Guest Editorial

CARING: DEALING WITH COMPLEXITY AND RELATIONSHIPS

1. The Loss of Caring

I meet more people who complain about lack of care in their dealings with the medical profession than people who spontaneously relate experiences of being cared for. Perhaps complaining about the medical profession is a popular pastime. But it could be an indication that caring in the profession is in trouble. Caring is no longer synonymous with the practice of medicine. Uncaring may have become a frequent occurrence. Let me give some examples.

A friend, the head of a department at a Medical School, was admitted to the academic hospital with atrial fibrillation, which is a rapid, irregular heart beat. The consultant who knew him, and had looked after him several times for the same problem, was not available. The resident took over. My friend was in the hospital bed in hospital clothes, but the resident knew him well. My friend had been one of his teachers. At the foot of the bed, the resident discussed the ECG tracing with the intern and students. He mentioned the gravity of such a tracing, the serious signs of insufficient blood supply to the heart (ischemia), and the need for immediate x-rays of the arteries to the heart (coronary angiography). He spoke in front of his colleague, the patient, as if he could not hear, as if he could not understand, and ultimately, as if he was no longer a human person known to him. The patient had become an object.

My friend lay there struggling within himself. How am I going to get out of this situation? How can I become a participant with a story, rather than an object of discussion? His story was that in the past, with exactly the same ECG-tracing, he had been fine after cardioversion (therapy to restore normal heart rhythm). There had been no ischemia. Fortunately, the consultant returned before any action was taken. The patient became a person again.

In a qualitative participatory research project, I participated in a group that looked at interpersonal violence. All the members of the group had to share their own experiences of interpersonal violence with the group. Although most participants were not health professionals, the hospital was repeatedly mentioned as one of the places where the most powerful experiences of being violated had occurred. One lady, who worked as a technician in a surgical research laboratory, was admitted to the Intensive Care Unit (ICU) following an operation. The surgeon was well known to her. She had worked in the research laboratory with him. He stood at the door of the ICU, and,

within earshot of the patient, insinuated to the ICU staff that she was the cause of her complications. He spoke in an impersonal manner as if he had never worked with her, as if she was an object. The result, for the patient, was many years of inner struggle for recovery, and much bitterness and suspicion.

Our Minister of National Health, Dr. Zuma, went *incognito* to a community clinic with her child. A lady who was seen before her, was castigated for bringing her child too late. Dr. Zuma was scolded for bringing her child too soon. This and other experiences led her to conclude that there is a major problem with caring in the health services of our country. She asked the Health Services Trust to research the question of caring in the health service. One of the findings of the research was that health workers themselves felt uncared-for. Some felt abused. Health workers felt that they had the ability to care for people. Being abused and uncared-for was offered as a reason for not being caring. Other reasons given were poor salaries, leading to poor self-esteem, unavailability of medications, the political atmosphere, staff shortages, and redeployment of personnel, causing insecurity. Caring is clearly not a purely personal matter. It is embedded in a wider socio-political and economic context.

General practitioners working in the community have been attacked, robbed, and even murdered in their practices. One thief left a note saying "Thanks doc!" There are people in the community who no longer have any regard for doctors and nurses, but who see them as easy prey. The days when a doctor or a nurse could move freely at night to do their work, feeling protected by the community, have gone. We do not feel cared-for ourselves, by the State or by the community. Patients no longer experience us as caring people, or a caring profession. How is this double lack of care to be understood?

2. Reasons for the Lack of Caring

There are many reasons for the lack of caring that I have described. I want to concentrate on one reason that lies closest to us as medical people. It is one for which we need to take responsibility. My view is that we are experiencing the logical consequence of our adherence to an outdated understanding of science. This understanding determines what we regard as real and respectable within our profession, and what we hold lightly or with ridicule. Michael Polanyi, the chemist who later became a philosopher, was convinced of the link between our view of science and the way we live. He believed that the inadequate view of science and the nature of reality that dominates the modern Western consciousness underlies the social disasters that have affected Western Europe. In the first section of this book, which deals with our clinical method, Jacques Kriel rightly spends much time analyzing our view of science.

Kriel reminds us that our view of science implies a view of the nature of reality. Although it is no longer unchallenged, the view implicitly held by both patients and doctors is that reality is found in the basic building blocks of matter. Only what is measurable in physico-chemical terms is real. This view of reality took root in science and society in the eighteenth century. But at that time people like Descartes and Newton still believed that there was another world separate from the basic building blocks, atomistic world of natural science. This was a world of the spirit, where emotions, relationships, and faith operated and mattered. This was a separate world, another reality. Thus, we call them dualists.

