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A Speaking Likeness: Poetry Within Health and Social Care

Here is a poem:

Love bade me welcome. Yet my soul drew back
Guilty of dust and sin.
But quick-eyed Love, observing me grow slack
From my first entrance in,
Drew nearer to me, sweetly questioning,
If I lacked any thing.

A guest, I answered, worthy to be here:
Love said, You shall be he.
I the unkind, ungrateful? Ah my dear,
I cannot look on thee.
Love took my hand, and smiling did reply,
Who made the eyes but I?

Truth Lord, but I have marred them: let my shame
Go where it doth deserve.
And know you not, says Love, who bore the blame?
My dear, then I will serve.
You must sit down, says Love, and taste my meat:
So I did sit and eat.

'Love' was written by the Anglican metaphysician George Herbert. He had survived the religious politics of the court of King James to become the priest of a small country parish, Bemerton, which lies among rolling Wiltshire hills and shallow chalk streams. Something of the hospitality of this landscape seems to have got into his famous poem, which speaks to us regardless of our religious beliefs.

'Love' is a poem of longing for a hospitable acceptance of our very selves. This longing is among the most profound human needs. We can imagine it as halfway between "Consider yourself /at home", as the boys of Fagin's kitchen sing in *Oliver*, and the "Somewhere over the rainbow", that Dorothy longs for in *The Wizard of Oz*. It's the object of redemption songs and revolutionary rhetoric; of liberation theology and utopian communities; of migration and enfranchisement. It's also, as it happens, the object of talking cures and of person-centered health care. Gerard Manley Hopkins, in 'Heaven-Haven', called it "Where springs not fail / […] where flies no sharp and sided hail / […] Where no storms come / Where the green swell is in the havens dumb /And out of the swing of the sea." The German philosopher Martin Heidegger called this notion of perfect adaptation to an ideal home "dwelling".

Some of these models are tendentious, some positively dangerous and a high road to extremism of various kinds. The need to be "bade welcome" is always imperfectly realised in our actual lives. Yet it's constantly manifesting itself. And it does so in two, not quite matching, ways. The first is that, when we feel *ourselves* to be far from the laden table, or the unfailing springs, of comfort, we struggle with meaning making. We need to make sense of bad experiences in a way we don't of good ones, which speak for themselves. The second is that when we see *other* people struggling we

feel an impulse, somewhat akin to hospitality, to do what we can to put them at ease. This the Californian poet Robert Hass starts his poem 'Faint Music':

> Maybe you need to write a poem about grace.

And he ends it, heart stoppingly:

> I had the idea that the world's so full of pain
> it must sometimes make a kind of singing.
> And that the sequence helps, as much as order helps—
> First an ego, and then pain, and then the singing.

Two different human efforts, then: to cope with what, employing a slightly dramatic-sounding shorthand, we could call suffering – and to alleviate it. And nowhere do they meet more intimately than in care settings. In health and social care, societies construct their *best* attempts at managing the suffering of individuals within their community.

Today, almost everywhere in our unequally resourced yet globally aware world, health care is still built on the *approximate* principles of the Hippocratic Oath. The doctor cannot promise to cure; but he or she can – and often still does – vow to "help the sick according to my ability and judgement, but never with a view to injury and wrong-doing". "According to my ability and judgement": this means that I (simply) need to do the best I can. In other words, there's a "fuzziness", a reliance on *best intentions,* in place of absolutes at the heart of care.

This *has* to be the case because – as we know from our own experiences – health care needs are individual. Yet health care is an absolute: a human right. It's enshrined in the Universal Declaration of Human Rights under Article 3 – "the right to life, liberty and security of person" – and Article 25 (1), which states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The *European* Charter of Fundamental Rights puts healthcare itself, and a more proactive model of that care, centre-stage. In its revised Article 35:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

The European Charter also has a more intimate starting point than the Universal Declaration. The latter, written in 1948 in the immediate aftermath of the second world war, opens with the Article:

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

This is a model of a just, egalitarian *society* of rational equal citizens, rather than of individual human experience.

