If you want good personal healthcare, see a Vet

Caveats for holistic healthcare
Part II

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The over-explicit and over-schematic can block our perception of larger and more subtle realities. This second of two articles explores further how this happens, and what we may be left with.

The fairest thing we can experience is the mysterious. It is the fundamental emotion which stands at the cradle of true art and science.
– Albert Einstein (1934), *The World as I see It*

1. **Never invade Russia!**
   This was Churchill's droll, jesting yet ominous response to an enquiry about his most crucial guiding military maxim.

   Napoleon and Hitler are the best-known examples of Churchill's warnings of epic folly: maelstroms of shocking, humbled hubris. Both launched their expeditions fresh from success in easier campaigns and fuelled by specious optimism. They were driven also by rhetoric for the rightness and feasibility for the possession of new territory. Both started with startling triumphalism, then slowed, then succumbed: exhausted by the vastness and strangeness of a climate, terrain and people they had poorly understood.

   There are useful analogies for some of our current enervating endeavours and conundrae in healthcare. First, our expectations have been primed and inflated: Life for millions in the Twentieth Century was positively transformed by applied science. Biomedicine has had spectacular success in countering, even eliminating, many infectious, inflammatory and degenerative physical diseases. In all this industrialisation – mass-production, standardisation, quantification, speed – has been essential. Such successes have led to a long flush of optimism: surely we can gainfully apply similar schematic, industrial-medical type thinking and interventions to *all* our other sources of distress and pain – our human dis-ease, our polymorphous anguish, our inevitable (yes, still!) decline?

   It is here that our invincible march founders, for ailments of our metaphorical heart are proving far harder to locate, define or reverse than those of our anatomical heart. Human motivation, meaning, communication and (un)consciousness yield very meagre territories to objectifying science. Beyond is our vast hinterland, navigable (sometimes) by other kinds of knowledge and influence.

Our reluctance to heed this accounts for many of our most curious and (superficially) indecipherable healthcare follies. In our thrall to measurement we neglect more important unmeasurables. In our urge to treat we do not pause to heal. In our (often unnecessary) compulsion to convergently image the part, we become blind to the divergent – the whole: *this* person, their story and networks. When we define, we also often confine – ourselves and others – to a tunnelled vision and selective deafness. For language, perception and action are tightly linked. If the language of our culture becomes restricted to the technical, the commercial, the procedural and the defined, then our patients – people, like us! – are seen as merely biomechanical problems to be controlled, managed, traded or disposed of. The abstract becomes hegemonic: the real become abstract.

Hyperbole?

Even in 'straightforward' physical care our over-industrialisation is producing shocking calumnies. Consider the following story recently widely reported in the media:[1]

- *A man is admitted to a London Hospital with a rare but well recognised physical complaint (Diabetes Insipidus) which renders him particularly and hazardously vulnerable to dehydration. He knows this and can usually communicate well. He is seen and assessed by a succession of healthcare workers, some of them specialists. In their complexly successive, jigsawedly interlocking, brief contacts with him they do not heed this increasingly desperate requests for water, which culminate in his calling 999* ***from*** *the hospital ward. Only after he dies does it become clear that all these algorithmically-managed practitioners had been effectively deaf to his voice and blind to his demeanour. Hospital spokespersons' public comments are woven with grave contrition and confusion. The former might need construction, the latter does not. The Hospital used to have world-renown for its standards of medical practice, teaching and academia; emblematised also by its historic, stately architecture. Relocated now in an undistinguished, unloved, ugly,*

airport-like, sprawling conurbation, the containing architecture expresses with unintended accuracy the healthcare culture – a hive of hired healthdroids.

That a highly-funded, well equipped and specialised *medical* unit can so misunderstand and depersonalise someone with a *physical* complaint can only bode poorly elsewhere – especially for those who require yet more personal and thoughtful kinds of listening and understanding. This is the case, but often less obvious. With non-physical complaints our failures of care and communication are less dramatic: a slow slide into lonely and dislocated oblivion will gather no headlines. Living silently with a broken-heart attracts no crowds; an untimely death from a heart attack does.

Our current healthcare is in increasing thrall to a Scientistic folly: that generic formulations can be mass produced for all individual distress – that human dis-ease can thus be easily subsumed to impersonally managed forms of civic engineering. Such is contemporary healthcare's Invasion of Russia: grandiose but flawed in assumption, then unsustainable, impossible and incurring vast casualties.[2]

Healthcare may be guided by our science, but science must rarely eclipse our humanity.

