Then & Now

A Long Day’s Journey Into Night

Pastoral healthcare, psychosomatics and professional intimacy

– recollections and reflections

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Our cleverness of invention and manipulation can so easily run over our wider responsibilities of stewardship and care. Is this happening in our healthcare evolution?

A multidecade personal odyssey explores.

September 1975. Teaching hospital, central London

I am the junior on-call psychiatrist – the one first contacted for all the uncontainable or indecipherable patient-human problems that might erupt throughout the hospital. The crisp and correct telephone voice of Muriel, the sharply organised and impressively head-dressed veteran ward sister warns me now: 'You'd better be ready … this one's particularly difficult!'.

I am ushered towards a side cubicle: 'He was seriously disturbing the other patients … of course they need to rest … our security people have more space in there, too, to restrain and cope with him.'

The fantasy-image I have already conjured of Cecil is potent, muscular and glowers with delusional menace. Yet the elderly frail man I am now shepherded towards is pallid, lax-fleshed, skitter-gazed and twitchy with bewildered agitation. Flanked now by two much younger and stronger security men, and tranquillised by injection, he lies in oblique and exhausted surrender across his iron bed, his hand raised to cover his face. His breathing is spasmodically and jerkily interrupted. Is he silently crying? I call his name, but he mutters only inaudible fragments.

Muriel beckons me to the doorway away from Cecil's earshot. She gives me a rapid run-through of essential events. '… Admitted last week from Surrey by GP because of severe and worsening bilateral heart-failure with rapid fibrillation … Came with his wife … Was very shy, enfeebled and uncommunicative at first … but on day three he started getting agitated. Despite being weak he wouldn't get into bed at night and later kept switching the light on, talking (to no one) very loudly, saying 'I am the Light!' and then attempting – despite his evident heart-failure and with his drip – to march military-like up the corridor. Of course, my nurses attempt to coax him back to bed but he won’t listen: despite his breathlessness he’s talking louder and louder, and then starts swearing at them when they try to reason…

‘Oh, but doctor, it got worse: while they’re trying to calm him, he starts masturbating … and then very deliberately exposes himself to two of them … that’s when we called security…

‘He’s so completely different to last week, when he came in. His wife is shocked and confused by how he’s been: she says they’ve been married fifty years and he’s never been remotely like this before, *never*. Poor woman.

‘But, doctor, I’ve this before: it’s mania isn’t it?’

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Muriel’s uniformed efficiency seems matched by her imaginative projection. Cecil’s now-slumped and drug-quietened, septuagenarian frame has played-out so many hallmarks of this always-startling acute disruption, mania. She shakes her head with bewildered sorrow: ‘I wonder why he’s turned like that, when he’s never been like it before? It’s very strange…’

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The next few days helped Cecil and I assemble an answer. As he emerges from his tranquilliser-haze I sit beside him and tell him that, when he is ready, I would like him to tell me what he has been experiencing, what it has been like to be him. I also float an observation: that beneath the tumult of his flailing angry defiance I thought I glimpsed, breaking through, tears of the abject. Cecil offers a brief nod, both embarrassed and relieved, I think.

‘What were they, the tears?’, I ask.

He now looks down, shaking his head sorrowfully, before gazing up at me, his eyes wet-rimmed and plaintive. His spectacles are lopsided from battle-damage, now sellotaped, and his torn pyjama tops safety-pinned by the staff – a reparative rehabilitation.

‘I can’t explain … it’s too confusing’, his irresolute voice trails into silence.

‘Sometimes it’s the confusion that masks what we most need to say’, I offer hopefully.

That hope did not anticipate the rawness, the boldness of this seemingly crushed and reticent old man: ‘How can I say, doctor? It’s my whole life, you see … and it’s coming to an *end*!’. His voice rapidly stirs and gathers to an angry bark, a still active redoubt of his angry defiance. ‘And how can you help with *that*…?’. A softer retreat.

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Over the next days Cecil settles and begins to talk. He tells me he is now doing so in a way he has never dared, or been able, to before. From hesitant beginnings he surveys with me a life shamed, he feels, by timorous avoidance and craven camouflage.

'How come?', I ask.

His voice trembles with the hesitant nervousness of a man released from a long confinement, yet his story is surprisingly clear and coherent. An only child born into a turbulent if prosperous Edwardian home. He has no memories of any parental or family happiness, joy or laughter. Father's stormy unhappiness, in particular, he remembers with particular fear: his sharply flashing eyes, his booming, threatening voice, a looming powerful frame sceptring violence, a ready stock of humiliating sarcasms. Mother cowered and adjusted with stoic retreat; Cecil sought diplomatic silence, compliance and invisibility, a survival in absence.

