Personal view

Learning from our patients

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Paediatricians in training learn not merely from tutors and textbooks but directly from children, too. Learning never stops and as we look at their emotional, conceptual, and spiritual development we may still learn from children lessons to apply to ourselves, our society, and our own priorities.

For good emotional development, committed relationships are vital

In the film 'Getting to know each other' Aiden MacFarlane has illustrated excellently the point that new babies are programmed for relationships, the natural key figures being their parents.¹ An older film, by Robertson, 'A two year old goes to hospital', showed the catastrophic effect on the child of an unaccompanied admission.² Emotional and physical pining portrayed the child's reaction to this experience. Chronic as well as acute social deprivation produces emotional and physical stunting. All this is now bread and butter to paediatricians and is also recognised intuitively by good parents, whose priority is to diminish problems for the child in crisis whatever the cost to the family. It is when parents are not prepared to think in these terms that paediatricians worry, although to see them respond to gentle pressure is usually to witness the enhancement of all the inter-relationships concerned.

There is, however, a distinction between standing by a child in need, who would not understand alienation, and pandering to that child's wishes for evermore. From toddlerhood on, parents have to learn a new kind of commitment, that of teaching the child that love can include a firm 'no'. Young parents fear that to oppose their child conveys lack of love, and it can be as much a discipline for them to apply correction as it is for the child to be corrected, yet it is in the balanced practice of loving direction that relationships and behaviour both mature. As poor parenting tends to be an inherited disorder and courts and clinics are filled with the

consequences of disturbed family relationships, it is never too soon to try to ensure that a child has warm, personal care on the one hand but fair limits to freedom on the other. Discipline may need to be reinforced by the child's temporary alienation within the family—for example, to the bottom step of the stairs—with apology and forgiveness to follow, restoration being marked by a kiss and a cuddle. Adapted for age, this process should go on to build the foundation for adult relationships.

Doctors are not immune from problems with relationships and many a doctor's family must know this all too well. It is possible to work very hard at our jobs but to give no input at all to knowing and nurturing friends and relations. Mutual vitality is therefore sapped, to the deprivation of all concerned.

The design for conceptual growth is from egocentricity to altruism

One reason why toddlers get into such trouble is because they are totally egocentric in thought and have yet to learn to see things from someone else's viewpoint. Unenlightened parents (and unenlightened professionals) make the mistake of thinking that children really think like adults and are just being deliberately perverse when they transgress, yet mystifying rules of acceptable behaviour have to be learned and this takes time (and consistency).

A new baby cannot even think in toddler terms, yet there is a noteworthy 'other centredness' made apparent by the great interest displayed in other people from the start. It is this that forms the basis for the child's responsiveness as relationships are built up. Interest in others, however, does not spell understanding of others and in these terms the child remains egocentric for at least two years. This, combined with the growing sense of power experienced with increasing mobility, produces the negativism of the toddler. By 3 years of age, ability to compare self with others has developed so that the concept of being 'big' (and therefore brave) or 'bigger than' (and therefore more deserving or more belligerent) begins here. Things tend to preoccupy

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more than people, although there remains a need to report back (on happenings and acquisitions) to care givers. Matching, categorising, and competing all begin in the preschool child and it is appropriate that they should do so. Judgment is, however, entirely face value and the awareness that things are not always what they seem only begins between the ages of 5 and 7. Even then, deductions often remain faulty with a face value element. Hence the child who had heard someone say that we are made of dust and return to dust informed his mother that someone was coming or going under the spare room bed! The double meaning of 'dust' in this context (as well as other proverbs and parables) would not normally be fully understandable until a child reached 10 years of age. It is from 11 to 14 years that children begin to think in the abstract, and whereas one may witness a generous spirit in quite little children, true altruism (based on thought for the needs of others in contrast with looking after oneself) is a mark of early adolescence. The response to the Ethiopian appeal by so many teenagers showed how genuine was their concern for others as well as the less mature reaction of copying a pop star.

The whole design in conceptual growth is, therefore, one of getting away from *self* centredness and enhancing *other* centredness, which was there from the start but needed to grow into full potential. Growth spurts may be painful and children need loving, understanding supporters to ensure that painful experience results in growth rather than arrest. Prolonged illness, with recurrent hospital attendance, will accelerate conceptual understanding as may (though not invariably so) a high intelligence. There will be times when face value judgment can *prevent* anxiety, because implications are not understood, but it can also *provoke* it, because what is seen is perceived as being worse than it is. Thus a 3 year old on an intensive care unit may be relieved to see a sibling there at all without understanding (and so fearing) the attached equipment, yet a 7 year old, big enough now to know that people sometimes die in hospital, may be terrified when a parent has to be admitted, even for a trivial reason. Attendant adults should have enough insight to see things through the child's eyes and make the necessary interpretations.

As we look at the normal pattern of conceptual growth in childhood and then survey the world scene it would seem that nations and individuals are at a stage of arrested conceptual development. Hostility between races and nations acts out 'I am bigger than you'. The de-forestation in Africa has followed on people's regarding trees as firewood yet being ignorant of their implications for rainfall and soil

erosion. Nearer home, we constantly hear of acts of violence, traffic accidents, or family breakdowns, many of which are based on a persistence of egocentricity. Perhaps the emergence of a spectator (rather than a participator) society prevents the personal interaction that would bring more thought for others. Acquisition of locomotor power, too (as at toddler level), may encourage its display. Is our own profession immune?