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2. If you want good personal healthcare, see a Vet

'I like peasants – they are not sophisticated enough to reason speciously'
– Montesquieu (1689-1755), *Variétés*

When Dr F takes his dog to the Vet, Mo, he is simultaneously disarmed, comforted, ashamed and envious: Mo has a guileless and effortless rapport and liking for the animals she is handling. Dr F wants to know more of these unaffected and unbookish skills: he asks to sit in with her.

What Dr F witnesses is humbling and radically refreshing. After asking the owner a few questions, Mo stands back from the animal, scanning it with

her eyes, listening carefully to its breathing and other sounds. Then she makes active contact with the animal, the approach being based, Dr F thinks, on some kind of 'holistic mind-set' that she senses the animal is now inhabiting. Dr F notices how different her approaches are: with one she gazes at its face with unwavering directness while speaking in a firm and commanding voice; with the next she averts her gaze, softens her posture and lowers her voice to a soft reticence. Sometimes she quickly and directly grasps the nape of the neck with decisive dominance, a wordless control. At others she is slow and light of touch, gently stroking the flank while humming; a trans-species fraternalism. Dr F wonders whether Mo's accuracy, range and speed of rapport with these different creatures is somehow akin to inducing hypnotic states in humans. He asks Mo:

'Oh, I don't know about hypnosis – I'm not that clever. Nor do I know much about humans: they talk too much for me to be able to understand them!' She curls a playfully commiserating look at Dr F. 'My furry friends here can't say much, but I have to understand them quickly: are they frightened, hungry, confused, in pain, angry, unloved? … Yes, really! … Do they need to feel they still control their territory, or do they need to know I am dominant? All such things I have to get right without much delay, otherwise I cannot get docility enough to do my job … Yes, I'll get scratched and bitten, too. With larger animals it can be more serious: you can easily become lunch or squash!'.

Dr F leaves Mo that morning with a deeper gratitude than he is easily able to express. With little psychological scholarship, theory or instruction, this open-hearted, open-minded, freshly-instinctive woman is able to resonate with, and thus 'read', the mind-set of these (humanly) mute creatures. What natural gifts we (all?) may have!

He thinks of the cumbersome, academically conceived, elaborate-yet-clumsy devices healthcare workers are being instructed to use, to inform all about the experience – the 'mental state' – of others. He thinks of the obedient but hopeless Scientism of giving detailed questionnaires to Kenny and Philip[3]. He then thinks of Mo: her almost wordless, seemingly magical,

rapid and affectionate rapport with very different animals. He wishes he could be understood like that, and laughs to himself. His laughter diffuses to a smile at the contrasted memories: Mo has inspired him to retrieve some fresh depth and contact in his work. He will reconnect with himself too, before and beyond words.

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3. In difficult encounters, think about sex

The tyranny of the explicit

'Every person's feelings have a front-door and a side-door by which they may be entered.'

Oliver Wendell Holmes Sr, *The Autocrat of the Breakfast Table* (1858)

Dr Y is thinking about sex. It is not the first time, but now it is different. He is thinking professional thoughts about how our thinking and behaviour around our sexuality could greatly enlighten our healthcare.

More specifically, Dr Y is thinking about a very delicate, complex and evanescent interweaving – of the implicit and the explicit: how these have to be rapidly and accurately discerned, deciphered, jointly understood and then responded to. All of this happens on a second by second basis. And choreographing this medley of meta-communications is essential for any kind of sexual competence – let alone deeper unifying satisfactions. We have to have a (usually) unspoken sense of what the other is desirous of, receptive to, 'on' for, and when and how. We must quickly sense error and redirection. Mostly, in better sexual congress, this can happen by dextrous implicit exchanges: the explicit may sometimes then be added potently and sparingly – a mutual aphrodisiac. If the explicit is necessary, the exchange is faltering. If it is necessary for long periods, the relationship is in serious trouble. If the explicit is used by one, without implicit desire by the other, the exchange becomes embarrassed, self-consciously clumsy, possibly abortive. Many such misattunements doom a relationship. Seriously regarded, they can become work for lawyers.

Dr Y is amusing and confusing himself with how weighty and complicated are the responsibilities of this ancient[4] and near universal activity. How do most of us ever (think we) get it right?