He sees how his following six decades never escaped this hazardous, trapped childhood. 'I always took the safest, quietest course. *Don't risk it! Just blend in*! That's how I've lived my life. Mary, my wife, is the same: that's why we chose one another, I suppose. We somehow managed to conceive our only child, Edward … though neither Mary nor I ever explored getting pleasure from that sort of thing…

'The same was true in my work: I never felt entitled to much. I was always an anxious worker, afraid of making mistakes or getting blamed… So I worked in the office for the same manufacturing company for the whole of my working life, until my retirement, with only some small promotions… That was two years ago: they had a small 'do', presented me with a traditional gold watch, shook my hand: *Thanks! Good luck!*

‘And then what? Our house is ghostly quiet. Mary is lost in a world of painful arthritis and a succession of TV soaps. Edward, our grown-up son, lives far away with a polite distance: “I want a different kind of life, Dad…”, he said to me…

‘And I suppose I do, too … but I’ve not had the courage. And now my failing heart is telling me *Your time is running out. That’s all you’re getting!’*

‘So your madness was a like a last-ditch protest, a way – if only briefly – of reversing your life-course…’, I ventured softly.

‘Yes…’, Cecil sighs and gulps, his swallowed tears rattling the back of his throat.

Remarkably, he now reaches across to the bedside table to take my hand: he is searching for a caring father at Life’s end – a man, myself, fifty years younger than he, offering this fleeting yet precious bridge.

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Over the next few days it is not just his manic defiance that settles with his expression of trapped and ancient sorrows. With this melancholic candour comes a new kind of acceptance of his largely compromised and spent life. And – surprising to his prescribing physicians – his refractory and perilous heart failure and arrythmia become rapidly responsive and contained, ‘a highly unusual development’, they say.

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Dr T, my supervising consultant, is less surprised yet certainly interested. As a Physician in Psychological Medicine he had devoted much of his attention and effort to understanding ‘psychosomatics’: how emotional and life-problems might precipitate or fuel all kinds of illness, including the most lethal.

Towards this project Dr T had, for some years, hosted the psychoanalyst Michael Balint's pioneering work with a small, stable group of GPs. They investigated the human, ‘non-clinical’ subterraneum of patients’ ailments and doctors’ interventions – the world of usually inexplicit fears, struggles, desires, conflicts and fantasies. The doctors (clearly a small, self-selected group) responded with increasing conviction and commitment to this mission – they did not just find their work to be more interesting and motivated: they observed how their diagnostic acumen sharpened and their therapeutic leverage deepened. This ‘cultural-cell’, later called the Balint Movement[1], grew a wide educational – some would say spiritual – influence in general practice for the next twenty years, until the serial neoliberalising and ratcheting NHS reforms.

So Dr T is a quiet luminary amongst practitioners who wish to deliberate on, and centralise, the themes of meaning and relationships as ways of understanding our illnesses, treatments and therapeutic influences. In this he wishes to invest in the art and philosophy of medical practice, to synergise its prevailing science.

I take to Dr T my serial reports of Cecil’s stressed disintegration, then poignant epiphany. He somehow conveys to me, within his elegant, understated professional detachment, a deep personal resonance. ‘You should write this up, it’s a seminal tale’, he says.

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I did. It was published in a mainstream medical journal in 1976 as *The Medical Model: its limitations and alternatives*.[2] Looking back now, several decades later, I see how this theme served as a prototype, a stem-cell, for my many subsequent investigations and essayed variations.

A more personal validation followed five years later. Cecil’s son, Edward, located me and wrote telling me of his father’s recent peaceful death. His handwritten letter said:

> *I wanted to tell you about Dad’s death last week, and also to thank you on his behalf, and also that of myself and mother. After he’d had that breakdown in your hospital he changed: he became much less inward, touchy and cut off. He wanted to be part of things more. He became much more affectionate.*
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> *Dad was able to talk about his childhood with us both in a way that he never had before, so we became closer. He said that his talks in the hospital with you helped him see things and unlock so much. He certainly became less worried – that has made his death somehow less sad and more OK for mum and I…*
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> *So whatever you talked to Dad about all those years ago, thankyou…’*

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1976 on. Small inner city general practice. Large hospital psychological medicine. It was a convergence of such early experiences – witnessing and understanding Cecil's struggles and healing, Dr T's guiding headspace and heartspace, the pioneering Balint Group's communal efforts to grow greater emotional intelligence and wisdom – all those helped me conceive a working lifetime of what I have later variously called Pastoral, Humanistic or Holistic Healthcare. The designation is a formality: what matters is the underlying principle.