By contrast, the first Article of the European Charter, originally promulgated in 2000, and made legally binding by the Lisbon Treaty in 2009 (though not here in the UK), states:

> Human dignity is inviolable. It must be respected and protected.

And this notion of *dignity* is key to everything I want to say today. It's an elastic concept, capable of slipperiness in judicial contexts. Nevertheless, "dignity" appeals to a notion of human-ness as more than the sum of its parts. True, it carries with it the risk of evasiveness, pride, and a dozen other human failings. But importantly it also allows us to leave what a person *is* as something under-determined; as a *principle* rather than a *definition*.

After all, we're still finding out the limits of human attainment (not to mention other human qualities). Humans can run faster than we ever thought. They can resolve mathematical conundrums, and explore regions of deep space, which previous generations believed were by definition beyond human scope. The era of global communication and travel has allowed each of us, wherever we're situated, to understand that there are more, and more radically varied, ways of speaking about the world than we realized. So the principle that dignity is fundamental to *what we are* is *not* an appeal to good

manners. It *is* a capacious (re)definition of being human: one that leaves us growing room and that says, in effect, nothing more or less than that "humans are intrinsically valuable".

The actual wording of the European Charter is, "human dignity is inviolable". At first sight that seems odd. Of course people's dignity can be violated. I saw a certain amount of such violation in the locked long-stay wards of the old asylums where I first worked. In those 12 and 20-bedder "Nightingale Wards" where the loos had no doors, where people with dementia were hit when they soiled themselves, where the most severely disabled residents were tied in their wheelchairs, residents were offered no remission in their decades-long punishment for the crime of being ill – or of having learning difficulties. P*risoners* are allowed parole and, largely, the redemptive path of rehabilitation. For these grey ghosts, with their lithium tremors, their rotten teeth and their fingers yellowed by the roll-ups that were their only recreation, there could be no end to the daily round of "Industrial Therapy" – that cheap labour scheme which had them sorting nails by sizes for hours a day, every weekday for years – occasionally mixed with rug-making, raffia- and, yes, basket-weaving.

What the system that controlled their lives had forgotten was that they were the ghosts of *people* and, like everybody everywhere, had the capacity and need to make meaning in and of their lives. The Romantic poet John Clare, writing in the early years of his own incarceration in Northampton Asylum, speaks for all the inhabitants of what I'd like to borrow from Fyodor Dostoevsky's portrait of arbitrary imprisonment and call *the House of the Dead* in his famous poem 'I am':

I am—yet what I am none cares or knows;
My friends forsake me like a memory lost:
I am the self-consumer of my woes—
They rise and vanish in oblivious host,
Like shadows in love's frenzied stifled throes
And yet I am, and live—like vapours tossed

Into the nothingness of scorn and noise,
Into the living sea of waking dreams,
Where there is neither sense of life or joys,
But the vast shipwreck of my life's esteems;
Even the dearest that I loved the best
Are strange—nay, rather, stranger than the rest.

I long for scenes where man hath never trod
A place where woman never smiled or wept
There to abide with my Creator, God,
And sleep as I in childhood sweetly slept,
Untroubling and untroubled where I lie
The grass below—above the vaulted sky.

Once again, this is a poem that arrives at the longing for peace.

So human dignity is inviolable in the sense that, while it *can* be attacked, it can't be reduced, because it is intrinsic. "Dignity" names the fact that what we do to support

people in health and social care is the outcome of what *they* are: not of what "nice" people we might be.

So: insofar as human rights are facts – and, even though they're *ideas* discovered in a particular, Western culture, I personally think they are – we have a *right* to be cared for. But no legislation alone can produce this care in its ideal form, because that ideal is as individual as the person who has a right to it. After all, care requires astonishing accuracy; the fine-tuning that makes it, paradoxically, into an inexact science. And not only in surgery, though that's the most obvious example. Prompt, accurate diagnosis can require radical *attention* to, and brilliant *interpretive* skills in, what a patient – inexperienced in their body's new forms of misbehaviour – hesitatingly reports. Medications work *differently* upon individual metabolisms and allergens, to say nothing of bodyweights. We can see how clumsy *legislation* is at providing the best care for each individual when we look at the effects, for example, of targets for treatment times: since though promptness is indeed vital, individual needs don't fit exactly into a single template.

