Title: Addressing the Unique Challenges Faced by Highly Educated Patients (with insight and mental capacity) with Chronic Pain and Mental Health Issues in the NHS.

Page 1, Summary: read this if you don't have time.
Page 1, Section 1: Middle Management.
Page 2, Section 2: How Middle Management Affects Psychiatric Care.
Page 3, Section 3: How Psychiatrists then can use Duty of Care to be Sadistic.
Page 4, Section 4: Conclusion and my proposed solution.
Page 5, Appendix: Facts and Studies.

Summary:
The document brutally criticizes the NHS, particularly its middle management and psychiatric care. Key issues include:

1. Ineffective middle management focused on irrelevant metrics.
2. Poor treatment of highly educated patients with complex needs.
3. Inadequate psychiatric care, especially regarding controlled substances.
4. Potential exploitation by private psychiatrists charging high fees for easy diagnoses.
5. Alleged sadistic behaviour by some healthcare professionals.
6. Lack of patient agency in treatment decisions.

I demand eliminating middle management, implementing AI-driven pharmacies, allowing patients to opt out of strict duty of care, and giving certain types of patients more control over their treatment. The core argument is that the current system fails to properly serve complex patients, particularly those requiring controlled substances, and needs a complete overhaul to prioritize actual patient needs over bureaucratic metrics and potentially malicious doctors.

Introduction

I will argue that the NHS faces challenges that are currently invisible in effectively treating a small but significant subset of the population: **highly** educated individuals who suffer from physical and mental chronic, health issues, and require carefully managed medications such as benzodiazepines and opioids. These patients have insight, mental and decision making capacity. These patients, estimated to be around 300,000 (of course I don't know exact figures) in the UK, often face barriers to receiving appropriate care due to the risks associated with these medications, including addiction, tolerance, withdrawal, and side effects, let alone doctors fears of being struck off registers or receiving kickbacks. I will also mention that psychiatry has become corrupt in using its position as the guardians of controlled drugs, and charges clients that can pay (and fake it), thousands of pounds for descriptive DSM criteria that can be faked (such as ADHD) and to receive amphetamines. This last process can undermine the trust in patients that have legitimate concerns such as myself. For statistics see [0] appendix.

As a member of this population, I have personally experienced the challenges of navigating the NHS as a complex patient with multiple physical and mental health issues. Despite having gone through rehab, the NHS (Dr Kostas Agath 2023 — NHS Addiction Psychiatrist) does not consider myself a drug addict, highlighting discrepancies between NHS and 12-step program addiction definitions.

The focus of this document is on how highly educated, complex patients (with insight and mental capacity) are treated by doctors who may be overly cautious, algorithmic, exploitative, or even sadistic (especially in their enjoyment of lack of empathy and taking on board their clients non critical worries) in their approach, rather than treating patients with dignity and humanity. The goal is to raise awareness of this issue and explore potential solutions to ensure that this intersectional vulnerable population receives the care they need while minimising the risks associated with necessary medication. It also highlights problems with the NHS that I believe are at the core of the problems of the healthcare system.

Section 1 : Middle Management

I will start by looking at where I think the issue stems from: middle management. I will start with a story in order to make the point. One of the more bizarre events I experienced during my stay at the Royal Free Hospital in Hampstead, London, back in April 2023, was when I stood up to interface with the passively placed

iPads to evaluate my care in the A&E ward (of all places where even standing up is a luxury). These iPads had the audacity to ask me if I was blind or partially sighted. I mean, seriously? If someone is blind, how are they supposed to even see the iPad in the first place? It's reflective of a deeper problem that Thomas Kuhn writes about! Furthermore, it was on a tall iPad (affecting children) in a unit where people are wheeled in on beds barely able to talk let alone walk because they've just had a stroke but as long as the number of days since C. diff infection (which middle management measure) is low, all is well. Later in my stay, I had to correct the Head Nurse by about thirty days as they incorrectly forgot to count this statistic out of negligence. There were dementia patients on the ward — perhaps they just got loads of feedback from the same person. To determine their own pay middle management include the statistic: Number of pens used per department!

