Observing Healthcare With Mary in Her Final Weeks of Life

Neil Seeman

Early in the year 2024, my mother, Mary V. Seeman (MD, DSc, OC, FRCPC), received news that would recognize her lifelong goal, which was to humanize and empower some of the most stigmatized members of society – the severely mentally ill and their parents and, in particular, their mothers. The American Psychiatric Association had chosen to honour her with the 2024 Adolf Meyer Lifetime Achievement Award, a prestigious tribute to her life's work in improving women's mental health. This accolade arrived in her e-mail in January; she died three months later, on April 23, 2024.

As was her nature, she said, she did not feel that she deserved the award. Did they make an error? She suggested to me that perhaps we could recommend many of her highly qualified students.

In spite of this award, and the many other commendations of her dedication to service and medicine, she and I struck a secret deal. As we navigated the end of her life – two weeks in Mount Sinai Hospital in Toronto, ON, followed by 10 days of palliative care at home – we agreed that my mother would be known to her care team only as "Mary," not "Doctor Seeman" or "Professor." She designated me as the note-taker, which I took on eagerly; she was always my wisest teacher. Our little game was neither born of whimsy nor humility, though these were her signature character traits. This was a deliberate scientific choice, rooted in her ongoing commitment to understanding the human psyche and how the intricacies of healthcare delivery respond to the mind's disposition. She felt that disclosing her profession at this time might prejudice the relationship between the observer (herself) and the observed (healthcare practitioners and attending hospital staff). Even in her final days, my mother remained an insatiable investigator. She would catalogue and analyze the myriad interactions that make up modern medical care.

Throughout her career, my mother had been deeply influenced by Jungian psychology, which emphasizes the importance of the collective unconscious and archetypal patterns in human behaviour (Jung 1959). Carl Jung's theory posits that the human psyche consists of conscious and unconscious elements, with the unconscious further segmented into personal and collective components. The collective unconscious, shared by all people, contains archetypes – universal, innate patterns and images that influence behaviour and experiences. Jung, and my mother, believed that such archetypes play a crucial role in shaping personality and guiding personal maturation through a process Jung called individuation (Jung 1959).

Mary V. Seeman

This theoretical framework helped my mother make sense of herself and of her troubled patients. She had escaped Nazi-occupied Poland as a child and later felt both different from and connected to the immigrant communities of Montreal in the 1950s. And though a formidable voice in the

psychiatric community, she was among just a handful of women to earn a medical degree from McGill University in 1960. Jungian theory and her clinical work with people suffering from schizophrenia led her to adopt a wide-angle lens on the practice of medicine. With her patients, she was increasingly drawn to the concept of *mothering* in healthcare – not in a paternalistic sense but as a holistic approach to care. Her holistic approach combined empathy, nurturing and boundary-setting to provide personalized, patient-centred treatment.

Her understanding of mothering helped salve some of the stigma that the most vulnerable people in society endure whenever in need of care. Women with schizophrenia, she argued in 2018, face a double stigma – that of mental illness and that of gender. This intersectionality of stigma can significantly impact their access to care, social support and overall quality of life (Seeman 2018). Societal stigma is a curse befalling those hidden from view, those in the creases of society, she said. She would point, by further example, to mothers blamed for their children's mental illness. Her desire to dispel this persistent myth inspired her to advocate for better education of the media and broader public.

Seven Archetypes of Caregiving

As she lay in her hospital bed, and later at home, my mother observed and classified the healthcare providers she encountered into categories. The classifications, she felt, each represented an archetype of care defined by certain strengths and potential pitfalls. As both her student and caregiver, I was surprised that she felt these archetypes were not limited to doctors but were embodied by various members of the hospital staff, from nurses to orderlies to administrative personnel.

1. *The diagnostician:* This archetype combined diagnostic focus with technical expertise. My mother observed this in a skilled nurse practitioner who approached patient care with scientific rigour, focusing on symptoms, tests and diagnoses. "She reminds me of Phil," she smiled, in reference to her late husband, whom she met on the first day of medical school at McGill University in 1957. While the nurse practitioner's expertise was invaluable, my mother noted that she sometimes struggled to see the patient as a whole person connected to a world rather than as a composite of bodily symptoms.
2. *The nurturer:* This archetype resonated deeply with my mother's concept of *mothering*. She saw it exemplified in a long-time bed transporter who offered warm, empathetic care, treating patients with compassion that went beyond physical assistance. He seemed to intuitively understand the healing power of gentle interventions, often pausing to offer a kind word or a reassuring touch. I asked one transporter what the most important skill is to have on the job. Strength? Stamina? "No. Connection," the transporter said.
3. *The educator-philosopher:* My mother, herself a lifelong educator, appreciated these providers who not only explained conditions and treatments clearly but also pondered over deeper questions around quality of life and ethics. She saw this quality in a medical resident who artfully broke down complex health information and in a Jungian-oriented caregiver who engaged in daily discussions about meaning and purpose in the face of terminal illness. This sparkling-eyed woman, who was caring for her dying mother in the hospital room we shared, engaged me in nighttime discussions about meaning and purpose when staring down terminal illness. She was Christian; we were Jewish. She explained the interconnectivity of all faiths.
4. *The coordinator-advocate:* In the lattice web of modern healthcare, these providers stood out for their ability to manage a patient's overall care journey and to champion their needs. My mother admired a consulting kidney specialist who manoeuvred the hospital's various departments and a social worker who ensured that all her patients had access to necessary resources after discharge. The kidney specialist was brief in his follow-ups, but he seemed to always be there, watching over us.
5. *The partner:* This archetype embodied the shift toward patient-centred care, involving patients as active participants in their treatment decisions. My mother saw this as a positive evolution in medicine, moving away from paternalistic models of care. She observed this quality in a physical therapist (PT) who collaborated with patients on setting their own rehabilitation goals. My mother was too frail to engage the PTs for help but nevertheless adored their tenacity, transposed onto their patients.
6. *The cheerleader:* With their positive, upbeat bedside manner, these carers focused on providing encouragement and moral support. While my mother appreciated their optimism, she recognized the importance of balancing positivity with realism, especially in end-of-life care. She saw this archetype in a volunteer who emitted cheer throughout the ward, though I dimmed the room lights when his Easter Bunny brigade made its rounds. We all need cheerleaders, just not all of the time.
7. *The empathetic professional:* Perhaps the most nuanced of the archetypes, these providers developed close, but not too close, personal rapport with their patients. My mother recognized the potential therapeutic value of such relationships while cautioning about the importance of maintaining professional boundaries. She observed this quality in a long-serving nurse who developed warm, friendly relationships with patients, speaking of the search for true love and the transcendental, walking the slippery line between professional care and personal connection.