So how can we think about this vital fine-tuning at the heart of care? "Person centered care" addresses the need to move away from top-down, "production line" provision and shape care around the individual needing it. The term was originally psychotherapeutic – it was coined by Carl Rogers in the 1950s – but has been applied to wider clinical provision in the US since the 1990s, with the Chronic Care Model and the Institute of Medicine's inclusion of "patient-centeredness" in its six criteria for quality care. In Britain, steps towards its adoption have included the 2000 NHS Plan, various reports, the 2009 NHS Constitution (in England), the scandals of Mid-Staffs, the 2012 health and Social Care Act (England), the Welsh White Paper "The Listening

Organisation" and strategies in Scotland and Northern Ireland. In its 2014 report, *Person-Centered Care Made Simple*, The Health Foundation resists defining person-centered care, since that would undermine its very project, but argues that it should include:

1. Affording people dignity, compassion and respect.
2. Offering coordinated care, support or treatment.
3. Offering personalised care, support or treatment.
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

This "*direction* of care" and the good practice that results from it is and has not been always the case. The American Confessional poet Anne Sexton, who killed herself in 1974 at the age of forty-five, excoriates one-size-fits-all Occupational Therapy in 'Ringing the Bells', from her 1960 collection *To Bedlam and Part Way Back*:

> And this is the way they ring
> the bells in Bedlam
> and this is the bell-lady
> who comes each Tuesday morning
> to give us a music lesson
> and because the attendants make you go
> and because we mind by instinct,
> like bees caught in the wrong hive,
> we are the circle of the crazy ladies
> who sit in the lounge of the mental house

and smile at the smiling woman
who passes us each a bell,
who points at my hand
that holds my bell, E flat,
[…]
and this is how the bells really sound,
as untroubled and clean
as a workable kitchen,
and this is always my bell responding
to my hand that responds to the lady
who points at me, E flat;
and although we are no better for it,
they tell you to go. And you do.

One problem with the scenario she describes is that this bell ringing isn't voluntary. It's a "treatment". Music can be an art; it can also be entertainment. The activity in this poem is neither, because it has nothing to do with a person and how they *choose* to "spend" their time. Instead it reduces each individual to a "hand", part of a human glockenspiel.

The arts in healthcare are often confused with Occupational Therapy, but they are not OT. Indeed, they are not any kind of "therapy". The reason for this is not that healthcare arts practitioners aren't trained clinicians – though we're not, and should never forget that fact – but that *art itself* is not therapy. In the same way, healthcare arts also get confused with art therapy: which views the art-work – indeed, all symbol formation – as pathological, that's to say as a symptom of what is "wrong with" an

individual. We see clearly how far this important *clinical* approach is from art when psychoanalytic critics take apart a well-known work of art or of literature. Their reading of it as an *involuntary* tracing of the psyche cuts out everything we might conceivably argue that art is – minimally, an intentional act of making, formally structured, related to other similar work – not to mention more detailed and contested notions like order, beauty, or expression.

Of course, every individual, including the artist-maker, has a psychological pre-history. But human rights legislation – and the practice of care itself – acknowledge that our human-ness *encompasses and is prior* to such pre-histories, just as it is to a broken leg or a blocked artery. So art in health and social care, an intentional, human practice, must be art *in the same way* as if it were produced in any other setting in order to *be art*. (As an aside there's an argument that some people wouldn't produce art in any other setting. Many of the people we work with have no prior engagement with the arts. Some have little literacy too. This is true, and something we're proud of; but it gainsays nothing of the nature of art. All it tells us is that health and social care represent an *opportunity* for art to happen.)