That principle is this: in all our healthcare encounters we must strive for our fullest portrayal – the best composite – that we can manage between objective biological and social knowledge (the *generic*), and the individual worlds of experience, understanding and meaning (the *idiomorphic*). Clearly that balance and mix needs to vary greatly throughout our care: requirements within an intensive care suite and a psychiatrist's consulting room are likely to be very different.

Generally these two elements of healthcare – the generic and the idiomorphic – are equivalent to other aspects we describe as important. So the generic is allied to science, standardised treatments, and mass production in practice. The idiomorphic is more concerned with the art, bespoke care and individual understanding in our encounters.

This became particularly clear to me in my poignant and very personal encounters with Cecil: while the generic discipline of the physicians predicated their scientific drug treatments etc, my efforts were conjured more in the art of the idiomorphic –

how by bespoke understanding and contact I might awaken Cecil's own natural internal resources for immunity, growth and repair – the components of healing.

All of these contributed, I believe, to how Cecil's life was not just lengthened, but deepened, enriched and engaged.

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For the next twenty years, working as both a small inner city general practitioner and a part-time physician in psychological medicine in hospital, I was freely able to base and design my work on these principles, according to patients' and colleagues' resources and requirements. The working culture, then, had sufficient flexibility and dis-organisation to allow for that kind of practitioner-autonomy and (I would say) creative discrimination.

Yes, it is true: such benefits of that period were mixed with a sometimes hazardous kind of variation and unevenness of expertise and approaches that were undeniable (now) problems. Such was the shadow of that bright period.

Yet for those that could operate in the freedom and light of that period, the blessings were considerable. Despite the burden of its inconsistencies it is now often referred to by veterans from that period as a 'Golden Era' in psychiatry and general practice. If, indeed, the technology, the governance and the consistency were all then much poorer, where was the gold?

Almost all of those erstwhile practitioners would now answer: in personal relationships that depended upon, and fed into, professional trust and intelligent autonomy. A much valued expression and product of this was personal continuity of care. It was such personal engagements, containments, commitments and anchorage that made possible the kinds of resonance, empathic comfort and support that could best help healing or, at least, the most creative endurance and comforted adjustments. For general practice and psychiatry in particular such skilled professional-personal identifications were the bedrock of the heart, art and spirit of practice. Getting to know people and their lives – colleagues as well as patients – was what made this often difficult work also humanly meaningful and deeply satisfying.

That is why in that 'Golden Era' so much functioned better: staff recruitment, morale, health, career endurance and colleagueial conviviality – and patients' overall satisfaction and trust – all this despite clear and widespread improvements in treatment technologies since that time.

Certainly in these forms of pastoral healthcare – mental health and general practice – a foundation of scientific knowledge and protocols is essential. Yet most experienced practitioners previously came to see the art of personal engagement, understanding and guided containment to be quite as important. And, crucially, that is where the work's deeper nourishments and sense of meaning lies.

It is in this personal familiarity that a particular kind of professionally defined and boundaried intimacy can develop its therapeutic leverage: it is not, of course, the same kind of reciprocated vulnerability of intimacy we may find in our personal lives – the practitioner here professionally makes their own vulnerability *implicit* only, so a certain asymmetry is necessarily maintained. Nevertheless, such asymmetry may serve as a powerful tool of compassionate identification, support, accompaniment and guidance. Most of us have been, at some time, intensely aware of the potency of its presence and importance … or the lonely pain of its absence.

Why is that?

We humans are beset with fears that are near-universal – for example, of aloneness, insignificance, powerlessness-meaninglessness and nothingness-death. Much of our personal and social life can be seen as procuring or offering help in enduring and navigating these. The art and humanity of medicine values and incorporates all this. Such practice becomes about how to thus personally contextualise *this* person's difficulty at *this* time.

Medicine is a humanity guided by science. That humanity is an art and an ethos.

That is what Dr T and the Balint Group showed me. And that is what Cecil responded to with his longer and more engaged life.

These were good lessons for me and similarly minded and spirited contemporary colleagues who – mostly – shared such fraternal human identifications. We did not then talk much about the often irreplaceable value of personal familiarity and continuity because it was not (yet) threatened: it was simply *there,* it was our modus operandi, an assumption.

