

On our best behaviour

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THIS essay is an attempt to crystallise several ideas which have concerned me for some time; an attempt that has gained impetus from Tait's recent (1975) advocacy of the establishment of a department of behavioural medicine in every medical school. This proposal which, as it stands, is a logical development of the influence that general practice is exerting on medical education, focuses attention on three questions: How far is it right to establish behavioural science as an independent discipline within medicine? How true is our current concept of the holistic approach to medical care? And, how do these questions reflect a breakdown in the relationship between modern medical practice and the vocation and philosophy of healing?

I suggest that such a breakdown does exist; that a misunderstanding of the word holistic is a reflection of it; and that the wrong emphasis on behavioural science in medicine will exacerbate the misunderstanding and the breakdown. I am sure I am not alone in my uneasiness and, even as I have been preparing this article, I have been encouraged first by the booklet, *The Health Care Dilemma* from the Office of Health Economics (1975), which expresses more completely than I have otherwise seen it expressed the false perspective of medicine and healing that our profession and our society are creating together. Every doctor in the country should be forced to read it slowly, three times, at gun point!

Some of the sentiments it embodies are echoed in two remarks by Byrne (1975) in his Marsden lecture recently published in this *Journal*. He says, "As doctors we are members of the society which we serve and we ourselves become tainted by its mores. We are losing our vocation and some behave, as they admit to being, as trade unionists." Unfortunately Professor Byrne side-steps the collusive nature of our relationship with society, and the roles and activities other than of a trade union nature which make up this collusion contribute to the tainting process, and undermine our vocation. Although the rest of the lecture does not point as vigorously in a new direction as I would hope, one of the closing paragraphs seeks explicitly to rekindle true vocation and the personal standards that should accompany it.

The inexplicable

My own attitude and the theme of this essay can be illustrated by a quotation from a broadcast talk by George Orwell on *The meaning of a poem*:

"I have tried to analyse this poem as well as I can in a short period, but nothing I have said can explain, or explain away, the pleasure I take in it. That is finally inexplicable, and it is just because it is inexplicable that detailed criticism is worthwhile. Men of science can study the life-process of a flower, or they can split it up into its component elements, but any scientist will tell you that a flower does not become less wonderful, it becomes more wonderful, if you know all about it." (Orwell, 1941).

It is relevant to mention here also the quotation from another author of totalitarian nightmares, Franz Kafka, which was quoted by Fulton (1973) in the symposium on *The Medical Use of Psychotropic Drugs*. A country doctor remarks, "To write prescriptions is easy, but to come to an understanding with people is hard." A behavioural interpretation of an illness may also be harder than the writing of palliative prescriptions, but is it the same thing as coming to an understanding with people in the sense implied, and may it not in a perverse way, and despite our best intentions, inhibit such an understanding?

Orwell's criticism retained a sense of the inexplicable and a sense of wonder towards the poem, and only by doing so, if the poem deserves it, is the criticism justified. Only if the botanist preserves, and indeed enhances the sense of wonder and delight we feel towards a flower is his work justified. Only if medicine preserves these same attitudes towards the uniqueness of individual illness and towards the process of healing is its own work justified.

Healing

Healing is not a matter of remedying defects, relieving symptoms, or modifying pathological changes. These things may be a part of the process or a result of the process, but they are not in themselves the process or the purpose of healing. Healing is not the same as cure. Chronic and progressive disease may co-exist with a state of well-being which defies the symptoms. Too narrow-minded a pursuit of cure may even prevent healing in this sort of situation. Such narrowness will also blind us to the possibility that disease or illness may not only be the antagonist of healing, but also the agent.

Healing is not always compatible with comfort. Certainly it cannot be when the illness is the agent of healing. Whether or not one accepts that particular concept, one may agree that understanding and change are often important ingredients of healing, especially in illnesses which would be the subject of behavioural medicine. One may also agree that understanding and change are often difficult and painful to achieve, for both doctor and patient. That is why they will both settle for second best, as often as not, and choose a palliative prescription instead—as Kafka pointed out. Even inflammation, the first healing process we encounter, is never comfortable.

Healing is a universal quality and a universal process. We all possess natural powers of healing in our own body, mind, and spirit. We all have access to personal qualities which can assist healing in other people. There are many techniques of treatment, from wart charming to neurosurgery. These are contributions towards healing which only specialists can make. But any person can contribute compassion, empathy, and insight. Healing is not bestowed upon people by doctors. Doctors do not make people better, they help them to get better. And so do friends, neighbours, comedians, poets, and the makers of 'Guinness.'

