Dear Dr Wollaston

‘Stakeholders’ in suicide prevention: isn’t that all of us?

Thank you for your recent thoughtful reply, which raises yet more interesting questions. This second letter takes up one such theme and links it to those in my first letter. This single theme leads to some currently inadequately discussed, yet often decisive, undercurrents. Experience from my long frontline service again informs my arguments.

You write of suicide prevention, saying: ‘*With such a broad and complex subject, the Committee is unable to look at every aspect in detail*’ and that to broach this complexity ‘*the Health Committee will be holding a follow-up evidence session with stakeholders…*’

Yes, this subject is certainly complex and difficult to contain. I can see your committee’s due diligence and consideration in approaching this, but I am already troubled by the language used. What is a ‘stakeholder’ in a person’s suicide, or its prevention? This term was unused in healthcare until very recent years. It has been adopted from the worlds of business and management consultancy: previously it was used to refer to parties involved in capital or commercial projects.

The derivation and thus connotation of this word can tell us much about the evolution of our healthcare. Especially here, when considering suicide. But we first need to ask about the nature of suicide. For suicide is the most existential, and least biodeterministic, of our healthcare problems: what is our will to live? What fuels it? What nullifies it?

Such questions are rarely answered well, if at all, by our prevailing discourses of medical-type diagnoses, biomechanical explanations and prescribed care-pathways. For with our will to live we are dealing with the often occult nature of humankind: we are simultaneously both blessed and cursed by our species' surfeit of memory, desire and imagination; the complexity and fragility of the human will to live is (as far as we can tell) unparalleled anywhere else in nature. All this is certainly daunting, but amidst such massive elusive forces one decisive factor seems clear: it is the quality of our relationships. This remains remarkably true even when there is overwhelming adversity elsewhere. It is in such relationships – if anywhere – that we may best find understanding and our often fragile therapeutic opportunities.

This presents us with a conundrum because we find that to tackle suicide head-on – as a public health policy – becomes unworkable because we cannot simply standardise, specialise and mass-produce its best deterrent: good relationships (though there is never a shortage of gurus who claim otherwise). Sadly, and perversely, we can certainly mass-produce conditions that are stymying or destructive of these essential good relationships – for example, in our architecture and town planning, the nature of our work and government, and how we arrange our social and health services. It is the last of these I wish to comment on.

My analysis and comments come from my decades of work.

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My long career has been as an NHS doctor – a psychiatrist and small practice family-doctor. In these roles I have had hundreds of relationships with anguished and despairing people, many lasting several years. Through this time it has become increasingly clear to me that people are 'saved' and healed mostly by the quality and consistency of personal contact and the consequent understanding and establishment of human meaning.

It is here that our current system is most tested, and fails most. For although recent developments in technology and managed systems of care have been much vaunted, they have contributed much less to these areas of pastoral healthcare. Yet such 'modernising' systems are now often defining and dominant: they have often displaced a more substantial, yet now unmodish, traditional cornerstone of practice – *personal continuity of care*. This displacement has produced serious distortions because the heart of mental healthcare must be alive in a humanly responsive way: such care is primarily an art and a humanity, though both may be guided by science.

The tragedy of the last two decades has been the heedless loss of that subtle balance: we have overextended and adulterated our science so it has often become a kind of scientism which – perversely – then destroys the art and humanity it should be serving[1].

This expanding realm of scientism and its systematisation, now dominant throughout pastoral healthcare, has been grievously depersonalising. These, of course, have been encouraged and amplified by the various arms of our NHS Internal Market: commercialisation, commodification, quantification etc – all of these tend to be inimical to personally invested relationships – those that palliate, nourish and heal.

Such changes – to more corporate and commodified healthcare – have also profoundly changed the way we think, talk and approach one another: we have introduced words like 'Stakeholder'. The destructive effect of all these changes in culture and language are probably clearest in the areas of pastoral healthcare I have worked in: mental health and general practice. I would like here to describe briefly what these changes have been like for my profession and the people who come to us.

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In the last two decades, increasingly, people do not know one another.

GPs working in increasingly large practices do not personally recognise patients, and although patients may be able to name their health centre, they rarely know 'their' doctor. This is paralleled among healthcare staff themselves who have largely lost colleagueial familiarity. A similar factory-like anonymity has plagued mental health services: emotionally insecure (of course) patients do not know a named practitioner who they are confident will provide continuity of care. Instead they are likely to describe a carousel of stressed, risk-managing, check-listing practitioners, few of whom do they feel they can bond with in a way that is personally and emotionally significant. This kind of feedback extends from our fragmented, rigidly sub-specialised, multi-teamed, relaying psychiatric care to our triple-tiered talking therapies (now often centrally administered by IAPTS and hegemonised by CBT).

I have had hundreds of lengthy conversations with both practitioners and patients over the last few years. Most describe complementary unhappiness, conflict and dissatisfaction – in their kindred ways they describe their frustrations of disconnection, proceduralisation and an inability to, personally, see things through. Practitioners lose the fraternal satisfactions that come from knowing their colleagues and patients, and thus the human meaning of their work. Patients complain of the lack of personal continuity of care – the enablers of security, comfort, healing and growth. 'It's always someone different, and if they're not looking at the computer then they talk to me as if they're reading from a script…' I have heard these kinds of comments so often that I know they lie beyond criticism of particular individuals and are thus crucial to understanding more broadly what has gone so very wrong. I do not believe most doctors wish to work and behave like this: we are all afflicted by systems of human disconnection.

So, the apparently disparate societal problems of suicide in the general population and the growing demoralisation in our healthcarers have in common this: the loss of relationships. Both could be helped by a restoration, then safeguarding, of our lost human bonds and meanings in our NHS.[2] None of this is addressed well by simple analysis or remedies: this is where we have stalled.

For many years I have been writing of such complexity with depressingly accurate predictions. As a single offering I have attached *Physis: healing, growth and the hub of personal continuity of care. A thirty-nine (39) year delayed follow-up correspondence with Sally*. This remarkable exchange was started by Sally, a retired senior palliative care nurse, many decades after I, in my callow but committed youth, had helped her refind her will to live.

Sally's words, so simply expressed, are seriously insightful and prophetic of our current healthcare predicaments. I do not think she would ever identify with the word 'stakeholder'.

Thank you for your good initiatives with these formidable tasks. I hope this letter may generate useful dialogue, between us and more widely.

With best wishes

Dr David Zigmond

References

1: *Idiomorphism: The Lost Continent. How diagnosis displaces personal understanding*, 2011. My Home Page, article 25.
2: *Plummeting morale of junior doctors: one branch of our blighted tree of welfare*. Letter to Chair, Medical Royal Colleges, 2016. My Home Page, letter 47.

Attachment

Physis: healing, growth and the hub of personal continuity of care. A thirty-nine (39) year delayed follow-up correspondence with Sally.