In such a culture the delicate yet powerful approaches of 'intimate' psychosomatics could flourish. This made up a large part of my decades in my long tenures as a family doctor, and in hospital as a physician in psychological medicine. This approach was much appreciated by both colleagues and patients, with much objective validation. Yet it was doomed.

What happened?

2023. A retirement retrospective

Such were the patterns of personal doctoring that I learned with such interest and gratitude early on in my career: alas, they would become increasingly unviable, even countermanded, in the last thirty years.

Curiously, yet instructively, this loss happened largely through serial reforms to the NHS that have been designed and mandated to improve our services, to make them more accessible and efficient. There is a German work for this kind of serious bathos: *Verschlimmbesserung*.

How did this come about?

Consider the neoliberal agenda, pioneered particularly in the Thatcher era, but still highly influential: it believes in the marketised commodification of all accessible activities. In our welfare services, particularly our healthcare, this has led to increasing modelling on competitive manufacturing industries. Coincidentally this has been massively enabled and amplified by developments in digital technology. The more this policy has been mandated, the more healthcare has been viewed as a system of interlocking and productive machines, rather than a responsive complex of living ecosystems. Our view then becomes more mechanistic and inorganic; less alive and organic.

Important consequences are bound to follow the devitalisation. These can be well understood using a comparative analogy from engineering (the inorganic) and ecology (the organic). To illustrate this distinction we can take the contrasting examples of an internal combustion engine and a conscious, social living organism.

The engineer's task, to design the maximum performance of his engine, will seek to improve the combustibility, flow and precise distribution of the fuel; improve the compression and gas-flow characteristics of the combustion chamber etc. All of these can be determined, designed and controlled by experts existing evidently outside the engine. All is *externally* resourced.

The ecologist, by contrast, asks questions about the viability and sustainability of habitat, the adequacy of ambient nutrients, the nature and reproducibility of relationships, the complex interdependence with other species … and if the ecological project is human, the presence and nature of meaning likely to be experienced and generated. These are all largely *internally* resourced, exchanged and recycled.

A crucial folly common to our decades of serial reforms has been the increasing privileging of engineering over ecology: we clamour with our clever manipulations but lose the patience and wisdom for good stewardship. Hence we have tried to design and manage NHS activity to become like competitive industries, expediently automated and commissioned to mass-manufacture for consumers. Hence the powerful forces to standardisation, commodification, scaling-up, digital/remote management, interchangeable rota'd and relayed staff…

What gets lost to these industrial reforms? The short answer is the vital nuances that make for sustainable living social systems. In particular the smallness of scale that makes familiar and trusting bonds; the stability of known staff who can invest in, and witness, the life-consequences of their work; the assumption of personal continuity of care whenever this is possible and wished for.

It is often and importantly true that our current industrially-skewed 'engineering' system has brought us many improved technical treatments for generically fixable conditions. Yet this is in many ways a pyrrhic victory: for the rest of healthcare – that which is not readily fixable – becomes increasingly unrecognised, neglected or misunderstood. In fact (surprisingly to many) this is the larger part of primary and mental healthcare. Consider: problems of maturation and development, stress-related and psychosomatic conditions, ailments of BAMI (behaviour, appetite, mood and impulse), all chronic conditions (by definition), irreversible ageing processes, and terminal care – none of these are readily fixable. So industrially conveyed 'treatments' tend to become hollow in their ready and decisive authority. Technology here may offer some limited biodetermined relief, but what is required more are the complex and less didactic skills of *care*.

What is this 'care'? It is certainly a different kind of activity from that followed by our current production-lined SFS (Sort, Fix or Send) system of treatments. Such care instead involves a subtle orchestration of both personal and medical knowledge. From such a combination of these very different elements we can then weave *this* person’s requirements for endurance, comfort, palliation, support … all these require our felt-attunement, and then – to introduce a marine metaphor – anchorage, harbour, mooring, navigational knowledge, buoyancy-aid and (more rarely) an outboard motor.

All these require a very different kind of alliance than the processes we usually understand as ‘treatments’.

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I think back to Cecil and the hundreds – even thousands? – of people I saw over the decades in my small, friendly practice and the large rambling hospital I worked in. Throughout those years I saw, time and time again, how perceiving and sharing underlying personal experiences and meanings would bring important welcome changes. This was true with both major and minor conditions. Often the change seemed to be in the patient: symptoms would be reduced, tolerated better, or even disappear. Or the change would be in *me*: I could now *understand* differently; my own tolerance, investment and ease with them, and maybe myself, increased; and that changed something significant in them … and so on.