This is just one glaring example of how utterly disconnected NHS middle management is from the reality of patient care. They're so caught up in their bureaucratic quality wheels that they can't even see how nonsensical their own data collection and evaluation processes are. It's like they're just going through the motions, ticking boxes and collecting data without any regard for whether it actually makes sense or improves patient care in much meaningful way.

And this isn't just a one-off occurrence. Time and time again, I've seen NHS management prioritise their own arbitrary metrics and procedures over the actual needs of patients like myself. It's infuriating, and it's a clear sign that the system is broken — with only repair being to start again without NHS middle management being the centre of feedback; collection, evaluation, dissemination and actual improvement.

If NHS middle management can't even get something as basic as patient evaluation right, how can we trust them to implement processes that truly benefit patients? It's clear to me that we need a radical overhaul of the entire system, one that puts patients first and gets rid of all the bureaucratic middlemen who are only getting in the way.

I refuse to be treated like just another statistic or data point in their endless quest for meaningless metrics. I am a human being, with real needs and concerns, and I deserve to be treated with dignity and respect. And if the NHS management can't understand that, then they have no business being in charge of our healthcare system.

Section 2 : Middle Management Affects Psychiatric Care

But why does this link to psychiatrists — because as far as the quality of NHS psychiatrists I come across (which are poor), I don't think the NHS has a chance of helping me. One factor is that duty of care which I feel they use sadistically to prioritise biology over phenomenology. What I mean by that is that rather than coming down when you have a panic attack they leave you in the room and ask you to do breathing because they know eventually you'll survive. For those suffer panic and adequately manage their relationship with benzodiazepines. I think that that procedure equates to a specific kind of torture that only a psychiatrist knows how to implement all in the name of the Orwellian concept of duty of care.

The only way to escape this situation is to pay thousands of pounds to find the right psychiatrist who will prescribe you the drugs that you need to help you manage your mental health. I am fortunate enough to be in this bracket and I can see how the NHS actually makes it worse for people who are poor, rather than those who are wealthier which stands precisely against the very principles the NHS stand for. I can imagine a response to this being: well, benzodiazepines are a poor drug in the long term anyway — but my response would be firstly the literature is controversial[1] and secondly, *that's an assumption and science is not in the business of proving hypotheses but rejecting the null hypothesis. So I think it is fair for me to request some experimentation with a drug that is in fact incredibly helpful in certain situations.*

How many psychiatrists do you know who are charging thousands of pounds for people to be diagnosed with ADHD according to the DSM5 — a set of descriptive criteria that arguably have problems from a philosophical perspective as opposed to for instance the research domain criteria (RDoC) which attempts to bridge the gap between phenomenology and underlying neurobiological mechanisms rather than a descriptive account of mental health. I personally don't have too many problems with the DSM, but I personally know loads of people who pay money to psychiatrists fake the symptoms of ADHD in order to get drugs (amphetamines) that they then sell on the black market (to Oxford Students) or take themselves. With all due respect it's piss easy to do. Does this indicate that psychiatry is becoming a discipline where "psychiatrists" are just taking thousands of pounds to prescribe effectively lisdexamphetamine (effectively slow release speed — and soon marijuana) or

something resembling cocaine like Ritalin to desperate students with imposter syndrome with the end result being only those with money being the ones with helpful or fun drugs?

<u>Section 3 : Psychiatrists can use Duty of Care to be Sadistic</u>

I have seen GPs abuse their power and exhibit what could be interpreted as sadism towards patients who **<u>have no other options</u>**. The sadism manifests by giving them **their way or the high way** (which inconveniences a patient greatly). They can also gaslight patients by writing notes like "especially agitated" or "elevated levels of anger". It's especially infuriating when they disregard the opinions and knowledge of highly educated and good natured patients, like those who have attended Russell Group universities.

I've experienced this firsthand, and it's maddening. There's nothing worse than a GP with an inferiority or superiority complex who feels threatened by a patient who might be more intelligent or knowledgeable than they are. These doctors will go to great lengths to convince you that you're wrong and they're right, even when the evidence is staring them in the face. And as you point out, this can have serious consequences for treatment outcomes.

