In 1977, I was assigned as a doctor to a geriatric unit specialising in chronic care hospitalization which was located in the near Paris suburbs. The patients I was responsible for were very elderly people. They were on the average over 80 years old. I also knew that sooner or later they would all die in our midst. As well as being preoccupied with improving the quality of medical treatment given to them, I also wanted to improve the quality of life within the institution, and to improve the conditions of death for these very elderly people. I was familiar with Elizabeth Kubler-Ross's (1969) work on the psychology of dying people. I knew that in England there was a hospice where the doctors were successfully using morphine to treat the suffering of terminal cancer patients. But we were in France: and this work was only known to a very few individuals. The notions of accompanying dying patients, and of palliative treatment were still not in medical vocabulary. Nonetheless, a book written by the famous oncologist, Léon Schwartzzenberg and the journalist, Louis Viannson-Ponte, entitled "Changer la mort" (Changing Death) was published in 1977. This beautiful, moving book, which foresaw active euthanasia negotiated between doctor and terminal patient, was incontestably to mark French medical and social thinking on the subject, and was to influence doctors' behaviour.

What attitude was I supposed to take towards the dying patient? Was I to desert him as I had all too often seen happen in many hospital units? I didn't feel that I had the right to. Was I to desperately go on trying to save him right up to the end? This denial of death seemed all the more absurd to me as the patients I was treating were very old and their death was in fact something completely natural. Was I artificially to precipitate inescapable death with some medicinal injection? This "clean" solution didn't satisfy me either. It wasn't a question of a religious attitude, but rather, I couldn't recognize my role as a doctor in it; nor the reasons why I had chosen this profession. Those were my internal conflicts. I was looking for my way. I was looking for a model of death which was appropriate for the old people who were entrusted to our care; appropriate for their families and for ourselves, the care deliverers who were to live with them for months and even years.

Since my arrival, I had undertaken to work very closely with the nurses and orderlies. I knew that I would be able to do nothing by myself alone, and that their role with the elderly patients was really primordial. As a result, we met frequently to communicate, and to discuss all the daily
material problems. And there were many of them, for at that time our means were still very limited in this sector which was under-developed, under-medicalized, and very little appreciated in French hospitals. Accordingly, in the course of one of these meetings we tried to deal with the problem of dying patients with the help of a psychologist and a physiotherapist who were particularly sensitive to it. I was in fact convinced that we could only change things together and only after talking about them. But we were still denying the existence of one problem: for care deliverers patients were never actually dying. They were only very, very tired! It was barely possible to talk about death. Our defenses were too strong. We were still living with the modern taboo about death which various French historians and sociologists had exposed very well. What were we to do? I was lucky enough to have the psychoanalyst, Hugues Liborel for a friend, and I spoke to him periodically about this new professional reality which I had been discovering for several months. Was he the one who had suggested it; or was I? He was to come once a month to help me, and the care deliverers who wanted to, to think about our situation.

This was the spring of 1979. The beginnings were difficult. Very quickly the group found itself rejected by the unit. What was a psychoanalyst doing in a chronic care unit? Someone who didn't see patients, and who kept his hands clean! So for one year we met once a month in Hugues Liborel's own home. There he received a small group of six or seven motivated people, determined to go into these issues in depth. In the reassuring warmth of the group, we dealt with our identity as a team confronted with our patients' death, and with our own anxiety about death. We would even imagine our own needs and expectations in the same situation. This self analysis was to allow us to truly begin to look at and to listen to our dying patients and to try to meet their needs. For us, it was an indispensable and fundamental stage. In fact, if anxiety which inherently has the characteristics of indecision and absence of any real object is not recognized and expressed by staff first, it can easily take the patient himself for its object, and thus prevent or at least interfere greatly with any relationship with the patient (1987). Later on we were to meet in the unit once a month. The group was always to remain limited in number and multidisciplinary, comprising six to ten people who were motivated by different technical specializations and levels of hierarchy, doctors, nurses, supervisors, physiotherapists and social workers, and the like. From one session to the next and from one month to the next, we spoke together about our dying patients and our problems. Every process of dying is different, and every dying person teaches us something new. One noteworthy fact: the majority of care deliverers in the unit didn't participate in these meetings with the psychoanalyst. Nonetheless new styles of behaviour spread throughout the institution at a disconcerting speed. This we will come back to. Some years later, in 1985, we were able to conceptualize our objectives. Our aims were simple:

1. To avoid moving or isolating the terminal patient, in order to spare him the trauma which— at the very moment when physical comfort and serenity are primordial—a change in material and relational surroundings always entails.

2. To treat physical suffering every time it occurs, using analgesics, notably morphine administered every 4 hours, just as we learned from the head pharmacist in our hospital—who knew St. Christopher's potion—and as we learned later from Dr Therese Vanier whom we went to see in London, and also from Doctor Michele Salamagne who did much to spread these techniques in France, and who translated Saunders and Baines' book, "Living with Dying: The Management of Terminal Disease" (1983) into French.