Ivan Illich's comments are not generally helpful to doctors in their day-to-day contact with patients, though they are a valuable ethical goad. However, in discussion during the symposium on iatrogenic illness organised by the London Medical Group in March, 1975, he made one simple remark which was helpful, and which suggested that he may misrepresent other simple ideas because of his grandiose style. In a discussion of his attitude to the treatment of pain, he made it clear (as he does in *Medical Nemesis*, 1975), that he is not asking people to put up with it. He only objects to the doctor and his drugs as the omnipotent "pain-killer". He said he would like doctors to "put their shoulder to the wheel" of the patient's effort to cope with pain. This less arrogant role is the proper role of the doctor, the healing role. The doctor is not the protagonist of the action. He must never be more than a supporting actor.

Communication

There was another comment made in a later discussion at the same symposium which has salutary implications for doctors who risk pre-occupation with behavioural medicine. The topic was the difficulty of communicating with distressed patients in a truly helpful way. Cicely Saunders, who I imagine must be universally admired among doctors and greatly loved by all who have contact with her, spoke of the advantage often possessed in this situation by people without too much sophisticated training, some nurses, for instance, who remain able to "listen without technique".

Also at that symposium was Marshall Marinker. Several of his papers, especially *On the Boundary* (1973) and *Medical Education and Human Values* (1974), both published in this *Journal*, have contributed greatly to my own exploration of medicine in general practice. He is also a leading medical behaviourist (if that is not a completely unforgivable title), with a firm Balint foundation. I wish to express genuine admiration for his literate, imaginative, and sensitive writing before going on to make him the butt of further comment. For despite his broad view of human behaviour and clever understanding of it, there is something just too academic in it, something just too remote from the sincerely compassionate relationship between humans which consists of "listening without technique" and responding without affection.

However, I expect he is well aware of walking this boundary. His paper at the symposium was a kind of apologia on behalf of modern medicine in the face of Illich's criticism, called *Why make people patients?* In it he referred with some humility to the medical student who expressed her uncertainty about continuing to become a doctor because she did not wish to become like the doctors who were her teachers. We do not know her reasons, but one of them may be that she saw the balance of medical education and medical practice on the one hand, and human values on the other, weighing too heavily against human values. If this is so, then I have sympathy for her, because it is this that makes me reluctant to go on being the sort of doctor that I was brought up to be, and which present-day expectations virtually insist that I should be.

Healing relationship

Marinker says: "To become a patient is to establish a healing relationship with another who articulates society's willingness and capability to help." I hope that from what I have already said it will easily become apparent that to me that sentence is both untrue as a generalisation, and self-contradictory. Because so much of medical practice is at variance with the spirit of healing, I do not believe that most of the relationships that patients enter into with us are healing relationships. More often they distract from, allow to persist, or reinforce the personal, social, or cultural disorders from which the illness and even the disease arises. This is a separate theme in itself, which I have hinted at already in this essay, and elaborated elsewhere (Swayne, 1976). As far as articulating society's willingness and capability to help is concerned, it is very difficult to see how those mores which taint our professional behaviour, and which are based on a large measure of self-interest coupled with a welfare system which generally absolves us from loving our neighbour as ourself, (having, as we do, precious little understanding of the difference between self-interest and what Jesus might have meant by loving ourselves), can possibly be articulated in any form of relationship that would be truly healing.

Elsewhere in the same paper Marinker admits that (to paraphrase), "The advent of the behavioural sciences in the curriculum of the undergraduate may help him to understand the nature of (the) dialogue between doctor and patient, but they do not pierce the . . . deafening silence of illness in the absence of disease . . . , and so they cannot frame for the doctor a meaningful reply".

The meaningful reply is the still small voice speaking within the patient himself to which we can help him to tune in by "listening without technique". Tournier (1954) says, "Our task is—to listen and understand. If we give our patients an opportunity of speaking of what is in their hearts, they will get to know themselves better; they will discover what are the real problems they have to face, and perhaps see the meaning of their sickness." Lao Tzu (1963) says "Therefore the sage keeps to the deed that consists in taking no action and practises the teaching that uses no words", though he was referring to the illusory distinction between beautiful and ugly, good and bad, and other traditional opposites. We do not always have to use science in our professional role, indeed often we must not. We need only to have the courage simply to be imperfect, but compassionate human beings. The problem is, will our professional role permit it?