In neonatal care we have had to learn to de-centre and to include the family even in high dependency units. Face value judgment ('We must rush this baby off for surgery') has given way to deeper implications ('Family involvement must start first'). We are entering an era where insight is immensely important, for on the one hand is the attitude that painful problems should be despatched or ignored. Thus abortion for potential handicap is increasing, while facilities for those living with handicap are concurrently decreasing. (To send such children 'into the community' is only attractive at face value unless the implications of this have been anticipated and prepared for.) On the other hand, there is more and more that can be done in life threatening states to stave off the inevitable. Face value judgment could say that we must do it because it is there to do, but insight suggests that peaceful death, even in hospital, should not become an anachronism. That the public is not altogether happy with the way that medicine is going is made clear to us by the vogue for alternative forms of treatment. We could be thwarting valuable experiences for patients and for ourselves by failing to see that pain may be necessary for growth (as in pruning) or correction (as in surgery). It cannot always be evaded, but neither should it be inflicted unsympathetically. If it is to bring optimal benefit there must be personal support during a painful process.

As individuals, doctors have probably been very much at risk for perpetuated egocentricity. The current revolt against paternalism and authority (albeit themselves the marks of an immature culture) may be creative in our own maturation, so that at last we take a greater interest in looking at things from the patients' viewpoints rather than our own. Untempered, technology could bring us into a total and fascinated preoccupation with the many new discoveries. Yet our very entry into a caring profession should mean that these exciting developments are tools towards the attainment of ideals in care, rather than their controlling us. We must not arrest at a 'me, too' level without weighing up whether what glitters really is golden or whether there are more worthwhile aspects requiring greater input that have passed others by. There is a real risk

that, unless we think through these issues, we each become trapped by our own egos and, by definition, remain less mature than we ought to be. Even to be disease centred is not enough, for this could spell ongoing aggression at a time when to be patient centred would mean terminal care.

Spiritual awareness may emerge at times of crisis

When a family suddenly faces a harsh and inescapable diagnosis their former preoccupation with material prosperity and the accumulation of possessions and status proves to have been building on shifting sand. Parents often comment how they would give away their all if only this could save their child's life. Dying adolescents, minds now mature enough to think up huge questions, may start a search for spiritual wholeness as other hopes disintegrate. Some have taken their parents with them on this search, to their mutual comfort.

Yet many a paediatrician with ears to hear is likely to have met at least one very young child for whom spiritual awareness is such a reality that profound statements of faith can be expressed without inhibition or embarrassment. The child's *mind* is too young to grasp that everyone does not necessarily hold the same views, yet the child's *spirit* is so alive with the truths perceived that they unaffectedly spill over into ordinary conversation. One such 9 year old commented, quite naturally, how she could not have endured her bone marrow transplant without the Lord's help. Poetry and prayers, written in an isolation tent, give moving evidence that for her, spiritual life was a reality to be lived in terms of a committed relationship between her and the Lord God Almighty Himself. Her experiences of suffering had no doubt accelerated her intellectual and conceptual development as, even at that age, she was able to recognise the purpose of her treatment and make up her own mind to accept it. Yet she was untroubled by the doubts and agnosticism of older intellects and able to accept her troubles without resentment, though not without questions. For her, life's meaning was in relationships. As she put it, 'Without mum and dad I don't know what I would do. I mean I wouldn't have anyone to love or care for. Without you Lord my saviour, I wouldn't be able to go through with all my treatment.' She was no goody goody, but this added to the impact of her spiritual awareness on all who met her.

We live in a materially minded society, yet as care givers doctors may be assumed to have different priorities. Is this really so? It is possible for us to be

so preoccupied with facts and figures, delighting in diagnosis, discussion, or debate, that we may be very clever—yet not wise enough to see that we are spiritually deprived and dwarfed. It is at the root of Judaeo-Christian beliefs that we are made in the image of God, which includes the idea of being in relationship with Him. Some of the old divines and older artists picture man gazing into the Creator's face with the same look of rapt adoration that a baby can give to a parent. Yet if this regard is not happening (through disbelief or disconnection) there will be a consequent spiritual failure to thrive and a powerlessness that leads to spiritual death, unless the relationship can be restored. It is the Christian message that this can be done—indeed, that divine initiative has been taken through the life, death, and resurrection of the Lord Jesus Christ to direct us toward contrition, forgiveness, and reconciliation with Him. To climb down hurts pride but is the lift off to new insights and changed priorities. To dismiss all this as a cranky creed or flight of fancy is to make a false deduction. Personal histories from all age groups affirm that spiritual life is one lived in a relationship that at last fills the previous God shaped gap. Struggling to fill this alone brings the alienation, infighting, and disease now pervading social, professional, and personal lives. It sometimes takes a crisis to see that, like all others, this supreme relationship needs nurture yet, like no other, is open to all.

The pages of this journal are not the place for full discussion of this important topic, but perhaps our little leukaemic friend can have the last word:

"The Lord loves us, we all should know that.
He cares for us too.
Buy a bible, read it and then perhaps people will understand.
Understand that the Lord does not want WAR.
He want peace for his people. LISTEN TO
THE LORD. He trust and loves us. AMEN."

My thanks to Edwin Hill for introducing me to his patient, Rachel, and to her parents for being so willing to share her writing with a wider world.

References

- 1 MacFarlane A. Film: *Getting to know each other*. Plymouth: Plymouth Medical Films, 1980.
- 2 Robertson J. Film: *A two year old goes to hospital*. London: Tavistock Child Development Research Unit, 1952.

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