These implicit-explicit dances are certainly at the heart of our sexual contacts, but extend throughout our important relationships. They depend on our being able to seamlessly interchange the implicit and explicit, by 'tuning-in' to the other. We want (and expect) our partner to understand what is troubling us, without our having to name it (yet?): soon after, we want them to now be receptive to the beginnings (or resumption) of the explicit. We want, now, to be able to talk. Yes, directly.

Familiar?

Dr Y extends his thinking to how important such exchanges are in healthcare. He remembers Maggie's[3] long story and considers how any success he has with her is due to his being mindful of such delicate dances: he had been patiently implicit with her before she trusted him with the explicit. And then, with gratified relief, her healing reverted to the implicit. Maggie had told Dr Y of earlier psychiatric interviews and how they had become too explicit too rapidly. She had retreated to the shelter of the implicit, but had not been understood. The implicit locked.

Dr Y remembers well the kinds of discussions he used to have with colleagues, at the beginning of his career. He recalls many years of interrupted-but-never-finished, free-wheeling explorations of our complex contact with others. The concepts and vocabulary were rich and wide: influence, confluence, identity, boundaries, encryption, territory, projection, surrender, escape … The notions and vocabulary were plastic and uncompleteable, yet each alightment could enrich – differently in different conversations: subtly or evidently, with immediacy or incubation, with implicity or explicity.

Dr Y now rarely has such polychromatic and rewarding exchanges. The computer has predicated a new healthcare language for the 21st century: a

restricted and restrictive machine-mandated vocabulary. Healthcarers communicate now – almost entirely – in dull narrow administrative, technical words: of conventions, clusters and codes; of quantifiable procedural activity and description; of conduction but not induction – all designating the objectively generic but excluding the humanly variable. Computer compatibility may thus build some bridges to our outer lives, but very few to our inner. What remains has little room for the nascent, the semiotic, the metamorphic, the ambiguous – all the subtle hues that we must mindfully respect to provide nourishment and meaning for our important relationships. The explicit now burgeons beyond our needs, understanding, tolerance or stamina: the implicit ails and dies.

Its passing takes much of us, too.

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The whole is more than the sum of its (explicit) parts.

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Healthcare is a humanity guided by science.

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Humanity may be commanded by the explicit: its best understanding is often implicit.

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'The water in the vessel is sparkling; the water in the sea is dark.
The small truth has words that are clear; the great truth has great silence.'
– Rabindranath Tagore, *Stray Birds* (1916)

Notes

1. It is hard to gain statistics about the human and economic cost of inflexible, officious practice and uncompassionate – if 'correct' – depersonalised care. What correlates does one measure? Who is going to fund this? Although quantitative research may be difficult to set up, vernacular evidence is plentiful and ubiquitous. See my articles 'Five Executive Follies' (Zigmond, 2011b) and 'Love's Labour's Lost' (Zigmond, 2010). Also letters to Clinical Directors of Mental Health Services.

2. Kane Gorny, age twenty-two, died on 25 May 2009 of dehydration as an in-patient at St George's Hospital, south London. The inquest in July 2012 revealed the facts recorded here. The story is only one of several similar in recent years, eg see also reports of Mid Staffs and West Midlands NHS Trusts. All have been met with convulsions of outraged incomprehension when made public. The fact that they come clearly to public view reflects well on investigative journalism but – of course – seriously damages confidence in NHS care. This is rendered more confusing when such episodes occur in institutions deemed to be 'performing' excellently by other, measured criteria. The responses of managerial gravitas, concern and contrition seem real enough. Some sceptics have averred that these conceal some kind of collusion, albeit unconscious. The latter possibility is easier to cite and sense than see. If true, this is cultural: powerful, but difficult to tether or examine, except by inference.

3. Kenny, Philip and Maggie are all real but anonymised victims of over-schematised and over-explicit mental healthcare. Their encounters with Dr Y are described in the previous article 'Words and Numbers: Servants or Masters?'

4. The activity itself is much older than many people realise. For example, this author – together with many of his generation – believed they were its initiators in the 1960s. However, since that time there has been increasing evidence from many sources, indicating that it far predates that period – possibly even prior to the birth of this author's own parents.

References

Zigmond, D (2011b) *Five Executive Follies: How commodification imperils compassion in personal healthcar*e
Zigmond, D (2010) *Psychiatry Love's Labour Lost: The pursuit of The Plan and the eclipse of the personal*

All the above, plus the letters referred to in note 1, are available online at www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.htm

Interested? Many articles exploring similar themes are available via http://davidzigmond.org.uk

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