Today that other world, and the non-material way of understanding ourselves and the world, has lost its credibility. For some people, that non-material world no longer exists. An important reason for this loss of credibility is the efficacy and power of the science and technology that has come from the materialistic view of the world. For the radical natural scientist, there is no truth outside the material. In the later sections of this book, Kriel repeatedly emphasizes that, if only matter is real, then consciousness has no reality status. It is purely a "side-effect" of biological, and thus ultimately material, processes.

If reality is understood in this manner, then data or information regarding the non-material has no scientific status. This means that realities such as consciousness, self-consciousness, relationships, even life, have a lower status compared to the world revealed by the hard sciences. In order to develop a new understanding of persons and relationships for our clinical method, Kriel insists that we need to develop a new understanding of the nature of reality. He seeks such a new understanding of reality in the emerging theory of complex systems and in the theory of evolution. He suggests that reality must be modelled as a hierarchy of systems of increasing complexity. The "basic" level, in an evolutionary sense, is matter-in-complex-system, but each new level of the hierarchy represents a new mode of reality. In this manner, he attempts to recognize the reality of the non-material worlds of consciousness, while overcoming the problems associated with the dualistic view of reality. In the theory of Family Medicine, we are already implicitly working with new understandings of science, persons, and relationships. We need to make those understandings explicit for ourselves and the rest of our profession. We need carefully and critically to assess Kriel's suggestions to see to what extent they meet our needs.

I hear a patient with a mental illness saying: "the doctor told me I have a chemical imbalance in my brain." The patient and the doctor thus have no need to explore and to face the imbalance in the person and in relationships. Relationships are imaginary, or, if they do exist, they are of lesser importance than the material factors. We find it quite natural to view hypertension as a condition in which the control mechanisms of the circulatory system are out

of control. How many doctors will take the idea seriously that hypertension is in the first place a symptom of a life, or a society, out of control?

In 1943, C. S. Lewis, the literary critic from Oxford, already saw the dehumanizing implications of the denial of the non-material world. In a small book called *The Abolition of Man*, he analyzes some of the prescribed high school texts on the art of literary criticism. Lewis showed how students were being influenced to see reality only in the material and the measurable. Emotions were subtly made suspect. Emotions and feelings have no status, no reality, in this new world of atomistic science. If taken to its logical conclusion, Lewis contended, this view would in effect abolish what is human.

An eminent surgeon from the United Kingdom recently stated that, for doctors to have integrity, they need to discern between emotion and truth. He was saying that a feeling could not be true. If such a view forms the basis of our profession's value system, then only an exceptional doctor will not treat people as objects or commodities. If only atoms are real, how can we respect persons, relationships, feelings, attitudes, and life? This denial of the non-material is the reason why we as professionals and patients frequently get the feeling that we are mere commodities in a world run by invisible and impersonal forces, a world of chance. In this impersonal world, the currency of family practice, namely, feelings and ongoing relationships, is not counted as real, and is ignored. These essential ingredients of being human, and of humane medicine, need to be vigorously defended.

Before I sound too self-righteous, let me add that statements such as that made by my surgical colleague, frequently slip off my tongue as well. We were educated within the same clinical method. I was taught to do a systematic interrogation of the case in order to get all the facts straight. If I dared to present feelings or emotions, my own or that of the patient, it was made clear to me that I was wasting the time of the professor and the tutorial group. We were all enculturated into the belief, and matching practice, that only the material and measurable is important in our quest to track down the single correct diagnosis. Only one understanding of the patient's condition is possible. It must be a purely material and linear understanding.

3. Our Task

The world-view, in which subjective experiential processes do not possess the same degree of reality as everything that can be expressed in the terminologies of the exact natural sciences, has become part and parcel of our professional thinking. In his book, *The Waning of Humaneness,* Konrad Lorenz refers to the view that only numerical and measurable reality has validity, as an epidemic delusion that must be confronted and contradicted, because it affects our perceptions of values, our understanding of our moral responsibilities, and thus our understanding of what it means to be human. If not confronted and

contradicted, said Lorenz, it will lead to the loss of our humaneness. Unfortunately, this view has become a fundamental assumption of our clinical method.

