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. Conversely, GPs who find themselves without professional support or collegiality have an increased chance of leaving the profession. 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’. 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. 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 are unlikely to proffer any meaningful therapies for a condition that historians

clinical encounter but cannot be reduced to: 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.

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. The structures of contemporary medical practice also work against sociality. There has, rightly, been a resistance to a medical ethic that resists regulated, boundaried relationships.

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, ‘morals built on the image of the independent, autonomous, rational individual largely overlook the reality of human dependence’. 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
The professional isolation of doctors and the social isolation of patients should not be thought through as separate problems.

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Provenance
Freely submitted; externally peer reviewed.

DOI: https://doi.org/10.3399/bjgp20X712541

REFERENCES