What, then, *are* the arts doing in health and social care? I think the answer lies in a principle which mirrors human dignity: that of hospitality. The American *literary* theorist Gayatri Chakravorty Spivak talks about *translation* as imposing a duty of hospitality on the translator, especially when she or he is translating texts originally published in the developing world into English, this language of global power. Spivak lives and works in the US, but grew up in Kolkata. She's well aware that poor translations disenfranchise texts, ideas, discoveries and authors. We all know this too: even without being literary

translators. When Hollywood gives villains thick Slavic or Arabic accents, we read its signal that these characters are "bad", untrustworthy, and different from the "us" it puts centre stage. What I've taken to calling "meerkat English" is used to indicate characters are at best naïve or unintelligent: anyway, less than that "us" and disposable as "collateral damage" in an action movie, or an admiring chorus throwing the blond protagonists of a romantic comedy into relief.

Spivak says a good translator must be like Herbert's Love: the proactive host who "drew near me, sweetly questioning if I lacked anything". They must *go some way to meet* the guest they are welcoming into a new language. It's not for nothing that we call this new language the "host". Such going out of the way to "meet" means thinking through the quality of a translation and paying attention to the very nuances that make it clear, authoritative and characterful in the original language: the exact synonym, the appropriate register, the grammatically elegant expression. This process is by definition anti-mechanical, and conscientiously reflexive. (It is not, and never can be, Google Translate.)

For all that Hollywood suggests we'd prefer language to be a flavourless carrier, which simply lets us digest *what it has to say*, language itself *is* what it has to say. Language *ain't what you do, it's the way that you do it*. Language has our fingerprints all over it. We are all native speakers not only of a national or international language called English, or Urdu, or Finnish but (as Jacques Lacan says in a more complicated way) something much more local, and personal: our own way of putting things. This means that to listen, really to pay attention, to what someone else has to say requires us to step outside our own native idiolect and try on another way of thinking and speaking. It means doing

something less automatic than seeing the world "in our own terms". That cliché says it all.

When I was first theorising writing in health care, I wrote extensively about how language is the way we make through the world (since we "have" the world via our *experience* of it). I don't want to repeat myself here, but just to remind us how hard different ways of knowing about something find it to coexist. Health care's an obvious example: domestic common sense (wrap up warm!), alternative therapies, a GP and a research scientist all frame even the common cold differently from each other. And *each* way of going on feels it has a monopoly on accurate knowledge.

"Tomayto, Tomahto, Potayto, Potahto: let's call the whole thing off!" We're like nothing so much as monarchs of our own little walled cities, occasionally emerging from the fortified barbican to parlay. And emerging thus can make us feel vulnerable. So why do it? Well, the *solipsistic* reason is curiosity. It's interesting to know about different worlds of experience. But the *ethical* reason is that the other person is another self. Immanuel Kant's "ethics of recognition" (my term) are developed in his *Prolegomena to any Future Metaphysics*. The other person is my mirror-image: and matters as much or as little as I do.

Kant founded his ethics on empiricism – on his study, in *Critique of Pure Reason*, of how we know anything – because he wanted to bind them into the world of facts. But there's another version of rights and obligations, one much closer to the personal, individuated and "fuzzy" heart of health care. Hospitality isn't a legal obligation but it *is* a

special kind of deep choice, for which we have words like "honour", "duty" and even "sacred". Arguably, it's with such deep choices that we assert our own humanity.

In cultures other than the Anglo-Saxon, where hospitality is a more central form of behaviour than it is here in the Anglo-American North, the special character of this kind of choice is both more apparent and more embedded in tradition. In some cultures hospitality becomes a proof of power, of masculinity (or of femininity). So it's not surprising that lavish demonstrations of hospitality are promised by, for example, the God of the Abrahamic traditions. The Judaic "land flowing with milk and honey" has the kind of geophysical detail you'd expect of a desert religion. In Deuteronomy 8 it becomes:

> [7] […] a good land, a land of brooks of water, of fountains and springs, flowing forth in valleys and hills,
> [8] a land of wheat and barley, of vines and fig trees and pomegranates, a land of olive trees and honey,
> [9] a land in which you will eat bread without scarcity, in which you will lack nothing, a land whose stones are iron, and out of whose hills you can dig copper.
> [10] And you shall eat and be full […]

Meanwhile the promise to Christians, "Come unto me all you that labour and are heavy laden, and I will give you rest", appears in Matthew 11:28; while Islamic descriptions of Jannah (Paradise) speak of a soil made of saffron, pearls or fragrant musk, of fruit trees, and of a life of perpetual happiness and youth. Hospitality is the proof of God's power; as well as the object of human longing.

