The Extinction of Care by Treatment
Our healthcare's heart-failure

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Care and treatment may be synergistic, yet they are very different. Our healthcare needs ceaseless and mindful balance between them. What happens when we neglect this?

Two months ago the media briefly frissoned another dark story from our NHS: six recent suicides and one homicide in the acutely mentally ill. The transient newsworthiness came from the probability that the deaths were preventable: psychiatric beds were sought for these patients, but none were available. Typically, the media-shocked story has rapidly passed from view and memory, but the vast problems it signifies are still very much with us. What are these problems? How have they arisen and what can we do about them?

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Forty years ago I was a young psychiatrist. I remember hearing hopeful talk about how more scientific forms of diagnosis and treatment would make longer-term and residential care unnecessary: specialist-delivered, focused treatments would make extended forms of human containment unnecessary. Benefits to mental healthcare would be like those in surgery: speed, accuracy, efficiency and economic savings. The closure of large mental hospitals became a celebrated symbol of this. My view, though youthful, was jaded: we were over-reaching our medically-modelled treatments to complex human distress.

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Most of these early doubts have proved dishearteningly accurate. As a now veteran inner-city GP I have seen the dismemberment, then disappearance, of our better forms of long-term containment and care: it is not just that the Asylums have closed – it is that the wider ethos of 'asylum' – compassionate containment – has become increasingly rare. I find it almost impossible now to find for my patients the kind of protective spaces and relationships that are essential for many kinds of healing and growth – the kinds of investment I could more easily make as a young practitioner.

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How has this happened? How – amidst our plethora of Royal Colleges, think-tanks, specialist trainings and massive resources (yes!) – have we departed so far from our better sense and sensibility?

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I think our error has been a failure to heed the subtle differences yet synergy between *treatment* and *care*, and then lose our capacity to craft our best *therapy*. What does this mean?

First, some subordinate notions: generally, care comes from ethos, while treatment comes from technology; care is about wholes and relationships, treatment is about parts and mechanisms; care springs from – then returns to – the intersubjective, treatment remains closely tethered to the objective. Treatment may fix, but it is care that heals. The best of our healthcare balances these with ceaseless sentience.

In recent times we have lost the skills of blending these delicate amalgams. Paradoxically, this is due to the many and dramatic successes of our technological treatments: we have then adopted such potent activities as the dominant and determining paradigm. So, increasingly we have replaced care by treatment; personal understandings by formulaic care-pathways. Pastoral healthcare* now suffers from a stark inverse relationship: the technologically complex sharpens and burgeons; the humanly complex is short-circuited and neglected.

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Such displacement of care by treatment is seductive, for treatment seems to bypass human vagaries and uncertainties and, instead, anchors us to what can be reliably manufactured, measured and managed. But like many seductions this is specious: it hazardously obscures what we may lose – our unindustrialisable humanity – our realms of relationship, imagination, meaning and spirit. Those are at the metaphorical heart of what we may circulate with others, to heal and grow – or to endure with equanimity.

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The economic costs of our lack of human containment are hard to measure but probably vast. This is because much distress is pleomorphic: it takes on

other forms and is then dealt with by other agencies: A&E departments, Police, Social Services, Probation, Courts, Lawyers, Prisons (a desperate asylum), other medical specialists … the list lengthens with investigation.

Such human and economic cost extends far beyond psychiatry. The submission of care to treatment has etiolated the entire spectrum of pastoral healthcare. In a culture dominated by goals, targets, financially linked points, managed procedures and care pathways there is, ineluctably, less and less head-space and heart-space to nourish human imagination, connection and meaning. What then?

To start, we become demoralized and alienated.

Morale and sense of connection are crucial to human activities and welfare. Several decades of research has recurrently shown how important these are in the genesis and outcome of innumerable health and welfare problems. Parallel to this is evidence of NHS healthcarers' increasing demoralisation and burnout: officially in statistics of sickness, early retirement, career abandonment, emigration, drug and alcohol abuse and litigation. More informally this flows steadily in innumerable stories and descriptions of professional loss, alienation and stress: how our convivial healthcare 'family' has turned into a hostile network of siloed and fractious factories; personally infused acts of care become executively managed procedures; the quiet warmth of vocation becomes the staccato clamour of career. Such accounts have common undertones: bleak loneliness, dispirited ennui and impotent anger.

By contrast, good quality care nourishes the giver as well as the recipient, for care – unlike treatment – is rooted in human resonance. This is what we have jettisoned.

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'Six suicides and one homicide' was a deserving headline, yet merely the iceberg's tip. Far beneath the surface, extending massively, lies the dying body of an ancient healthcare ethos.

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How can we resuscitate a dying culture?

What are the best conditions to foster experiences of meaning and connection in our work?

As with any living culture we must first depend on a nurturing substrate. Yet our NHS substrate is now formulated in a way that becomes heedless of this vitalising principle. Our realm is now governed and notioned by language and institutions of objects and the lifeless: purchasers and providers, competitive markets, commissioning, commodification, and boundaried, autarkic trusts. In such a milieu our contacts and experiences become disinvested in human interest and relationship. This situation now confronts us with a very difficult dilemma, for to make a path back to a humanly nourishing and sustaining culture will require much demolition of many of our recent developments.

The stakes are high: contention will be fierce.

Note
* *Pastoral healthcare* refers to all those therapeutic engagements that cannot be resolved rapidly by standardised, technology-based interventions. The input of pastoral healthcare is thus best understood in human (*v* technical) notions and language. Pastoral healthcare thus spans most of mental health, general practice, chronic disease and rehabilitation.

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