Analysis

Loneliness:

an incommunicable disease?

ATOMISATION

For many people the experience of isolation did not begin with the current pandemic. Loneliness has long been a problem on both sides of the GP's desk, but with opposing consequences. Socially alienated patients are more likely to experience health problems, and a desire for companionship can motivate a visit to the GP.[1] Conversely, GPs who find themselves without professional support or collegiality have an increased chance of leaving the profession.[2,3] The lonely patient is more likely to be in the surgery, and the isolated doctor less likely to be there. It is a poignant image: two contrapuntal lonelinesses, neither of which finds solace in the other.

The problem of patients' social isolation has attracted attention from many quarters in recent years, with a ministerial appointment, a national campaign, and research from scholars of public health, neuroendocrinology, sociology, psychology, and history. The former surgeon general of the US states that combatting disconnection is the *'greatest challenge facing us today'*.[4] The health effects are still debated: loneliness is associated with, but perhaps not fully responsible for, cardiovascular and neurological morbidities, inflammatory dysregulation, and a contributor to early mortality.[5–7] Yet medicalisation can only take us so far in understanding isolation: biomedicine may be able to identify some of the physiological consequences, but it is unlikely to proffer any meaningful therapies for a condition that historians and sociologists have located, *inter alia*, as the result of increased affluence,[8] surging inequality,[9] and modernity's individualistic obsession with self-cultivation.[10] This is a problem, like racial inequality or environmental pollution, that saturates the clinical encounter but cannot be reduced to it: doctors are no more responsible for loneliness than they are for imperialism or diesel emissions. But clinicians in primary care do need to determine what loneliness is, how it might be impacting their practice, and how they might begin to address it.

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The prevailing concepts in medical ethics are not that useful here. The Beauchamp and Childress 'four pillars' are inadequate for conceptualising loneliness. Addressing excess solitude is clearly not a question of autonomy; indeed, giving loneliness proper attention counteracts the prioritising of autonomy in medical ethics by highlighting the necessary intertwining of human lives. Beneficence is not quite mutualistic enough; non-maleficence is hardly an adequate basis for intimacy. If loneliness is a problem of justice, as David Vincent has argued, and companionship another wildly unequally allocated resource, it is also something that resists redistribution.[11] The structures of contemporary medical practice also work against sociality. There has, rightly, been a push towards a professional formalising of the doctor–patient relationship over the last 40 years, so doctors do not set out to become friends with their patients. Professionalism is not compatible with preferential affections, and there is a spontaneity and lawlessness to intimacy that resists regulated, boundaried relationships.

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UNDERSTANDING LONELINESS

Given the difficulties of accounting for a non-medical problem with serious clinical sequelae, and an ethical problem without easy ethical answers, how can GPs address loneliness? If medical philosophy is not much use, we can look to a body of literature that nursing theory has sometimes found helpful. The ethics of care, as expounded by Nel Noddings, Carol Gilligan, and Virginia Held, argues that caring for others, far from being an undesirable burden, is at the heart of all social relations. As Held argues, *'moralities built on the image of the independent, autonomous, rational individual largely overlook the reality of human dependence'*.[12] Our survival, individually and collectively, depends on the giving and receiving of care. Although we may not provide and take equally at all points in our life, we need to have some sense of reciprocity: loneliness emerges as much from not having anyone to care for, as from not being looked after.

With this in mind, we cannot try to combat loneliness just by filling up someone's day with casual meetings. Although current social distancing measures have alerted many of us to the importance of brief encounters — the previously unnoticed pleasure that we derive from quotidian conversations at work or on the street — social connection cannot be conjured exclusively from voluntary groups, as is sometimes assumed with isolated older people. Indeed, loneliness is not a necessary consequence of being alone: one can be content in one's own company or be isolated in the midst of a crowd. It emerges from the subjective experience of the lack of companionship and, equally importantly, the inability to withstand this lack. Counterintuitively, this second capacity is relational: it depends on the strength of a person's experiences of previous bonds. The paediatrician and psychoanalyst Donald Winnicott posited that the ability to be happy alone is cultivated by early infant

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experiences of feeling held in mind.[13] We do not need to be signed-up psychoanalysts to agree that feeling regarded, remembered, and cherished elsewhere makes solitude bearable. Loneliness, then, as the cultural historians tell us, is a highly social emotion.

RECONNECTING

If there are two distinct aetiologies of loneliness, there are two potential pathways for palliation: reducing solitude and increasing the capacity to bear it. Many GPs are already providing opportunities for high-quality company, both through social prescription, and through organising in-house projects. The success of these schemes lies not only in aggregation of people together, but also in offering a chance for socialising that is purposive (park runs, maintaining a garden, community volunteering) and intimate (carers' support, group therapy). These projects often create a mutual, if not necessarily equal, network of care, with each participant offering and receiving support to and from other members. Second, and more challengingly, GPs can provide resources to buttress their patients' capacity to withstand feeling alone. They can offer support in plugging in to digital supplements to social contact (for example, Silver Surfer clubs). They may consider encouraging their patients to use mindfulness and meditation to find contentment in their own company. Even more difficult is to try to replenish the reservoir of social experience and memory that maintains us when we are alone. With the home visit already on the rocks, the days of the GP's social call are definitely numbered; but the reminder that doctors care about their patients can, and does, play a role in combating isolation.

The two issues of isolation — too much solitude, and insufficient enjoyment of the solitude — can be useful when thinking about GPs' isolation, as well. Staff can be brought together more: a weekly lunch for the practice, a federation of surgeries that meets regularly, a Balint group for analysing the emotional residue of the clinical encounter. Equally, it is possible to reinforce the structures that help doctors work independently: respect for their professional autonomy, readily available support and guidance. Although the current turn to remote appointments risks cocooning both doctor and patient behind a screen, it offers the possibility, after the pandemic has subsided, of using the saved time for deeper consultations with patients and colleagues alike.

The professional isolation of doctors and the social isolation of patients should not be thought through as separate problems. Both are catalysed by the same gross structural developments in society — increased movement between places and jobs, incapacitating and alienating bureaucracy, a loss of wider support network — and enter the clinic through the same mechanisms — decreased appointment length, calcified professional boundaries, rapid turnover of staff. The Renaissance poet John Donne observed, while confined with typhus, that *'as sickness is the greatest misery, the greatest misery of sickness is solitude ... even the physician dares scarce come'*. Donne understood that, even if the solitude *is* the sickness, it is part of a doctor's duties to alleviate this misery. Far from inevitable, solitude is *'so near a degree towards'* a vacuum, that Nature *'love*[s] *it not'*. If there are aberrant crises that require the temporary sequestration of the population, the quarantining must not persist any longer than necessary; Donne writes that *'retiring and recluding'* oneself from society so *'as to do good to no man'*, *'mistake*[s] *a disease for religion'*. We must not become permanent worshippers of separation. After coronavirus, many people may never return to regular workplaces, losing one of the main reservoirs of connection and collegiality, and so be at even greater risk of loneliness. Resources are currently being poured into making sure that people isolate from one another. When social distancing can be safely lifted, there must be the same energy in bringing them together.

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