

Pastoral healthcare often needs a very different approach from our treatment or prevention

I must create a system or be enslaved by another man's

– William Blake, *Jerusalem*, 1804-20

Key points

- Advances in curative and preventative healthcare continues apace.
- These advances often neglect, then displace, pastoral healthcare.
- The consequences for the NHS? The technology is much better; the personal is mostly worse.
- Why?

In a recent public interview¹ you shared clearly your perspectives about trends and responsibilities in healthcare. In particular, you described how advances in biological science were leading to radical innovations in *curative healthcare* – explaining how genetic mapping can now direct precise and personalised treatments for serious illnesses such as many cancers.

But you cautioned us. For alongside such potent curative healthcare we will always need other kinds of knowledge and science to implement our best *preventative healthcare*. For example, you talked of intelligent anticipatory measures we can take about the way we live: our intakes of sugar, alcohol, drugs and tobacco; the exercise we take; the contaminated air we breathe. You were clear: any sophisticated health service must recognise the necessity of prevention whenever we can manage this – we save not only people, but money.

So, you emphasised, each of these elements is equally important and must be synergised. Yet, to my mind, your view hardly included a third element quite as essential to our health services: *pastoral healthcare* – the engagement of *personal care*, rather than your rightly vaunted *personalised treatment*. These two terms may sound similar, but they are very different in terms of how we understand them and what each may deliver. I raised this point in your public interview: you seemed to acknowledge its validity, but many other participants’ questions and strict time constraints guillotined further dialogue. I thought then that this relegation of pastoral care was a small example, a microcosm, of what has happened culturally: we have less and less time, headspace and heartspace for personal aspects of healthcare.

The following is diagrammatic of this:

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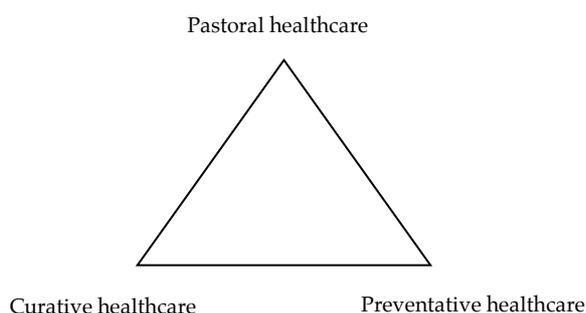


Figure 1
Holistic healthcare

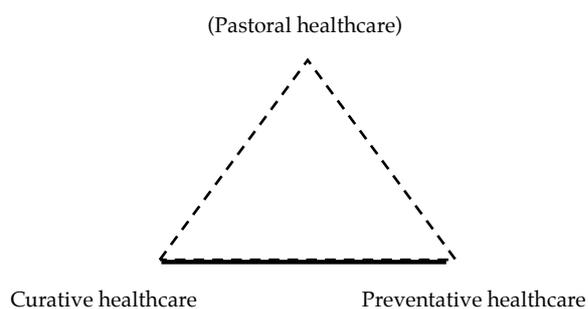


Figure 2
Industrialised healthcare

Before considering these figures we need to define *pastoral healthcare*: it is what healthcarers can offer when we cannot rapidly and completely fix a problem with

technology or instructions. So it comprises our many influences toward healing, comfort, palliation and compassionate fraternal connection. So it is the 'art' of the medical practice; in contrast, the 'fixes' of cure and prevention are derived more from its science. Pastoral healthcare may also be said to be personal and humanistic.

Clearly previous generations of practitioners had far less reliable science, so relied far more on pastoral healthcare though often this was presented, unreliably, as curative treatment – something we now consider placebo-type practice, or specious – sometimes fraudulently so. (From historical and anthropological perspectives this is fascinating.)

Over the last century our science has become much more potent and precise, and with that our treatments and prevention have drastically reduced or eliminated vast areas of serious disease. So what then remains of our need for any humanistically-based pastoral healthcare? Paradoxically and surprisingly, probably just as much as before – if not more. For our anguished human confusions and dissonances – so often expressed in functional and mental-health conditions – remain unabated, possibly increased; and then our increasing longevity is bought often at the price of slowly failing systems and parts – our eventually irreversible degenerative conditions. None of these can be easily 'fixed', yet all are increasing: pastoral healthcare must bear the brunt.

