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Essay topic - 'Seeing the whole person beyond the diagnosis'

A Clinical Flatland

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Introduction

Flatland: A Romance of Many Dimensions by Edwin A. Abbott tells the story of a Square, who lives in a mathematical fantasy world, namely Flatland (Abbott, 1884). Flatland is a two-dimensional world where its inhabitants are all geometric shapes and this determines their identity, intelligence and status in society. In this universe, woman are straight lines, blue-collar workers are triangles, professionals are polygons, and finally at the top, aristocrats are circles. The story unfolds when one night, a Sphere appears and brings to light the knowledge of a third dimension. Slowly, Square begins to understand that there is more to the world than what he can perceive and asks, "if there is a third dimension, why not a fourth? A fifth?" Although Flatland is a satirical piece about the Victorian class structure, it has many parallels to modern psychiatry: Flatland reduces people to shapes, and psychiatry reduces people to a diagnosis. Classification is intrinsic to medicine, with current Medicare frameworks even demanding a diagnostic label in exchange for funding (Australian Government Department of Health and Aged Care, 2025). However, this can lead to a dangerous progression: from recognising a patient as 'Jane Doe', to then referring to her as 'the borderline patient', and eventually reducing her to simply, 'bed 4'. This essay explores how unidimensional perspectives, diagnostic labels and broader system pressures can flatten psychiatric care, highlighting the importance of understanding a person as a whole, in what is becoming an increasingly digital mental health landscape.

Lineland

When Square travels to a one-dimensional world, Lineland, he realises the limitations of his perception. The inhabitants of Lineland can only perceive points along a line, reducing complex shapes to their points and edges. Here, his reality is a singular point of view in a singular point in time. Telepsychiatry carries a similar risk of taking a one-dimensional view of a patient. Australia's

first telepsychiatry service began in 1998 (Hawker et al., 1998) and has since grown rapidly during COVID-19, now becoming a part of the Medicare Benefits Schedule (Department of Health, 2020). Telehealth services were rare pre-pandemic, however in 2025, 1 in 5 Medicare-subsidised mental health consultations are delivered via telehealth (AIHW, 2025). Although telehealth improves access to psychiatric care, like with any healthcare service, it comes with its own set of challenges. An article by RACGP highlights the dangers of telepsychiatry, especially with the rise of single-issue telehealth providers, particularly regarding weight loss, medical certificates, and medicinal cannabis (RACGP, 2024). During my acute inpatient psychiatry rotation, I observed numerous patients presenting with first-episode psychosis following recent prescriptions from online cannabis services, often without any communication between the prescriber and the treating doctor. An Early Psychosis Centre in Queensland found that 66.7% of their patients (n = 67, 11/2022 - 7/2023) with THC-induced psychosis had obtained medicinal cannabis online, and many continued to receive these online prescriptions even post-psychotic episode (Lupke et al., 2024). In all of these cases, the clinical indication was anxiety, despite TGA guidelines advising that THC products are not appropriate for patients with a history of psychosis or concurrent mood or anxiety disorders (Lupke et al., 2024). Alarmingly, AHPRA found a doctor had issued over 17,000 cannabis scripts in 6 months — equivalent to 1 prescription every 4 minutes (ABC, 2025). This is not an isolated finding and over 100 similar cases have been documented, with some clinics advertising free phone-only consultations and online questionnaires “coaching” patients to give the “right” responses to receive a THC prescription (ABC, 2025). In these situations, it is evident that patients are not treated holistically, instead they are reduced to a diagnosis, and their vulnerability is commercialised. Despite the misuse of telepsychiatry, there are clear strengths when used appropriately, including: improved access, reduced practical barriers such as travel and cost, shortened wait times, and maintaining a continuity of care when there are workforce and inpatient bed shortages (Sharma & Devan, 2023). Ultimately, telehealth is not inherently inferior — much like Lineland, it is only a different dimension of psychiatry that is most effective when integrated with the biopsychosocial model to provide holistic patient care.