A Mothering Approach to Care and an Integrative Approach

Although often associated with her body of publications, the concept of *mothering* did not begin with Mary or her peers. It has its roots in psychoanalytic and developmental theories that emphasize the importance of a nurturing, supportive environment for holistic psychological development (Bowlby 1988; Winnicott 1960). I saw first-hand how any health professional can be mothering in orientation, regardless of gender, age or role. Mary added a twist, however, emphasizing to me how mothering invites an agile, integrative style of care and, also, promotes what the academy calls "knowledge transfer and exchange." In this spirit, my mother would salute *Healthcare Quarterly*'s new mental health lens as a recurring theme for this journal. Mental health and physical health cannot be separated, Mary taught the world, both in the classroom and at the bedside.

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As she observed these different archetypes in action, my mother reflected on how her specific concept of mothering in medicine could potentially integrate the best aspects of each of the archetypes. She envisioned a form of care that combined the analytical precision of the *diagnostician*, the compassionate touch of the *nurturer*, the intellectual depth of the *educator-philosopher*, the organizational skills of the *coordinator-advocate*, the collaborative approach of the *partner*, the uplifting spirit of the *cheerleader* and the balanced empathy of the *empathetic professional*. This integrated approach, she believed, could offer a more holistic and personalized care experience, addressing both the medical and emotional needs of patients.

Mary further believed that this model could deliver the highest form of holistic and personalized care. This said, she emphasized the critical importance of maintaining appropriate boundaries. The mothering concept in medicine, as she saw it, was not about creating dependency or blurring professional lines. Rather, it was about creating a safe, nurturing environment where patients could heal and grow, much like a mother provides for her child while also encouraging independence.

My mother's Jungian background influenced her belief that this mothering approach could tap into deep-seated archetypal *receptor* needs within all patients, providing a form of care that resonated on both conscious and unconscious levels no matter their preferred relationship with a provider. This *receptor* analogy stuck with her. It was inspired by my late father Philip Seeman's discoveries about how the five dopamine receptors in the brain function to "receive" the brain chemical, dopamine, which gets released at different speeds and rates of flow in different people's brains (Seeman 2022: 81). That differential dopaminergic response explains how any individual sees life events differently and assigns different levels of meaning to those same events. And so, my mom saw the potential for the mothering-receptor approach to enhance the therapeutic alliance, improve patient outcomes and heighten satisfaction for all patients and providers (Bowlby 1988; Jung 1959).

As her life drew to a close, my mother remained committed to her role as an observer and expansive thinker in the field of medicine. Even as her body failed her, her mind analyzed and synthesized her experiences into wisdom that she hoped would contribute to the ongoing evolution of patient care.

In Mary's view, healthcare workers who integrated multiple archetypes – combining technical skill with empathy, education with advocacy and coordination with philosophical reflection – seemed to provide the most comprehensive and satisfying care. During our hospital stay, she was particularly impressed by how these qualities manifested across various roles in the hospital, from the most highly trained specialists to the support staff who kept the hospital humming along at all hours.

Her end-of-life experience reinforced her belief in the potential of the mothering concept in medicine. She saw how this approach, when implemented with appropriate boundaries, could create a healing environment that addressed not just the physical aspects of illness but also the emotional, psychological and spiritual dimensions of the patient experience (Sulmasy 2002).

As I sat by her bedside and watched her interact, as an investigator, with her care team – from doctors and nurses to orderlies and volunteers – I saw her spark of curiosity aglow. Even in her final moments, she was learning, observing and theorizing – a true clinician-scientist and healer to the very end.

My mother's passing marked the end of a remarkable life and career, but her ideas live on. Mary's vision of a more holistic, personalized approach to medicine and mental health, grounded in the concept of mothering but tempered by clear professional boundaries, offers a compelling direction for the future of healthcare. As we race down the technologically driven airstrip of modern medicine, we would do well to remember my mother's counsel – that at its heart, health is about human connection, empathy and care. These are qualities that can and should be embodied by every member of the healthcare team. The breadth and skills of that team and each patient under their care deserve respect, no matter their name, credentials, or accolades.

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