Cure

A talk given to doctors and nurses in St Luke's Church, Hatfield, on St Luke's Sunday, 18 October 1970

Using this opportunity that I have been offered, I wish to try to verbalize some of the thoughts and feelings that I imagine are common to us all.

I do not deal with the religion of inner experience, which is not my special line, but I deal with the philosophy of our work as medical practitioners, a kind of religion of external relationship.

There is this good word in our language: CURE. If this word be allowed to talk, it can be expected to tell a story. Words have that kind of value, they have etymological roots, they have a history: like human beings, they have a struggle sometimes to establish and maintain identity.

At a most superficial level, the word 'cure' points to a common denominator in religious and medical practice. I believe cure at its roots means care. About 1700 it started to degenerate into a name for medical treatment, as in water-cure. Another century gave it the added implication of successful outcome; the patient is restored to health, the disease is destroyed, the evil spirit is exorcized.

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In medical practice there is to be found a gap between the two extremes in the use of the word. Cure, in the sense of remedy, successful eradication of disease and its cause, tends today to overlay cure as care. Medical practitioners are all the time engaged in a battle to prevent the two meanings of the word from losing touch with each other. The general practitioner, it might be said, cares, but must know about remedies. By contrast, the specialist is caught up in problems of diagnosis and the eradication of disease, and what he must make an effort to remember is this: that care also belongs to medical practice. At the first of these two extreme positions the doctor is a social worker and is almost fishing in the pools that provide proper angling for the curate, the minister of religion. At the other extreme position the doctor is a technician, both in making a diagnosis and in treating.

The field is so vast that specialization one way or another is inevitable. Nevertheless, as thinkers we are not exonerated from the attempt on a holistic approach.

What do people want of us as doctors and nurses, what do we want of our colleagues when it is we ourselves who are immature, ill or old? These conditions – immaturity, illness, old age – carry with them the fact of dependence. It follows that what is needed is dependability. As doctors, and also as nurses and social workers, we are called upon to be humanly (not mechanically) reliable, to have reliability built into our overall attitude. (For the moment I must assume that we have a capacity to recognize dependence and to adapt to what we find.)

There is no dispute about the value of effectual remedy. (I owe the fact that I am not a cripple, and my wife owes her life, for instance, to penicillin.) Applied science in medical and surgical practice is to be taken for granted. We are unlikely to undervalue the specific remedy. From an acceptance of this principle, however, it is possible for the observer and the thinker to proceed to other considerations.

Reliability meeting dependence is the theme of this talk. It

will become quickly evident that the theme leads on to infinite complexities, so that artificial boundaries will need to be set up to delineate areas for discussion.

Immediately you will see that this way of talking separates the doctor practising in his own right from the doctor who acts for society.

If I criticize the medical profession, it should be stated that I have been proud to have been a member of that profession ever since I became licensed fifty years ago, and I have never wanted to be anything else but a doctor. This fact does not stop me from seeing glaring faults in our attitudes and social claims, and I assure you I know all about the beam in mine own eye.

Perhaps it is when we are patients that we most easily see the faults in our colleagues, and alongside this we may place the fact that we know what we owe to the medical and nursing professions best when we have been ill and have recovered.

I am not, of course, referring to mistakes. I personally have made mistakes that I hate to think about. Once, before the days of insulin, I drowned a diabetic patient in a stupid and ignorant attempt to apply instructions from above. The fact that the man would have died anyway does not make me feel better. And I have done worse things. Happy is the young doctor who does not get exposed as ignorant before he has built up some position among colleagues that will see him through disasters. But all this is treading well-worn paths. We accept fallibility as a fact of human endearment.

I wish to look at the way you and I practise medicine and surgery and nursing, *when we are doing well*, and not building up material for remorse.

How can I choose? It is necessary for me to call on the experience I have had of a specialized kind, that is, in my practice of psychoanalysis and of child psychiatry. I suggest that there is a great deal of potential feedback from psychiatric to medical practice. Psychoanalysis is not just a matter of interpreting the repressed unconscious; it is rather the pro-

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I personally turned over gradually from being a physician to children and their parents to being a psychoanalyst. Psychoanalysis (like analytical psychology) is linked to a theory and to the intensive training of a few self-elected and selected individuals. The training aims at providing psychotherapy that reaches to unconscious motivation, and that essentially makes use of what is called 'transference'. And so on.