Spaceland

Within the Flatland universe, Spaceland represents an expanded level of perception — a contextual opposite to the narrowed perspective of Lineland. In Spaceland, Square gains the ability to see depth, finally seeing shapes in their completeness, rather than their points or edges. Square is now able to perceive complexity and meaning that was once invisible to him in the lower dimensions. Just as Square learns that the one-dimensional Lineland and the two-dimensional

Flatland only reveal a part of reality, likewise, we learn in psychiatry that a person is never just a diagnosis, a series of symptoms or a moment in crisis. This leads us to consider the biopsychosocial model of health. I have observed this principle in a gender dysphoric South Asian patient who was grateful for his diagnosis of major depressive disorder as it provided an explanation for his symptoms and validated his distress. He initially struggled to seek help due to stigma and taboos surrounding mental illness and sexual identity within his strict family and community, as is frequently the case for South Asian cultures (Hu et al., 2024). Slowly, with the support of his friends, he recognised his diagnosis was only a fraction of his identity and went on to pursue his dream of becoming an artist. Here, it is evident that mental health outcomes are shaped by more than a diagnostic label — particularly in Australia's diverse population. In the multicultural melting pot that defines Australia, it is essential to take into consideration the contemporary social, political and economic shifts in society that affect mental health. The Israel-Gaza war is a pertinent example of an event that has caused psychosocial reverberations worldwide. A longitudinal study by Rees et al examined the effects of the Middle East conflict on the mental health of Australian women with Palestinian origins between 2023-2025 **(**Rees et al, 2025). This study found that these women experienced a statistically significant increase in panic disorder symptoms and poorer quality of life, particularly those born in Palestine or had family members harmed or gone missing (Rees et al, 2025). This phenomenon of "vicarious trauma" arises when people are exposed to recounts or images of other's suffering. Vicarious trauma has the strongest impact when individuals closely identify with the affected demographic (Rees & Moussa, 2023). In the context of the Israel–Gaza war, Palestinian and Muslim communities face an increased risk of complex PTSD, panic disorder and identity-based anxiety (Rees & Moussa, 2023). This highlights the importance of broadening one's perspective and tailoring mental health treatment to the current sociopolitical climate.

Pointland

As Square travels from Flatland to Spaceland to Lineland, he eventually reaches Pointland. Pointland is a zero-dimensional solitary entity that perceives itself as the entire universe, with no concept of space or motion. Isolating a patient to their diagnoses mirrors Pointland's extreme reductionism. During my training, I observed a patient with a significant forensic history, antisocial personality disorder, and schizoaffective disorder on an ineffective community treatment order. My consultant's approach to his treatment was "discharge him — wait until he does something illegal then he can go to jail — where he belongs". With the immense burden on the public mental health system, it is not uncommon for psychiatrists to adopt a jaded attitude. This burden even

results in the whole system itself tipping to the point of collapse, as was evident with the resignation of 206 of the 270 public psychiatrists in NSW (Looi et al, 2025). As a result, the mental health pressure falls onto emergency departments and GPs, who “already have a significant mental health caseload and are time poor” (RACGP, 2025). The frequency of mental health-related presentations to ED has increased from 109 to 115 per 10,000 Australians from 2022–23 to 2023–24, and continues to do so (AMA, 2025). Emergency departments have become the default, and often, the only option for people in mental health crisis due to underfunded community services. Despite the desire to “treat a person as a whole”, there are many barriers clinicians face that need to be addressed in order to achieve this goal. This is most evident within the realm of forensic psychiatry, the lowest resourced and punitive environment (Davidson et al., 2020). Dr Trevor Ma describes his experience working in forensic psychiatry, where initially, he was motivated by his moral duty to improve prisoner mental health (Ma, 2025). However, he quickly realised that Australian prisons are fundamentally incompatible with mental health, and he questioned - was he actually doing more harm than good? Dr Ma describes feeling “trapped between the constraints of the system” and his “obligation to patients, the health service, the prison, the law, and public safety.” He “juggled rationing [his] time between doing everything [he] could for the few or doing the little [he] could for the many.” This exemplifies the moral distress felt by many psychiatrists, where systemic barriers prevent holistic treatment. Overcoming this requires courage, resilience, and the determination to challenge systems that undermine ethical care.

Conclusion

Viewing patients beyond their diagnosis is a luxury reserved only for the psychiatrists who have the time, energy, and resources to do so. In a system that incentivises diagnostic reductionism and prioritises bed flow over holistic care, patients’ biopsychosocial needs are often compromised as clinicians manage an unsustainable caseload. Most psychiatrists aspire to see the whole person, yet current structures make this ideal difficult. The resulting moral distress arises from knowing what ethical care is required, but being limited in what can be provided. Addressing this demands expanded workforce capacity, improved telepsychiatry support, increased inpatient beds, and strengthened community mental health services. Without reform, psychiatry risks regressing into a clinical “Flatland.”

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