What, then, is our task as family doctors? How do we confront and contradict this world-view in order to bring comprehensive caring back into our profession, and into the world around us? All that I have said thus far has appeared in some form or another in the writings of most of the leaders in family medicine. But we all struggle to implement the principles of our discipline. I attended two major congresses of family physicians in 1998 where doctors repeatedly said: "We are struggling with the application of the principles that we believe in." The epidemic delusion is so rooted in our society, our schools, our medical schools, and even our religious institutions, that we all struggle to practice in a different manner, even though we are intellectually convinced of the inadequacy of the clinical method within which we received our undergraduate training.

We need to continue to seek new ways of relating to the world and to our patients. We need to create a new vocabulary with which we challenge the prevailing dogma and its vocabulary. Johan Degenaar, the philosopher from Stellenbosch, has pointed out that if we are victimized by a discourse, we are in need of a new discourse, and that we are ourselves responsible for creating a liberating language which structures in a new way the world in which we are living.

Thirty years ago, Ian McWhinney expressed the values that family practitioners need in order to care for people comprehensively within the context of their full complexity. His was a plea for an ecological perspective on ourselves and our patients. He encouraged us to be committed to the person and not only to the diseased organ. He showed us the importance of the complex context of a person and of the subjective. Today there are many teachers, doctors, and students who can recite his work off by heart, but we still fail in practice. This failure is a mystery that we need to address, and confront, if we want to move out of this era of dehumanization and lack of care in our profession.

How do we in our practice allow patients and ourselves to become persons again? How do we regain our capability for and commitment to an ongoing healing and nurturing relationship with others? To come to understand more about how to care in practice, we cannot progress much merely by reading. The things we read are mostly written from the point of view of the supremacy of the material, the atomistic. Furthermore, skill in action does not naturally follow from reading. To create, with Degenaar, our own liberating language, I suggest that we put the books aside and learn by acting consciously in terms of the principles of our discipline, rather than reflexly in terms of the clinical method that we were taught. But then we must reflect on that action in the light of the literature.

This method of action-followed-by-reflection has become our preferred way of teaching and learning in the Department of Family Medicine at the Medical University of Southern Africa (Medunsa). The most powerful changes come from immersing students in action, guided by the values and the principles that I have mentioned. Then, together in small groups, we reflect on that action. One example: We ask each final year student to accompany a patient *incognito* from a health center to the hospital for an admission. A young male student went with a teenager who requested a termination of pregnancy. He was verbally abused by the doctors and nurses who assumed him to be the boyfriend of the patient and the father of the baby. He observed the unsympathetic manner in which the girl's physical and emotional discomfort was managed by the attending personnel. That student is not likely to be the same again. He had to face the full clinical context of the patient. And then he faced the medical system's response to her. This type of unsympathetic treatment is not the rule in our system, but reflecting on that experience helped the student and the group to understand a little more about caring and what kind of caring we want to become involved in. It is then that the principle of commitment to the person starts to make sense.

Caring is an attitude that can be displayed toward things as well as toward conscious and self-conscious beings. We need more than an attitude. We need to choose a commitment to the person who is our patient. The attitude of caring should become a consciously chosen policy to translate our caring into action. We must commit ourselves to a policy in which we value and protect the importance of an ongoing relationship to other persons for the promotion of their well-being. Perhaps we should just call it a relationship of love.

There are two important skills that are of value in helping us unravel the mystery of how to care in our time and in our environment. These skills are: critical self-awareness and participatory action.

4. Critical Self-Awareness

In the conventional clinical method, we are taught to be aware only of those factors in the patient that are relevant for a biological diagnosis. Critical self-awareness is the ability to be consciously aware of everything that is happening during the consultation. It is like maintaining a critical conversation with yourself about what is happening within yourself, within the relationship, and within the other person. Critical self-awareness during and after the consultation enables us to hear things that are not addressed at all in the world of the atomist. We will hear stories, metaphors, and words that will help us to care holistically, especially if we extend that critical awareness to the context around us. We can learn this skill if we create a space for reflection on our own, and with patients and colleagues. In order to understand the complexity of caring, we need continually to reflect critically on ourselves, our feelings

and actions, and our relationship with our patients. We must remain suspicious of all who pretend to have a complete understanding, of all who have a fixed recipe, which soon becomes a dogma, and of all who act as if there is no mystery, no complexity.

It is very useful to reflect on our own illness experiences and try to understand them well. When we understand our own pain or wounds, we are able to care better for others. But we must allow our patients to discover their own personal understanding and solutions, rather than have ours imposed on them. To develop a mature and nurturing relationship with others, we need to reflect on, and become aware of, our own identity, and ourselves as persons. We need to face our own tendency as health workers to control others by caring for them and using them for our own ends.

