

# Lessons in pity and caring from Dickens and Melville

Deborah Kirklin

Suffering, grief, and marginalisation are just a few of the human experiences closely observed by authors in this issue of *Medical Humanities*. None of these are easy to endure or to witness, and yet the latter is exactly what these scholars have chosen to do. Using, among others, the prisms of literary studies, social history, and film and television studies, they ponder the role of healthcare practitioners—for good or for bad—in responding to what Barker and Buchanan-Barker term “problems in human living” (see page 110).<sup>1</sup> According to Barker and Buchanan-Barker, as a society and as healthcare professionals, we have lost sight of what is required of us in the face of human suffering. When an individual is no longer able to cope psychologically with the challenges life offers, we no longer understand “what *exactly* are we called to do as *people*—whether as professionals, friends or fellow travellers”.<sup>1</sup>

Rather than focusing resources and energy on simply containing or attempting to control those affected in this way, they suggest instead that the primary concern should be to help people to address and live with these problems. This proposed reframing of what is currently known as mental illness echoes the reframing of disability as a social rather than a medical concern, reminding us that “people need to be *agents* rather than *patients*”.<sup>1</sup> Caring for people rather than controlling them will, they suggest, take courage—courage that Barker and Buchanan-Barker find sadly missing in their own profession of psychiatric nursing. Instead, they judge it to be intoxicated with the narcissistic allure of academic success and driven by political and economic imperatives. This apparently harsh evaluation has implications far beyond nursing, challenging society as a whole to answer the charge that fear—and not a desire to care—dominates the provision of modern mental health services.

**Correspondence to:** Dr D Kirklin, Department of Primary Care and Population Sciences, Royal Free and University College Medical School, Archway Campus, Holborn Union Building, 2–10 Highgate Hill, London N19 5LW, UK; d.kirklin@pcps.ucl.ac.uk

The competing demands of fear and pity were familiar to Charles Dickens, living as he did at a time when the vulnerable in society were all too often at the mercy of whichever sentiment prevailed. He invested considerable effort in educating himself about the plight of patients detained in asylums in England and America, as evidenced in both his non-fiction and fictional writing. While skilfully identifying in Dickens’s work a number of psychiatric conditions that correspond to the current International Classification of Diseases, Douglas<sup>2</sup> reminds us that Dickens’ characterisations were not bound by psychiatric conventions (see page 64). Instead, he was a close observer of the human condition with a keen sense of the importance of caring for rather than containing people. On visiting a Boston asylum that Barker and Buchanan-Barker would have been heartened by, Dickens declared moral influence—born of kindness and caring—to be infinitely more effective in discouraging violence and disorder than straitjackets and the like. Sadly, now as then, the courage to care is often tempered by the fear that those suffering from mental health problems can engender. The challenge for any society is to find a way to empower those whom we expect to do the caring to have the courage to overcome their fears and ours.

Pity, like fear, is a powerful human emotion. In this issue’s Editor’s Choice, Laurie Rosenblatt, an oncologist, interrogates two of Melville’s literary masterpieces as she tries to make sense of the way in which the unbearable nature of suffering can come between those who are ill and those charged with their medical care (see page 59).<sup>3</sup> Rosenblatt’s premise is that, in fulfilling their role as witnesses to suffering, there is a risk that healthcare professionals will choose to or find themselves disengaging or distancing themselves emotionally from patients. She argues that those who consciously or otherwise adopt this distance may be doing so to avoid burn out, secondary trauma and depression. Equally, this distancing could be a manifestation of these conditions. By grounding

a close reading of *Moby Dick* and *Bartleby the Scrivener* in the story of a cancer patient, told in her own words, Rosenblatt invites us to consider whether there is a middle ground between pity and disengagement. Perhaps, she suggests, one way forward is for patients and healthcare professionals to find “mutual respect for our shared, imperfect, terrifying, vulnerable, embodied state, a way to preserve our small human-scaled grandeur that acknowledges our limited capacities so we don’t abandon one another in catastrophic times.”<sup>3</sup>

