

KEYNOTE ADDRESS DELIVERED BY PROF DETLEF R PROZESKY  
AT THE PROMOTIONAL BREAKFAST ARRANGED BY THE DTD  
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Thank you for inviting me to address you today on this occasion of the launch of Gerrie Lubbe's book, 'Just ask'. Gerrie and I have known each other since I was a student and he a young minister and we were both involved in student Christian work. We then went our different ways until we met up again recently and re-established contact.

I'd like to share a few ideas with you this morning on a subject which is close to my heart, very much related to Gerrie's book and what it sets out to do. Let me begin by considering the health care professions to which many of us belong. As we know each profession has unique elements. It has its own scope of practice and service, its own body of knowledge and skills, its own way of regulating itself. One way of classifying the professions is according to the primary focus of their practice – whether it is the material world (such as engineers, architects and laboratory scientists) or whether it is people, human beings (such as teachers, lawyers, social workers, ministers of religion and, of course, health care professions). The people centred professions serve their fellow humans in different ways. They provide help with tasks which oil the wheels of society (such as educating the new generation, drawing up legal contracts, or even keeping people healthy). But what particularly distinguishes the health care professions (together with social workers and psychologists) is that for much of the time they deal with people who are suffering in some way, who are in some kind of personal need.

There is a 15<sup>th</sup> century aphorism which says that the role of the healer is 'to cure sometimes, to relieve often, to comfort always'. It has often been quoted since because it is so apt – it so neatly captures the tensions between cure (and life) on the one hand, and comfort (and death) on the other, and relief (and suffering) somewhere in the middle. These tensions have been embedded in the health care professions since their distant beginnings: the great Hippocrates wrote that 'it is the suffering individual that physicians must face, not just his pain' – a holistic view of the work of healing, placing the whole individual in the centre. But as the healing professions advanced in science and skill over the last century this began to change: curing came to seem the rule rather than the exception, and it was as if humans were finally conquering disease and cheating death. Looking back I was trained in this paradigm – the paradigm of the powerful doctor, the master of biomedical science who could heal the body and who was not overly concerned by other aspects of human suffering, or at least didn't associate those with the practice of her or his profession. We were certainly taught no skills to deal with anything outside the biological sphere, other than those which came naturally to us (or did not). Yet at the same time we encountered those special teachers who exemplified a more holistic approach in their practice, and felt intuitively that theirs was a better way.

As so often happens in human history it was inevitable that the pendulum should swing back from this kind of biomedical reductionism in practice and training. I would like us to take a brief look at two of the leading figures in this return to holism, George Engel and Cecily Saunders.

George Engel practised and taught medicine in Rochester, New York, in the latter half of the 20<sup>th</sup> century. His reaction to the reductionism of his time was a return to the understanding of medicine as an art as well as a science, and it was he who in the 1970s developed the 'biopsychosocial' paradigm of health care practice – the word is self-explanatory. Engel's seminal work was taken up with enthusiasm by the burgeoning discipline of Family Medicine which continued to develop and popularize it – so much so that medical students in South Africa now imbibe this approach as it were with the mother's milk of their undergraduate training (although it must be said that some of their older teachers still regard it with a measure of skepticism as 'that soft stuff'). Students now learn that many patients 'somalise', that they present with physical complaints when their real issue is one of unhappiness; they learn to identify and deal with such 'help-seeking behaviour' in a consultation. They learn the importance of the role of the family in maintaining health and dealing with illness; they learn how a person's community and physical environment affect health and how such influence needs to be considered in a management plan. They are constantly confronted with the need to examine the ethical implications of medical practice and to analyse situations where these are operating. These new young doctors are now comfortable with the fact that the suffering they will encounter has at least three dimensions – the physical, the psychological and the social. They are more or less comfortable with these dimensions, have some skills to deal with them and expect to include them in their practice. One of our fifth year students recently told me of an experience that he had had earlier that day in one of the wards. He said that a consultant had just informed a woman that she had inoperable cancer, 'and Prof., he did it so badly! She started crying and he just walked away. If only he'd asked me to do it I could have done it so much better!'