Which brings us back to George Herbert. His hospitable principle is an interlocutor, not merely a provider, who approaches, questions and smiles at the narrator, and even takes his hand. Most memorably, it is "quick-eyed": that's to say, *reactive* and *individual*. And so we have three strands of the same *flexible* principle: dignity, translation and hospitality. The Welsh word *ystwyth* means winding, flexible (I should know: I was brought up in a town named for it) and this indirect-ness, this hospitable refusal to "cut to the chase" and do away with humanizing niceties, is what allows the most dazzlingly accurate translations, the most acutely attentive welcome, to greet the guest: whether they're visiting a language, or a healthcare unit.

It's mirrored in poetry's equally capacious indirectness, the "slant" that allows us to "tell all the truth", as Emily Dickinson said we should:

> Tell all the truth but tell it slant—
> Success in circuit lies
> Too bright for our infirm Delight
> The Truth's superb surprise
> As Lightning to the Children eased
> With explanation kind
> The Truth must dazzle gradually
> Or every man be blind—

Working with the arts in healthcare adds to the gestures of hospitality being performed by clinicians and social carers. Art is many things, but above all it is additional, creative, disobedient and indirect. Poetry, that cheapest and most portable of all its forms, sneaks into the unit, on the bedside table or overheard in a day-room. It arrives as a piece of

paper folded into a paperback, a poster in the long corridor down to X-ray, something heard on hospital radio, or as a few words jotted down in a notebook or dictated to an arts worker. Half remembered, it stays in the mind like an earworm or a guide: the "Everyman, I will go with thee and be thy guide/In thy most need to go by thy side" of the old Everyman's Library books (and the eponymous mediaeval play that is its source).

I like to think there's a paradoxical correlation between the unassuming forms poetry takes in the world – its apparent physical fragility and small scale – and the explosive power of all that can be compressed into it: William Blake's "World in a Grain of Sand", perhaps. The Chilean poet, diplomat and Nobel Laureate Pablo Neruda acknowledges its power to step forward and greet us, even when we don't expect it:

> And it was at that age... Poetry arrived
> in search of me. I don't know, I don't know where
> it came from, from winter or a river.
> I don't know how or when,
> no, they were not voices, they were not
> words, nor silence,
> but from a street I was summoned,
> from the branches of night,
> abruptly from the others,
> among violent fires
> or returning alone,
> there I was without a face
> and it touched me.

I did not know what to say, my mouth
had no way
with names
my eyes were blind,
and something started in my soul,
fever or forgotten wings,
and I made my own way,
deciphering
that fire
and I wrote the first faint line,
faint, without substance, pure
nonsense,
pure wisdom
of someone who knows nothing
[…]

Poetry's capacious makes it somewhere within which to make meaning. In translation by the Palestinian American poet Fady Joudah, Mahmoud Darwish's 'Your Night is of Lilac' opens:

The night sits wherever you are. Your night
is of lilac. Every now and then a gesture escapes
from the beam of your dimples, breaks the wineglass
and lights up the starlight. And your night is your shadow—
a fairy-tale piece of land to make our dreams equal.

Like Neruda, Darwish was a "national" poet, a spokesman for his generation and people. Like Neruda's, his spokesmanship was all the more powerful because it was not literal but "poetic". Poetry allows us to go beyond what explanation and denotation allow us to say: in T.S. Eliot's "raids on the inarticulate". Poetry allows for evocation and allusion to what is too risky or controversial to make explicit. Famous examples include the playful, magical realist parables of Central European verse under communist censorship. A poem from, say, the controversial Polish poet Zbigniew Herbert's 1974 book *Mr Cogito* blinks its wide-open eyes innocently at the censor. Closer to home, this makes poetry the advocate's tool in health and social care. Whether they compose or simply quote it, someone in a position of institutional weakness can use it to express, for example, anger or other dangerous emotions.