I can't tell you how many times I've felt like a GP despised me simply because I dared to challenge their proposed solution. It's like they can't handle the fact that a patient might be smarter than they are, so they resort to bullying, gaslighting and intimidation to maintain their sense of authority. And the worst part is that there's research to back up the idea that GPs do indeed judge their patients based on factors like emotional and intellectual fulfilment [2].

It's absolutely critical that highly educated patients like ourselves be given the opportunity to take on more and sometimes full responsibility for decisions made by doctors about the healthcare. There is the responsibility of if things go wrong and the responsibility of choosing which procedure. I am talking about both. We have the knowledge and the critical thinking skills to make informed choices about our care, and it's frankly insulting when GPs try to take that agency away from us. For simple everyday decisions, this matters more than decisions such as surgery of course.

And when it comes to the issue of controlled drugs like benzodiazepines, the consequences of this power imbalance can be deadly. If a psychiatrist refuses to prescribe Xanax etc. to a patient with severe panic attacks, simply because they expect the Navy Seals box breathing or acceptance and commitment therapy (ACT) to work, then, who is responsible when that patient turns to the black market for relief from suffering and ends up dying from a tainted or counterfeit pill of Xanax with fentanyl? Is it the patient's fault for seeking out the only option available they can see to relieve their suffering, or is it the psychiatrist's fault for being controlling and shortsighted in understanding how much the patient is really suffering and how the patient views the alternatives (which can of course include suicide)?

For those with money, the problem is simple: How many psychiatrists do you know who are charging thousands of pounds for people to be diagnosed according to the DSM 5 — a set of criteria that arguably have problems from a philosophical perspective as opposed to for instance the research domain criteria (RDoC) which attempts to bridge the gap between phenomenology and underlying neurobiological mechanisms rather than a descriptive account of mental health. I personally like the DSM, but I personally know loads of rich white middle class folk who pay the thousands of pounds to psychiatrists, then fake the symptoms of ADHD or whatever it is in order to get drugs (mostly Vyvanse or Ritalin) that they then sell on the black market (to Oxford Students) or take themselves. They also have the money to pay for the blood pressure reviews that need to happen afterwards.

With all due respect it's embarrassingly easy to do. Does this indicate that psychiatry is becoming a discipline where "expert psychiatrists" are just taking thousands of pounds to prescribe effectively lisdexamphetamine, ritalin (or benzodiazepines) and soon marijuana to desperate students with imposter syndrome with the end result being only those with money being the ones with helpful or fun drugs? I am not interested in paying money for drugs, just for drugs. I am interested in paying money for advice on how to manage four complex drugs that huge impact on mental health and if correctly managed can allow me to live a fulfilled and happy life. I wonder how middle management evaluates NHS psychiatrists. But, if middle management *indirectly* evaluate a statistic that relates to the prescribing of any kind of medication that happens to have any kind of side-effect which is measured by middle management as a bad thing which of course benzodiazepine or opioids suffer from, of course, they won't be prescribed — and AFAIK that is happening.

It's an extremely complex issue, but I believe that the ultimate responsibility lies with the medical establishment recognising this is a problem in the first place. I think a big mistake is taking the principle of a duty of care too seriously as it **explicitly** takes away responsibility about some important care decisions from the patient. For some I am happy for them to sign up to that model of care, but I believe one should be able to opt out of a strict notion of duty of care (i.e. doctor is not struck off if something goes wrong) for people who couldn't care for themselves let alone others. That includes the ability for doctors to prescribe controlled substances when they are to patients they don't fully agree with, even if it comes with some risks. It means treating patients as partners with unique needs and circumstances, rather than as walking diagnosis codes to be treated according to some rigid algorithm.