But there is a further element to the suffering that our patients encounter – and by the way I hate the work 'client' in this context: it has a Thatcherite ring to it, and the fact of the matter is that the people who entrust themselves to health professionals do so because they are patients (from the Latin 'patiens' – the one who is suffering) and not because they are entering into a business transaction with us. The person who most clearly shows me this fourth element is the admirable Cecily Saunders, who as we all know founded the modern hospice movement. Her epiphany took place against the background of the increasing technical success of the health care professions, of situations where in the words of T.F. Main, 'The sufferer who frustrates a keen therapist by failing to improve is in danger of meeting primitive human behaviour disguised as treatment.' At the same time this success had led to a distancing of the average person (and the healer) from the unpalatable reality of death and dying, and this at a time when a widespread loss of religious faith in some communities had diminished the avenues of solace available to people confronted with suffering and death. The story is well-known, of how the young medical social worker met a refugee from the Warsaw ghetto who was dying in hospital in London. As she and David Tasma became friends and were able to talk about his coming death it became clear to her that people like David really needed: holistic care, based on the understanding that they were suffering from 'total pain' (a word she coined). In her understanding there are four elements to this 'total pain': the physical, the psychological, the social and the spiritual; and she spent the rest of her life responding to this understanding by working out how to respond practically to 'total pain'. As we know the small start at St Christopher's Hospice gave a name to this art (which had never completely disappeared) and palliative care has mushroomed into an international movement which has attracted thousand to its cause and has been a

blessing to millions. And as a result the paradigm of training of young health workers today has been even further enriched, by the inclusion of the science and art of palliative care.

Again this inclusion of the spiritual in the process of healing is a return to the past – Hippocrates's well-known oath for new practitioners starts by calling on the gods to witness and judge their intentions and practice: 'I swear by Apollo the Physician, by Aesculapius, by Hygeia, by Panacea, by all the gods and goddesses, making them my witnesses that I will carry out, according to my ability and judgment, this oath and this bond.'

It is not hard to understand why Dame Cecily included the spiritual dimension in her understanding of suffering. It is surely when people suffer greatly, and witness the suffering of people they love, and when death is clearly approaching, that the great questions around the mystery of existence inexorably present themselves: 'Why was I born?' 'Why has this suffering come to me?' 'Have I done the best I could with my life?' 'What about the people I've harmed, wittingly or unwittingly?' 'How will the people I love remember me?' 'How will the people I love cope when I am gone?' 'When will I die, and how?' 'Will I die courageously?' 'What kind of suffering will I have to go through in the process of dying?' Then there is the mystery of what follows death, the Great Unknown: 'What is going to happen afterwards – is it good or bad?' 'Will there be an existence to follow?' 'Will there be some kind of judgement on my life?' Humans through the ages have placed their hopes on answers to these questions developed by spiritual leaders and thinkers: from the ancient Egyptian Book of the Dead where the heart of the dead person is weighed against the feather of Ma'at, the Truth, and either enters the eternal bliss of the 'Field of Reeds' or suffers eternal oblivion; to the Epicurean's expectation of eternal extinction; to the certainties of reincarnation of the Hindu and Buddhist faiths; to the Christian and Muslim promise of eternal life as a reward for faith or good deeds, in the Celestial City or in Paradise.

Although we see examples of militant atheism in celebrities such as Richard Dawkins the fact is that the large majority of the patients that South African health workers will have the privilege of serving identify themselves with a religion and practise it with greater or lesser devotion and orthodoxy. As a result many doctors regularly find themselves in the presence of the fourth element of 'total pain', even if they are not aware of it. Even more than that, I remember a priest once remarking that many people no longer talk about these issues with religious leaders and bring such problems to their health practitioners, even if subconsciously. These professionals may have the skills and the confidence to deal with their patients biopsychosocially but may in many cases not even consider that they have a role to play in dealing with what Dame Cecily called the spiritual side of suffering; I think it has been the tradition among us that this is the almost exclusive domain of religious leaders and ministers. But surely what we want of our doctors is for them to be aware of the spirituality of their patients and to be comfortable with it – not only in suffering and death but also in the way patients understand disease and the nature of an appropriate doctor-patient relationship.

This is where Gerrie's book seems to me to fill an important gap, as a resource we as the teachers of young health professionals can use to open up the area of patient spirituality in an appropriate way. Firstly it demystifies the spiritual in our patients by

providing solid information about it in all its South African variety and richness, and we can use to approach the subject and discuss it with our students. Secondly it suggests a practical way of bringing the issue into the open in a way which fully respects patient autonomy, by 'seeking the patient's view' – 'simply asking' courteously if the patient would like any particular religious practices to be borne in mind, any assistance from any source. At the same time, as Gerrie puts it, 'the golden rule is not to assume anything when it comes to religion', so the health professional becomes not a guru but a sounding board and if necessary a bridge, responding sensitively to any information provided.

Gerrie's book has been written in response to an awareness of a neglected dimension of health care. I believe that if health professionals and their teachers use this resource their practice will be greatly enriched: they will no longer have to feel nervous or embarrassed or ignorant, and instead will be able to approach the spiritual dimension in their patients with sensitivity and insight, and a measure of confidence. Interestingly I was recently informed that the topic of spiritual suffering and care has been introduced in the undergraduate medical curriculum of the University of Sydney, and I believe that South African programmes should follow suit. We now have a resource which paves the way.

Thank you!