5. Participatory Action

Participatory action is a basic skill in democracy, in qualitative research, and in the patient-centered clinical process. In the clinical consultation, it is the skill by which the doctor and the patient come to a negotiated and mutual understanding of the problem and a mutually acceptable plan of action. If to this is added a greater critical awareness, we discover, together with our patients, new worlds of complexity and multiple possibilities for caring. Participatory action introduces us to the infinite variety and capacity for healing inherent in individuals and groups. Above all, it reintroduces us to the patient as a person. We also experience ourselves as persons again. A consciously chosen policy of participatory action helps us to become more effective carers.

In research, this skill of participatory action opens up areas and possibilities of learning which cannot be discovered if we remain objective and distant, as we try to do in a double-blind clinical trial. Participatory action opens our minds to "the researched." It makes us open-eyed, open-minded, and open-hearted. We become one research team with the patients, a team that constructs knowledge and meaning together. This type of research, consisting of acting and reflecting together, is as rigorous as other kinds of "objective" research. It was research based on participatory action that enabled us to see the hospital, and the medical system, as a place of violence, a place where the humanity of health workers and patients is diminished, a place where we all become objects and commodities. Using classical objective research methods, we were not able to see this aspect of our profession and the health system. Quality Improvement Cycles (QICs) harness these two skills: acting together and critical self-awareness. Practitioners who introduced QICs into their practice have experienced this as the reintroduction of hope into their professional lives and the health centers where they work.

6. Tools for Dealing with Complexity

Some tools have been particularly helpful to unlock the complexity we face in clinical practice.

(1) The Patient-Centered Clinical Method, first described by Stanley Levinson and his colleagues, is a method by which the patient's agenda leads the consultation process rather than the doctor's interrogation. This method has the immediate effect of taking us as practitioners out of our medical comfort zone into the world where the patient is the expert.

(2) In our department, we have been practicing the patient-centered method with the help of another tool, the Three-Stage Assessment. This tool is a way of dealing with the problem, or the illness, which is presented for attention, from the perspective of the doctor and the patient as persons-in-a-relationship within their particular contexts. It is a tool that places complexity and relationship on the table. Those who practice with this tool are at first surprised, and even intimidated, by the complexity it opens up. Later this complex of interrelationships becomes a help, as previously unimagined ways of responding to the complexity become apparent.

(3) The diagrammatic assessment of family relations in the form of genograms and ecomaps, as described by Ann Hartman, have also proved useful tools to gain an understanding of the complex interrelationships within the context of people and their families. Patients and doctors are often amazed to look at themselves within a genogram. They suddenly make new connections between life-events and illness, or they see patterns of reactions related to their problem within their own family narrative.

Medicine, especially Family Medicine, is in search of a new and appropriate clinical method. It is in the use of tools such as these, and reflection thereafter, that we are starting to see a way out of our crisis in caring.

7. Conclusion

There is a crisis in Medicine. I am suggesting, and it is the also the contention of Kriel in this book, that the crisis is largely because our society and profession live by a view of science and reality that denies or belittles the reality of the subjective. Our life-stories are reduced to anecdotes. Our feelings are reduced to data that can be ignored. In the end, our humanity is denied.

To overcome this crisis, we need to do more than agree to a new view of science and a new metaphysics. We also need to immerse ourselves in a new form of practice that remains aware of the conversation going on within and around us. We have to learn by participating with patients, with families, and with colleagues, to discover new words for our profession and for our own lives. We need to overcome the delusions of the narrow professional world into which we were socialized by our professional schools. This does not

mean a total rejection of the atomistic view of the world. What we have learnt from the atomistic approach must be put in perspective as one of the options of understanding, in balance with other realities and other ways of understanding ourselves and the world.

We need continually to practice, and then reflect on our commitment to move beyond the linear, the material, and the objective. We need continuously to demonstrate to ourselves that we have included persons, as they live in a creative web of infinitely complex relationships, in our clinical commitment, and that we have entered this complex world with the necessary respect and care.

The last word is from Albert Einstein. He is reputed to have said that the most beautiful thing we can experience is that which is full of secret and mystery. This is the foundational experience of all true art and science. I hope that this book will assist us as we work at the task of discovering new ways in which we can become sensitive to the secret, mystery and complexity of the relationship with our patients, so that our medicine can again become a caring and humane medicine, a medicine fit for human beings.

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