and meaning. Yet I could provide this care in the 1970s: not just the Asylum's asylum, but its better and wider ethos. Now I deal regularly with the casualties consequent to

our professional abandonment of the personal: I do my best to salvage some haven of personal recognition, safety and care – for neither my patients nor I know where else to find this basic asylum. Such losses have accrued through our systematised follies, our production-lined approach to pastoral healthcare¹. Tragic catastrophes seemed inevitable. My generation of practitioners have endured and signalled this process for many years: but it needs a death to get a headline.

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What has happened? And why? How – amidst massive resources, good intent, Royal Colleges, vigorously differentiated specialties and their rigorously prescribed trainings, thronged think-tanks and their acolyte academics – have we departed so far from our better sense and sensibility?

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First we must understand the differential nature of our two elements of therapy: care and treatment. Then we can understand what happens when care is cumulatively displaced by treatment.

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Generally, care comes from ethos, while treatment comes from technology; care is about wholes and relationships, treatment is about parts and mechanisms; care springs from – then returns to – the intersubjective, treatment remains closely tethered to the objective. Treatment may fix, but it is care that heals. Clearly our healthcare needs both, and often together: for it is by weaving the disparate that we get synergy, and from synergy comes what is most therapeutic in Medical Practice – the art of our science and the science of our art. But we can only do this if we allow for a delicate and ever-changing weft of these two elements: for this there must be reciprocity but not hegemony.

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Yet hegemony – of care by treatment – is very much what has happened in the last twenty years. And this process continues to accelerate. In all aspects of healthcare the technical and procedural are supplanting interchanges based on personal bonds and understandings. Sometimes this is clearly welcome and does not merit dispute: for example, a case of unstable Angina does far better with an unknown cardiac surgeon in 2015 than he would with his personally known and trusted cardiologist in 1965. Such benefits of generic, technology-based treatments are clear. There are many examples of these astonishing advances. They are the blessings of tightly scheduled and managed treatments.

Yet the blessings evaporate and the curses coagulate when we assume that *all* our healthcare needs can be processed in this way, and then not know when to stop. For such biomechanically-centred or modelled approaches are only suitable for certain ailments, and then only for restricted windows of opportunity. At all other times we need a wide access to other ways of thinking and relating.

Such other approaches are those concerned with human and personal understanding, meaning and quality of contact. All of these can have powerful effects on our healing and palliation, our faith and our growth, our libido and Mojo. Yet while we can adopt a scientific *attitude* to these things we can never make a substantial scientific *activity* of them because they are not directly measurable or manipulable. In a healthcare culture of computers, informatics and statistics, such approaches easily become devalued and then peripheral.

So it is that massive problems have arisen due to the displacement of the personal by the procedural; of healing by treatment. As we have seen, this is little contested in, say, acute cardiology. But what about the massively large area of pastoral healthcare where our personal contact is a decisive part of therapeutic influence: in general practice, psychiatry, the care of frail elderly, the care of incurable neurological and rheumatological disease? What happens here?

The answer is that we have largely destroyed the heart and art of pastoral healthcare. We have done this inadvertently, by thinking that we can replace all the ambiguities of open-ended person-centred care by the apparently more standardised and thus efficient systems-based micro-managed treatment packages. The failure to recognise the differences and limits of each is now exacting very high economic and human costs. We are discovering how excessive packaging and systems in pastoral healthcare can easily harm more than help.

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There has been parallel and equivalent misunderstanding, too, in our institutional attitudes to dependency. In the 1950s and 1960s researchers revealed how much human disability and functional restriction was due to the constraining effect of residential care institutions: the entrapping container itself had become first hermetic, then pathogenic. Partly to avoid a repeat of such perverse iatrogenesis, and partly to make savings from redundant services, there were massive and decisive moves against and away from our large containing institutions. If institutions could so disempower and sicken people they should be closed. If attachments and dependency could so disable they should be avoided. Dependency, attachment and containment were deemed obsolete, even abhorrent. Anonymous team-delivered care-packages would be unsullied and safer.

Such decisive cultural change in healthcare conferred its initial blessings, but then its follies. Certainly many were freed from a shocking perversion of care: institutional infantilisation. But this progress was mixed, for probably an equal number of people had very different and positive experiences: of sanctuaries of personal safety and unintrusive inclusion that could root and catalyse intrapsychic immunity, growth and repair: the Asylum's asylum. In these more benign situations the Asylums provided the essential conditions for humane containment and dependency. In this way these containing

institutions are like our organised religions: they offer both the best and the worst of our humanity to one another.

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Throughout pastoral healthcare it is the skilful play of bonds, contacts and containments – relationships – that can induce healing and growth in the other. But like the complex life-forms such healthcare relationships are attempting to engage, these relationships are protean and not directly manageable. And here is our conundrum of contemporary healthcare: we can apparently reduce some hazard and harm by avoiding or short circuiting much human ambiguity; but such elimination-by-systems then shuts off vital human currents. Tragically we have not seen that such insulation can kill as well as protect.

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Six suicides and one homicide ... 'Regrettable accidents' consoled one healthcare pundit on the radio. Partially true. But here is a fuller, more instructive truth: they are victims of collateral damage from a system whose severe and limited internal logic drives out the kinds of human engagement that, paradoxically, enable us to meaningfully bond and heal.

In our increasingly regulated, commodified and packaged world, what we are increasingly missing is this: that the best of our living and loving energies cannot be simply transferred by plan, order or edict. They are like growing and living tissues: they are fragile and need meaningful vital connection, protection and perfusion. And an environment that can sustain life.

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The hidden harmony is better than the obvious.

– Heraclitus, *Fragments*, c 500BC

Note

¹ *Pastoral healthcare* is a term little used but much needed. It refers to all those personal influences that comfort, heal, guide, contain, encourage, vitalise and illuminate. Pastoral healthcare is thus primarily concerned with human meaning rather than biomechanism, though in practice it is often essential to combine the two. Any enduring distress or dis-ease that cannot be decisively and speedily despatched by technical procedure is thus likely to call on our capacities for pastoral healthcare.