Fear and pity are not emotions that Dr Gregory House, star of the popular television series “House MD”, acknowledges or accommodates in either his professional or private life. He is arrogant, rude and considers all patients lying idiots. He will do anything, illegal or otherwise, to ensure that his patients—passive objects of his expert attentions—get the investigations and treatments he knows they need. As Wicclair argues, House disregards his patients’ autonomy whenever he deems it necessary (see page 93).<sup>4</sup> So why, given the apparently widely-shared patient expectation that their wishes be respected, do audiences around the world seem so enamoured of House? Wicclair’s answer raises interesting questions about the extent to which patients trust the motivations of their doctors. Perhaps, he suggests, for the many viewers drawn to this arch paternalist, there is something refreshing about a doctor willing to risk all—job, reputation and legal suits—in order to fulfil his duty of care to his patients: the duty to take care that his actions or inactions do not harm his patients. Because, for good or for bad (your call), once you’re House’s patient there is nothing he won’t do, no inaction he will tolerate, if he believes that by failing to act he will harm you. Like Dickens, the scriptwriters for House are not governed by convention. Nor are they required to reflect the real constraints of the clinical process or hospital procedures. Perhaps, as such, they are able to provide for doctors and patients alike an escape from both and, for medical humanities scholars, an enticing glimpse of the sorts of fantasies that real-world medical care might suggest to the weary minds of patients and their doctors.

If the world of House has its attractions, there are some fantasy worlds, conjured by the makers of film and television, that none of us would like to escape to—places and times where people’s bodies and minds are controlled and manipulated in an attempt to undermine

their sense of self. This is the world explored by Dakin's paper on visual media from the 1960s, a frightening world in which psychiatrists are portrayed as unsympathetic agents of the state or malevolent manipulators (*see page 80*).<sup>5</sup> A nightmare fantasy, yet one that resonated with audiences in the years after the Korean war, a war during which American prisoners of war were submitted to psychological tortures and deprivations in an attempt to break their will. Abhorrence at the idea of using psychological approaches to break the will of another, to control them, lies behind international efforts to stop secret rendition, detention and interrogation without trial of terrorist suspects.<sup>6</sup>

While the spectre raised by brainwashing is disturbing, it is a far more mundane and real fear that encounters with the medical profession can evoke for us all. It is the fear of loss—of our own life, of the future we had been counting on and, most frightening of all, of the companionship and comfort of those we love most in the world. So it is fitting to end this journey through the powerful human emotions encountered in this issue of *Medical Humanities* by drawing the attention of readers to the story of two grieving fathers, as recounted by James and

Williams (*see page 70*).<sup>7</sup> The source materials for this historical research are manuscripts written by two fathers in the early 20th century in England who lost much-loved sons to childhood disease. These two case studies reveal the “manner in which two Georgian fathers cared for their small children when sickness struck and reacted when death deprived them of their loved one”. In addition, it provides an insight into the medical market place available to affluent citizens at that time and a touching reminder of how close the relationship between father and child can be.

The emotions revealed are, as the authors recognise, timeless and, I would add, without geographical boundaries. I am reminded of my time as an inner city GP when a number of my patients were refugees fleeing war-torn countries. One woman had lost 6 of her 10 children. I hoped, but with little hope, that in a country where famine and war took so many children so young that somehow a certain resilience to the pain would have developed. I've heard similar thoughts expressed about England 100 years ago, or even 50, when people bore many children knowing that at least some of them would die. Gilbert, one of the grieving fathers, writing 7 months after

the death of his 3-year-old son Charles, described how “the Temperament of my Mind has undergone a lasting change”. Suffering like this can be hard to witness, let alone to endure. Perhaps, by drawing on Rosenblatt's mutual respect for our shared, imperfect, terrifying, vulnerable, embodied state, the people helping people faced with problems in life will find the courage needed to care.

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