And here we come to a cruel yet seminal paradox: the more potent, charismatic and quantifiable has driven out the more subtle, humble and unquantifiable. Our last century's evident and often dramatic success of preventative healthcare (eg the elimination of smallpox or poliomyelitis) or curative healthcare (eg the surgical cure

of cataracts or hip arthritis) have – because of their massive success – come to model radical and rational types of problem-solving and intervention throughout our healthcare. We then create management templates and algorithms which become assumed as default. All these predicated approaches tend to directive interactions that are generically packaged, thus relatively heedless of personal subtext or context. This has serious practical consequences because this selective neglect of human context, meaning and understanding then neglects the essential nucleus of pastoral healthcare. This may not be what is intended, but it is what happens.

Healthcare becomes more industrial and less fraternal, less holistic.

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We can think of these changes as being a kind of exclusion by displacement. This has led to a change of character from *holistic healthcare* (Figure 1) to *industrial healthcare* (Figure 2). This is certainly not all bad. Generally – in broad outline – that which depends on procedure and technology has got better; but that which depends on personal meaning and relationships is worse.

This is true of both patient and practitioner experience: research of both academic and journalistic kinds has been demonstrating this, repeatedly, for many years.² But these changes – towards an industrial type of healthcare that largely discards its personal and pastoral aspects – also possess a massive momentum and a complex economy: they are very difficult to change or reverse direction.

The current commercial fragmentation of the NHS has, albeit unintentionally, added to these juggernaut qualities.

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Often we are unsuspecting of this complexity. This may account for why it keeps eluding our analysis and reform. For example, at this meeting you said of GPs: '[they] work best in large amalgamated practices where they are contractually employed, not self-employed in their own small practices ... This scaling-up and systemisation is what most GPs want, too...'

I assume your sincerity and good faith in sharing these notions, yet they are substantially untrue for most GPs and their staff and patients. Twenty-five years ago, say, these people were, generally, much happier and better served by smaller, more local and autonomous, surgeries where people knowing one another could lead naturally to *personal continuity of care*.² Frequently this was an assumed cornerstone of practice – not an add-on or bolt-on as we are struggling to achieve now.

But successive governing authorities have been determined – by all sorts of means – to industrialise, scale-up and micromanage. Very problematically these ratcheted reforms have had the *reverse* effect to what you mistakenly implied: GPs, in fact, are increasingly demotivated and ailing. Voluminous and alarming statistics all indicate a grave condition with a poor prognosis for General Practice; increasing poor recruitment, earliest retirement, career abandonment, sickness (many kinds), litigation, burnout, drug and alcohol abuse...²

Most GPs will tell us³ that such problems are due to depersonalising pressures, the depletion or derogation of relationships and thus of the satisfactions of personal, pastoral healthcare: the vocational heart of medicine is dying.

This is not just impoverished humanity, it is perversely doomed economics.

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So to return to your interview. Yes, we have good reason to be optimistic about what you talked about: curative and preventative healthcare.

And about what you did *not* talk about – pastoral healthcare? The outlook here is very different. As I look toward my own old age and need for care, I do so with increasing and well-founded trepidation.

I hope that, in your senior advisory role, you may be able to explain to government how and why our successive reforms – always vaunted for the undeniable greater good they will bring – have so often had such paradoxical and perverse consequences.²

Meanwhile thank you for your devoted and important work: the conditions and times are certainly difficult.

Dr David Zigmond

Notes

1. 23 April 2018 at the Royal College of Physicians
2. The statistics, from reliable sources, are voluminous and convergently consistent. They show clearly, for example, increasing and record levels of GP staff loss, sickness and poor recruitment over the last decade. Easily accessed are those from the Health and Social Care Information Centre, the Kings Fund, the British Medical Association, Office for National Statistics, NHS digital. Compilation-reports are many via *The Guardian*, *The Times*, *The Telegraph* and the BBC.

To specify and list a small fraction of these would require a very long document.

3. I have written and published extensively about these problems. I have been fuelled by nearly fifty years' experience as an NHS doctor and, latterly, hundreds of conversations and interviews. Relevant articles are most readily accessed via my Home Page. If you are interested I recommend:
 - a) Article 31. *From Family to Factory. The dying ethos of personal healthcare*
 - b) Article 100. *Collectivising the Personal. Seminal lessons from Bolshevism*
 - c) Article 93. *People or Procedures? Personalised treatment can be very different to personal care. Why?*

Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learning-systems.com. Many of his videos are also on YouTube.

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