HASLAM'S VIEW



Professor Sir David Haslam
CBE FRCGP
Past President BMA,
Past President RCGP

Is there a cure for loneliness?

WHERE EXACTLY DO THE BOUNDARIES OF HEALTHCARE END?

For those of us who work in the medical frontline of general practice, we are faced with this complex issue every day. Where does unhappiness end and depression start? When is the normal abnormal?

These simultaneously esoteric and everyday musings were triggered by a newspaper article I came across. It featured a clinical psychologist who had described loneliness as being a 'social isolation syndrome'.

The article then went on to discuss the possibility of drugs being developed in the future to address the problem.

Let me be absolutely clear that in no way do I mean to decry the incredible importance of loneliness, the despair and heartache it can cause, and the strong and important correlations between loneliness and ill health.

Loneliness really does matter, as so many people in this era of lockdown in the Covid-19 pandemic will personally confirm.

Loneliness can increase the likelihood of premature mortality and has been linked to an increased risk of developing coronary heart disease and stroke. Other studies have shown clear correlations with cognitive decline, the development of dementia, depression, and – perhaps not surprisingly – suicide.

Lonely people are more likely to visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long-term care. Loneliness is a serious problem.

However, if anything demonstrates the potential overmedicalisation of society it must be the concept of prescribing medication to ease loneliness. The thought of an apartment block, or even a village, populated by lonely people all of whom are taking medication for their loneliness while never having human contact with each other fills me with despair.

'Lonely people are more likely to visit their GP and have higher use of medication'

However, this is not at all straightforward. All these lonely people are the very people who often present to doctors, and who are at risk of developing the problems that are very much our bread and butter.

Should we not be passionate about prevention? Is there any logic or kindness in waiting until these lonely people are ill before we step in to help them?

In an ideal world we would all have teams who could address these issues, taking the time to adopt a non-medical approach, to practice humanity – not humane medicine – just humanity. However, most of us don't have such teams, or the breathing space to ponder these problems and how best we might approach them.

I well remember patients with long-term conditions, such as leg ulcers, where I felt that their failure to improve was linked, at least in part, to the fact that the only social contact they had in their week was with the nurse who did their dressings.

Of course, we could never prove that the persistence of ulcers was artefactual, but nothing else seemed to explain it. We may well have been treating their loneliness rather than their leg ulcers. We just didn't recognise it.

In future, we will need to work much more closely with individuals or teams who are skilled in the social aspects of care. However, this is entirely different from classing loneliness as a medical condition requiring medicine.

Designating an ever increasing number of facets of normal human life as medical conditions that need treatment is bound to defeat us all.

As to where the boundaries actually are between medicine and life – well, that's quite a tricky problem.

Tell us what you think?

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