I will enunciate certain principles that emerge from the sort of work that my colleagues and I find ourselves doing. I have chosen seven descriptive categories:

1. Hierarchies.
2. Who is ill? Dependence.
3. Effect on us of care-cure position.
4. Further effects.
5. Gratitude/propitiation.
6. Holding. Facilitation. Individual growth.

1. First, the matter of hierarchies. We find that when we are face to face with a man, woman or child in our speciality, we are reduced to two human beings of equal status. Hierarchies drop away. I may be a doctor, a nurse, a social worker, a residential houseparent – or, for that matter, I may be a psychoanalyst or a parson. It makes no difference. What is significant is the interpersonal relationship in all its rich and complex human colours.

There is a place for hierarchies in the social structure, but not in clinical confrontation.

2. From here it is a short step to the question: which of the two is ill? Sometimes it is a matter of convenience. It is valuable to understand that the concept of illness and of being ill brings immediate relief, because it legitimizes dependence, and the one who succeeds in the claim to be ill benefits in a specific way. 'You are ill' naturally moves me into the position of one who responds to need, that is to say,

of adaptation, concern and reliability, of cure in the sense of *care*. The doctor or nurse or whoever it be moves naturally into a professional attitude to the patient. This carries no sense of superiority.

Which of the two would it be? One could almost say that the assumption of the cure position is also an illness, only it is the other side of the coin. We need our patients as much as they need us. The Provost of Derby recently quoted from St Vincent de Paul, who said to his followers, 'Pray that the poor may forgive us for helping them.' We could pray that the ill forgive us for responding to their illness needs. We are talking about love, but if love is to be provided by professionals in a professional setting, then the meaning of the word must be spelt out. In this century it is the psychoanalysts who are doing the spelling out.

3. We can now look at the effect that this assumption of the role of one who cares has on us ourselves, who care for, and who care-cure. We note five main things:

(*a*) In the role of care-curers we are non-moralistic. It does not help a patient to tell him or her that he or she is wicked to be ill. Nor does it help a thief, or a person with asthma, or a schizophrenic to be put into a moralistic category. The patient knows we are not there to judge him.

(*b*) We are dead-honest, truthful, saying we do not know when we do not know. An ill person cannot stand our fear of the truth. If we fear the truth, let us take up another profession, not that of doctor.

(*c*) We become reliable in the way that we can only sustain in our professional work. The point is that by being reliable persons (professionally) we protect our patients from the unpredictable. Many of them suffer from precisely this, that they have been subjected as part of the pattern of their lives to the unpredictable. We cannot afford to fit into this pattern. Behind unpredictability lies mental confusion, and behind that there can be found chaos in terms of somatic functioning, i.e. unthinkable anxiety that is physical.

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(*d*) We accept the patient's love and hate, are affected by it, but we do not provoke either, nor do we hope to gain in a professional relationship emotional satisfactions (loving or hating) that ought to be worked out in our private lives and in the realms of the personal or else in the inner psychic reality, when dreaming takes shape and assumes shapes. (In psychoanalysis, this is studied as an essential factor, and the name 'transference' is given to the specific dependencies that arise between patient and analyst. The doctor who is involved in physical medicine and surgery has much to learn from psychoanalysis, in this area especially. To take up a very simple point: *if a doctor appears at the time arranged, he experiences a tremendous strengthening of the patient's trust in him* (*or her*), and this is not only important for the avoidance of patient agony, but also it enhances the somatic processes tending towards healing, even of tissues, certainly of functions.)

(*e*) We assume and easily agree to assume that the doctor or nurse is not being cruel for the sake of being cruel. Cruelty comes into our work, inevitably, but for *cruelty indulgence* we must look to life itself outside our professional relationships. And there is no room for vindictiveness in our professional work. I could, of course, tell of cruelty and vindictiveness practised by doctors, but we would find no difficulty here in putting this sort of malpraxis in its place.

4. To reach to further effects on us of our recognizing the illness and therefore the dependence needs of our patients, we must consider more complex matters of personality structure. For instance, a sign of health in the mind is the ability of one individual to enter imaginatively and yet accurately into the thoughts and feelings and hopes and fears of another person; also to allow the other person to do the same to us. I suppose that care-curing parsons and doctors, by self-selection, are good at this sort of thing. But exorcists and remedy-curers do not need it.