Privacy

I also challenge another assertion by Marinker (1975), in an article on behaviour in general practice, that "The general practitioner must learn to feel unafraid in that no-man's-land that lies between the 'private lives' of his patients and the 'public performance' of the consultation." If the general practitioner were not such an actor as behavioural science may make him, and if he were not such a public and authoritative figure, so protectively costumed for his professional role, then the consultation might not be a public performance. And I believe that the general practitioner *must* always have the courage to feel afraid in the no-man's-land that inevitably exists between his patient's and his own deeply personal humanity. Surely this fear is partly a sense of awe at the inexplicable and wonderful which tempers Orwell's criticism and the botanist's dissection?

I remember my fear as a schoolboy singing the tiny part of one false witness in the St Matthew Passion, awaiting the, for me, difficult entry, and eventually doing it wrong. It was partly a fear of making a fool of myself, it was partly awe at being involved in so great a thing. The subsequent embarrassment was alleviated by the sympathy of the most musical, and above all by the realisation that it did not matter, that the music did not suffer by my incompetence, that in its wholeness it was so much greater than its parts and could recover from any number of defects in those parts.

As Marinker also says, we have to learn to tolerate uncertainty; that is a kind of humility. But to be unafraid in no-man's-land is inhuman. To be human is to go fearfully on across no-man's-land in order to touch the person on the other side, who will surely be helped more by our compassionate fearfulness, than by a superior fearlessness. We have to be willing to sing out of tune, to mistime the counterpoint, to spoil the harmony. That may make us less professional, but if we are sensitive to our mistakes they do not make us less musical.

Holism

The language of medicine can be greatly enriched by the use of such metaphors from the arts, because they remind us that we are sharing with our patients in the continuously creative opportunities of their lives, and discourage us from trying to recreate them in our own, or some other theoretical or socially acceptable image. This perspective makes us aware of (though we cannot know) the wholeness of the person who has become our patient that is *greater than* the sum of all his parts. This is the truly holistic approach.

The word 'holistic' has been used frequently in recent years to describe the attitude of general practice towards illness, but until I looked it up it had always seemed to mean only the sum of all the parts. I may have drawn the wrong inference each time, but even if the implied use of the word was not wrong, it was not clearly right. It is not enough to formulate our diagnosis in physical, psychological, and social terms, or in other terms, or subdivisions of those terms. Our understanding must seek to be literally holistic. And to succeed we need to be more brave, more fearful and more modest. Behavioural medicine must not be allowed to become just another part which distracts from the greatness of the whole. General practice has gone a long way in widening and deepening medicine's perspective of illness and healing. We must be careful not to go too far in a direction that will cause the perspective to contract.

Simple sensitivity

I am not a dyed-in-the-wool opponent of behavioural medicine. In fact it was a special interest from my trainee years when I was introduced to Balint's (1964) teaching. I have subsequently tried to offer patients psychotherapy when I judged that it would help, and have undertaken further training for it. I emerged from a week's residential psychotherapy workshop greatly helped, but disabused of much previously adopted

theory and technique, and convinced of the over-riding importance of simple sensitivity towards the patient and honest awareness of oneself. I do not pretend that these qualities come easily. Perhaps they just do not survive the mind-bending journey through the "hidden curriculum" (Marinker, 1974) of our medical education. In any case, I agree that these qualities need to be nourished in most of us who need to use them in a professional relationship, and that this can only occur through experience, and in part through organised learning experience.

Dangers in too much analysis

However, let us think carefully about what we are doing. The ability of human beings to tolerate, accept, listen to, perceive, and respond genuinely and compassionately to each other, are qualities which we need to confirm in each other in every relationship and in every way we can. They are qualities of love.

I fear that by making these things too much a matter of analysis and technique, we may distort these simple human qualities in ourselves, and in the people whose needs and weaknesses make them so susceptible to our example and our teaching, and in the society of which we are all a part. I also fear that we may deprive ourselves of the priceless healing quality that I believe is innate in any human being, but which a doctor's vocation should make him especially heir to, which is, by our presence and our attitude, through the deed that consists in taking no action and the teaching that uses no words, to catalyse the healing process which goes on within the individual, given the chance, and which cannot be classified or dissected.

Let there be departments of behavioural medicine by all means, but let them be sure to respect and wonder at the true wholeness of Man, and not diminish it. At the end of the day we must be able to say of each patient who invites us to share the challenge and opportunity of their illness whatever is our own equivalent of "what a wonderful poem" and "what a beautiful flower". Our profession, more subtly than any other group in society, has the opportunity, by professing a true healing, to pass on the message of creative and redeeming love that should be the foundation of our vocation, or by losing our own way to guide people more surely towards George Orwell's bleak vision of 1984.

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