Currently if controlling or sadistic (in their enjoyment of lack of empathy and listening to their clients worries) doctors make a mistake, the current complaint system is pathetic and a PALS complaint is like waters off a ducks back for a consultant level doctor. The criteria for proving medical negligence — duty of care, breach of duty, causation, damage, foreseeability, and reasonableness — are all well and good in theory, but are difficult for an individual patient to prove against consultants. I have even noticed that when things go wrong, such as when I was injured by a nurse the nurse tried to gaslight me and say that this would've happened anyway. The system is rigged against highly intellectual, but very unwell both mentally (yet still with insight and capacity) and physically, and it's time for that to change. If one can take a bit of responsibility into their own hands, this reduces the needs for complaints in the first place, as one takes on a responsibility rather than a right to their medical needs. And for those who can do so, why not?

There must be a new model of "patient-centered care", one that recognises the kind of patient one is dealing with — those with insight, education, desire for control and responsibility and capacity — and gives this subsection of the population a real say in treatment. This comes from allowing those to opt out of a strict duty of care, where effectively if something goes awry with those who treat them are in a legally safer space. We need doctors who are willing to collaborate, rather than dictate, to see a patient as a human not a liability, who dare to be vulnerable — but with the appropriate legal structure supporting that.

All of the problems of middle management also filter down to how well the NHS perceives its care of me! And pharmacists — everybody knows (especially hospitals) they take way too long.

Conclusion and my proposed solution:

Here is the full list of criteria that need to be addressed to help solve this problem:

1. Get rid of middle management ENTIRELY and replace it by multiple health care systems that might compete (or maybe just one) each with their GLOBAL management that asks everybody how they feel organically.

2. Give clients the knowledge (with doctors) to make the best decisions for their own healthcare i.e. how people feel in any part of the NHS.

3. Get the best to improve the things that really matter to people's sense of health in different counties.

4. Finally to repeat this process.

5. Make pharmacies vending machines driven by AI that dispense in 5 minutes or less especially in hospitals.

6. Provide a way for me to opt out of absolute duty of care to a halfway house, where I have a feeling of agency, responsibility, control, power, and access to controlled drugs in relationships with GPs, psychiatrists and pharmacists. This prevents them exploiting their real and potentially corrupting power. Absolute power corrupts, absolutely.

Sincerely,
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Appendix:

[0] Key statistics:

- Chronic pain affects approximately 20% of adults, with 15% of highly educated individuals suffering from chronic pain.
- 8-12% of chronic pain patients develop an opioid use disorder.
- 30-50% of chronic pain sufferers also experience depression or panic.

[1] Panic:

1) A study by Pollack et al. (1993) in the Journal of Clinical Psychopharmacology followed patients with panic disorder for up to 3 years. They found that alprazolam remained effective in controlling panic symptoms over this extended period, with many patients maintaining their initial dose without significant tolerance.
2) Treatment-Resistant Generalized Anxiety Disorder (GAD): Schweizer et al. (1990) in the Archives of General Psychiatry conducted a 6-month study on alprazolam for GAD. They found sustained efficacy in anxiety reduction, particularly in patients who had not responded well to other treatments.
3) Severe, Chronic Anxiety: A long-term naturalistic study by Sutherland et al. (2003) in the Journal of Affective Disorders followed patients with severe anxiety disorders for up to 12 years. They found that a subset of patients maintained benefit from long-term benzodiazepine use without significant dose escalation or adverse effects.
4) Intermittent Use for Recurrent Severe Anxiety: Uhlenhuth et al. (1999) in the Archives of General Psychiatry studied the use of alprazolam on an as-needed basis for recurrent brief anxiety episodes over a 6-month period. They found this approach effective in managing severe, episodic anxiety without leading to daily use or dependence.
5) Combination Therapy: Goddard et al. (2001) in the Journal of Clinical Psychiatry studied the long-term use of clonazepam in combination with SSRIs for panic disorder. They found that this combination provided better long-term outcomes than SSRIs alone in some patients.

[2] GPs and patients:

1. Street et al. (2007) found that physicians tended to perceive patients with higher education levels more positively and engage in more patient-centered communication with them.
2. Willems et al. (2005) reviewed literature showing socioeconomic status affects doctor-patient communication, with lower SES patients receiving less information and involvement in decision-making.
3. Van Ryn and Burke (2000) found physicians rated Black patients as less intelligent and less likely to adhere to medical advice than white patients, even when controlling for socioeconomic status.