It may sometimes be a burden to be able to play too well

with cross-identifications. Yet somehow, in selection of medical students, surely one of the important features (if this could be tested) would be an assessment of the capacity for what I am calling cross-identifications, standing in the other person's shoes, and allowing the converse. There can be little doubt that cross-identifications greatly enrich all human experiences, and that those who have but a poor capacity in this respect find themselves bored, and are boring to others. Moreover, they cannot get far beyond the technician-type function in medical practice, and they can cause much suffering without knowing it. James Baldwin, speaking recently on the BBC, mentioned the sin the Christians forgot to mention: the sin of unawareness. I could add a note here on delusional cross-identifications. These cause havoc indeed.

5. Next I come back to the matter of gratitude. I referred to this in giving the quotation from St Vincent de Paul. Gratitude looks very nice, and we like the odd bottle of whisky and box of chocolates that are expressions of thanks from patients. Nevertheless, gratitude is not as simple as all that. If things go well, patients take the going well for granted, and it is only if there is neglect (a swab left in the peritoneum) that they become true to themselves and complain. In other words, most gratitude, certainly exaggerated gratitude, is a matter of propitiation; there are avenging forces latent, and they had better be appeased.

Ill people lie in bed planning generous gifts or codicils to wills, but doctors and nurses and others are pleased that after discharge the sad patient soon forgets, though perhaps is not forgotten. I would claim that it is doctors and nurses who experience reduplicated and repetitive mourning; one of the hazards of our professional life is that we may become hardened, because the repeated losses of patients make us wary against getting fond of the newly ill. This is especially true of nurses who care for sick babies, or who take over the care of babies who are left in telephone kiosks, or are found

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General practice in a country district may be the answer to this problem, because the doctor lives among his patients – surely the best kind of doctoring. The doctor and the patient, each always there, but only at times doctor and patient.

There is a very great deal for the practising doctor to learn from those who specialize in care-cure, rather than in cure to eradicate evil agencies.

6. There is one thing especially that needs to feed back into medical practice, and I will end with this. It is that care-cure is an extension of the concept of holding. It starts with the baby in the womb, then with the baby in arms, and enrichment comes from the growth process in the infant, which the mother makes possible because of her knowing just what it is like to be this one particular baby that she has given birth to.

The theme of the facilitating environment enabling personal growth and the maturational process has to be a description of father–mother care, and of the family function, and this leads on to the whole build-up of democracy as a political extension of family facilitation, with the mature individuals eventually taking part according to their age and capacity in politics and in the maintenance and rebuilding of the political structure.

Along with this is the sense of personal identity which is essential for every human being, and which *can only become fact in each individual case because of good-enough mothering* and environmental provision of the holding variety at the stages of immaturity. The maturational process alone cannot take the individual through to his or her becoming an individual.

So when I speak of cure in the sense of care-cure, here is the doctors' and the nurses' natural tendency to meet the dependence of ill patients, but now this is spelt out in terms of health: it is written down in terms of the natural

dependence of the immature individual, which calls out in parent-figures a tendency to provide conditions that foster individual growth. This is not cure, in the sense of remedy, so much as care-cure, the subject of my talk, and it could be the motto of our profession.

In terms of society's sickness, the care-cure may be of more importance in the world even than remedy-cure, and all the diagnosis and prevention that goes with what is usually called a scientific approach.

Here we are at one with social workers, whose term 'casework' can be looked at as a highly complex extension of the use of the word 'holding' and as a practical application of care-cure.

In a professional setting, given appropriate professional behaviour, the ill patient may find a personal solution to complex problems of the emotional life and of interpersonal relationships; and what we have done is to facilitate growth, not to apply a remedy.

Is care-cure too much to ask of the clinician? This aspect of our work seems to fail in terms of the claim for higher fees, and it undermines the status system of accepted hierarchies. Nevertheless, it can easily be learned by suitable persons, and it brings something much more satisfying than the feeling of having been clever.

I suggest that we find in the care-cure aspect of our professional work a setting for the application of principles that we learned at the beginning of our lives, when as immature persons we were given good-enough care, and cure, so to speak, in advance (the best kind of preventive medicine) by our 'good-enough' mothers, and by our parents.

It is always a steadying thing to find that one's work links with entirely natural phenomena, and with the universals, and with what we expect to find in the best of poetry, philosophy and religion.

Part 2

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