Such is care, such are eco-systems.

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All this was so much easier throughout our earlier NHS healthcare when the modus operandi and working environment meant people could become familiar enough to make meaningful bonds and pay good attention to the less explicit. But the subsequent ‘modernising’ reforms that bring us automation, larger-scale, carouselled and multiple teams – often remotely delivered – has made this more and more unlikely. Increasingly both staff and patients submit to no one-knows-anyone-but-just-do-as-you’re-told-and-follow-the-algorithm regime in which most are dissatisfied and unhappy. In this apparently slicker, more corporately managed world there is little opportunity for the kind of headspace and heartspace that are essential for the kind of professional intimacy that might best enliven and strengthen the internal resources of others … and ourselves.

And it is not only that the industrialising/commodifying culture cannot effectively engage with such strata of healthcare; such connections are no longer even seen, so how can they then possibly be heeded or tended?

The more you see of someone, the more of someone you see.

When I had the responsibility of Cecil’s care this maxim was a valued working assumption, buttressing personal continuity of care, and thus underpinned all pastoral healthcare. Dr T and the (then) flexible management structure encouraged this: I continued to see Cecil as an out-patient, monthly, for a year after his in-patient treatment. Was this ‘value for money’ for the service? Well, my professional time was much less expensive than further hospital admissions would have been in a distressed and shortened life. And Cecil and his son clearly communicated this.

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An elderly doctor of similar vintage and kindred mindset, Dr E, recently said to me, ‘In healthcare now they don’t seem to talk about psychosomatics. The problems can’t have disappeared, so why is that?’

I knew how he was using the much-mystified word ‘psychosomatic’: it was close to my understanding – the study of how emotional and life-problems might precipitate or fuel physiological disturbances and illness.

We elaborated convergent views: how, to even perceive – let alone begin to understand – these subtle, often hidden, connections, we need to make imaginative, trusting bonds that lie outside procedures; that the skill and ethos of making such bonds constitute ‘professional intimacy’.

E nods and smiles warmly with memory. ‘Yes’, he says, ‘in many ways I found that the most fulfilling part of our work…’

I interject: ‘I notice how you talk of *our* work…’

‘Well, I used to feel we were all in this together, the work was somehow shared, like in a good family or community … we were in it together…’, his reminiscent glow turns bleak, ‘but by the time I left, all that was largely gone…’.

We nod together. ‘Why? What happened?’, I ask with disingenuous curiosity.

‘Well, it certainly isn’t the practitioners themselves: when I talk with medical students or young doctors I can hear that they’re quite as idealistic and bright as we ever were… It's the system that then stymies them…'

I agree, but continue to press him: 'so what is it about the system?'.

Asking this question of E is probably unnecessary, for we then rapidly define and express an agreed litany of culprit-causes: the coercion of phoney markets with competitive commissioning and autarkic Trusts; the blind rhetoric of scaling-up with loss of localism; industrial standardisation with its micromanagement and overregulation; the prevailing influence of management consultants over clinicians … we greedily added to our list with gloomy glee.

'Amidst all this, how can our erstwhile skills and practices in psychosomatics possibly survive? …', E asks, abject yet acerbic.

I tilt my head and gaze toward him: I want him to continue.

'Well, to work in that way requires at least two things from practitioners: they must have the time and working arrangements to get to know people, and they must have the trusted autonomy to do so creatively. Only with these can we foster the very valuable 'professional intimacy' you speak of…'

'Yes', I pick up this thread, 'so the current generation of doctors can't readily manage those kinds of personal understandings that depend on flexible, nuanced contact – often over years – with patients. So they come up with concepts and categories more suited to their short-term and episodic encounters. We now talk of "social determinants", "PTSD", "stresses", the "biopsychosocial" and so forth as if these are data. But data are very different from delicately shared personal stories. And “social prescribing” – whatever its other values – cannot substitute for the psychotherapeutic effect of skilled a timely professional intimacy…’

‘Ah! There’s something else we’ve left off our list, something not talked about nearly enough!’ E suddenly cuts into my disquisition. His voice has an urgent edge, as if telling me a vital object was missing from the packing for a long trip.

‘What?’

‘Digitalisation: computers and IT. It can’t deal with this kind of approach.’

‘Why?’

‘Because such processes and systems work best with numbers, data, discrete categories. At base, computers are binary: they build on ‘0s’ and ‘1s’ – so playing with ideas of symbolic connections or displacements, for example, is outside the machine’s modus operandi. And that becomes important because doctors’ thinking and actions are now expected to be computer-code and algorithm compatible. Other perspectives, increasingly, become regarded as irrelevant or non-existent.’