Speaking from such a position has symbolic value no matter what is said. The passive "patient", enduring care, becomes a speaking Subject of that care. What they say has yet more power when it has a discrete discursive identity, as poetry does. We can see this from the counter-example of not speaking. The leading British Surrealist poet of the interwar years, David Gascoyne, was famously "discovered" living in a back ward of Whitecroft, the Isle of Wight County Asylum, when a volunteer on the ward read a poem in the dayroom which had been written by him, and which he spoke up to claim. Gascoyne went on to leave the asylum and marry the volunteer. (Of course, though he was rescued by Judy's recognition, Gascoyne wasn't "discovered" *to himself: he* was there all along.) While Gascoyne was growing up, another fine poet, Ivor Gurney, was being committed in turn, first to Gloucester County Asylum and then to Stone House Hospital at Dartford in Kent, for the last fifteen years of his life, thus ending his poetry writing and musical composition, too.

For a couple of years I worked with Sue who, mute while sectioned, was released to day care after she began to speak again. She writes about this in her poem 'Lost for Words'. Because of the way she uses repetition and rhythmic line-breaks, you can hear the tearing effort involved in pulling herself out of silence into the position of the one who speaks. To read her poem is to be forced to *go through* these language experiences:

You see I could
I could speak
I could speak a few words
Some strange
Some strange half felt sentiment
I could
I could try
If only I could make the connection
The connection
Connection between thought
Between thought and sound
Sound
That's it
Sound
A collection
A collection of
Of what? Yes that's it
A collection of vowels
To string

To string

To string a sentence

A sentence together

To connect

To make

To make some sort

Some sort of contact

A statement

A statement to

A statement to the effect

To the effect

To say

To say

I am still alive!

This is explicitly autobiographical stuff. But poetry can also offer a kind of privacy. Its indirectness is a fancy dress that may disguise serious intent; or anyway distance it. What a poem "says" need not be taken as confessional. This privacy extends to the *amount* that's understood by a poem's readers. Maybe Edward Thomas's 'Lights Out', for example, really is just a poem about rest, despite its military title and the context of its composition; or maybe it's about death. We let the possibilities oscillate as we read, according to the way we're feeling:

I have come to the borders of sleep,

The unfathomable deep

Forest where all must lose

Their way, however straight,

Or winding, soon or late;

They cannot choose.

[…]

On the other hand, poetry can make a point memorable. Poetic form is a mnemonic device. Its attractive qualities – attract us. "What is this life if, full of care, / We have no time to stand and stare?" the Welsh poet W.H. Davies asks in his poem 'Leisure', as so many have before and since; but because *he* asks in rhyme, we remember it.

Most of the poems I've chosen for this lecture are also well-known: they demonstrate how there *is* no separation between what poems do within and beyond health and social care. Poetry in health and social care is not instrumental: it works *as* poetry. But perhaps because it's positioned precisely here, at the nub of what both art and human nature are, the hospital arts movement has sometimes had trouble keeping its identity straight in the minds of decision-makers. The tendency is to see it as neither good art nor germane to health and social care, but as only halfway to art and halfway to care. In fact, of course, it offers the very best of what art and care are, since it goes to the heart of each matter.

The Wellcome Trust's acquisition of the healthcare arts movement's national archives is an important milestone, and I hope will encourage all stakeholders to think again about the field. Medical Humanities can sometimes seem the preserve either of medical historians, or of artists' representations of health care, or of scientific research. These are fascinating: but research into what happens when the arts are actually at the place and moment of illness, vulnerability and care is surely as urgently important. We

need to ask providers to consider this, so that today's practitioners and researchers aren't forced away from the arts in health and social care, as I was, by the absence of a joined-up career "path" or the opportunity to research these practices. Today, we do have academic research communities, including the Centre for Medical Humanities at Durham University where Mike White himself was based. We need to resource and reward such examples of good practice. We need a growing body of curatorial, publishing and archival work to continue to make the arts in health care audible and visible. We need to stop assuming practitioners are half-and-halfs, incapable of thinking about and articulating their practice; and instead to see them as *doubly* skilled. And we need to remember to integrate their practice in health and social care with the rest of their artistic practice and their working (i.e. earning) lives, so that the very best people continue to work where art is most coherently and urgently itself.

5,256 words