‘Oh, yes, I agree,’ I say, ‘but I suspect younger people, more conditioned by the informatics-culture, might not understand. Would you be able to give them an example?’

‘OK. A real one!’, E is eager. ‘A middle-aged man dies suddenly in a car crash. His lovingly devoted wife discovers, in her shocked grief, unmistakable evidence of his substantial and longstanding deceits and infidelities. To protect her, and her children's, dignity, reputation and stability, she tells no one. Three months later she becomes seriously ill with a first-ever episode of ulcerative colitis.

'Due to some very delicate "unprocedural" and lengthy conversations, I hear this story.

'How can this be computer-coded and retain its meaning? Is there an algorithm? A care pathway? On which statistical list shall I place this event?...'

We both laugh, but it is the ironic laughter of fatigued outsiders.

2023. And now?

Now, in my late seventies, I am anxiously grateful for my geriatric version of good-enough health. The gathering shadows are not yet dense – I have only the common (well-controlled) risk factors, age-diminished loss of stamina, strength, flexibility and quick coordination.

Unless I die very quickly, it is inevitable that I will get a dread-disease or be incrementally diminished-to-death by multiple irreversible degenerations. If I get a dread-disease I hope it is a curable one: that, of course, is what most satisfies doctors and patients – the clever power of medical science – treatments – decisively eliminating illness and disability.

But, eventually, we all must face the limits of such treatments: most of us decline and die with more pathos than drama. This process and period requires increasing investments of care as treatments lose their potency and possibilities. In this realm doctors lose their leverage and command as manipulating engineers, and must now establish their role as skilled human-medical ecologists. By mixing the different kinds of knowledge – personal and intimate about *this* individual together with technical and objective knowledge about their conditions – they can offer a different kind of powerful effect: in providing skilled guidance, support and encouragement to endure while we can Life's most difficult transition most creatively, face loss, diminution and death with a greater sense of courage, connection and peace.

This is pastoral healthcare. This is what Dr T and the Balint Group urged and mentored me to do with Cecil nearly fifty years ago.

I am poignantly aware that I am a little older now than Cecil was when I first met him then, in 1975. My realisation slowly sharpens that, in the next decade or two, my body will then irrevocably fail. When it does, I hope that my mind and spirit will retain their resilience and integrity until very near the end.

And what if they do not? What kind of doctors or healthcarers will be there to not only look after, but look out for me. Who will attune themselves to the unexpressed hinterland of fear, loneliness and receding life? With an NHS frontline so often staffed by carouselled, stressed and demoralised, often stop-gapped, part-timers it is extremely unlikely that such nuances of pastoral healthcare would receive anything much more than a glancing recognition.

True, my heart failure would now be treated far more effectively than was Cecil's fifty years ago. So I may expect much better technical *treatments*, if I can access them. But I fear for the lack of personal *care* that can only come from continuity, and a kind of professionally familiar intimacy.

What our successive reforms have recurrently and increasingly overlooked is how this fundamental art and ethos of medicine cannot be mass-produced by any amount of regulation, algorithms, sticks or carrots.

Our healthcare dilemma here may be seen as a microcosm for our now increasingly troubled and unravelling anthropocene: our extremely clever and expedient powers of manipulation are overwhelming, and eventually eliminating, our capacities for greater wisdom and patient stewardship of more vulnerable life-forms. Our engineering power destroys our eco-systems.

What are we then left with?

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Notes and references

1. Zigmond, D. *Hospital Update*, 424-427. August 1976. This was republished, with minor revisions and an additional subtitle *How humanism may synergise biomechanism* for the author's anthology *If You Want Good Personal Healthcare, See a Vet*, New Gnosis Publications, 2015.

2. The psychoanalyst Michael Balint worked with a small group of GPs, examining with them the possible personal meaning of their patients' illness patterns and the consultation interactions. This pioneering work was particularly influential from the mid-1960s for about twenty years. During that period morale, motivation, recruitment and intellectual creativity of general practice

became unprecedently high, despite clear variations in standards otherwise throughout the service.

The Balint Movement lost such influence and momentum largely due to serial organisational reforms from the late 1980s which made personal continuity of care more and more unusual. Without such familiarity and frequency of contact, insighted understanding usually becomes thin, slight and unuseful.

Interested? Many articles exploring similar themes are available on David Zigmond's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html).