

ISSN 1743-9493

Published by

British Holistic Medical Association
West Barn, Chewton Keynsham
BRISTOL BS31 2SR
Email: contactbhma@aol.co.uk
www.bhma.org

Reg. Charity No. 289459

Editor-in-chief

David Peters
petersd@westminster.ac.uk

Editorial Board

Jan Alcoe, Richard James,
William House

Editor

Edwina Rowling
edwina.rowling@gmail.com

Advertising Rates

1/4 page £130; 1/2 page £210;
full page £400; loose inserts £140.
Rates are exclusive of origination
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Design

karenjigsawdesign@gmail.com

Printing

Spinnaker Press

Cover illustration

From: *Medicine for Beginners* by
Richard Clark and Tony Pinchuck.
London: Writers & Readers, 1984

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Editorial



David Peters
Editor

The NHS – who cares?

Do we care if the NHS is being dismantled? We'll cope won't we? Maybe we will, but you don't have to be an altruist or a socialist (remember them?) to have a vested interest in its future. Most of us were brought up with the NHS, born into it and will die with it around us. Former Chancellor Nigel Lawson said it was 'the nearest thing the English have to a religion'; sarcasm perhaps, but it also rings true: the NHS is rooted in values of social solidarity, public benevolence, of being part of a humanitarian whole, of not putting profit before people. But if for some it is a sacred relic – the saintly bones of less selfish times – for others it is a relic of a bygone age with no place in our neo-liberal world.

If the NHS is to survive our stormy times it will have to set a course between these two extremes. But babies have been thrown out with the bathwater before, and on 1 April 2013, the founding principles of Bevan's NHS were laid to rest. Then, for the first time in 65 years, the Secretary of State became no longer bound by law to provide a comprehensive health service. Soon after, and denationalised in all but name, a last-ditch effort in the Lords to block competitive tendering hit the buffers (see William House's column in this issue). At a stroke, the most lucrative parts of the NHS became low-hanging fruit for transnational investors to pluck.

Do we care if for better or worse the NHS has had the rug pulled from under it, or that the social glue it once provided is now looking distinctly watery? Perhaps in the long run, a small-is-beautiful, locally organised, more patient-centred, engaged and compassionate healthcare system will emerge, heralding a golden age of sustainable biopsychosocial holistic healthcare. Time will tell, but we had best not hold our breath while NHS services endure the long haul of upheaval; and without the steadying albeit costly and bureaucratic hands of strategic health authorities and primary care trusts at the helm. So let's hope that while they are shaping coherent new services, all those new kids on the block – clinical commissioning groups, wellbeing boards and local authority public health directors – can pull together and hold the NHS off the rocks.

Do we care about their unenviable task? Instead of the expected annual growth, the NHS is expected to 'save' (read 'cut') £20 billion a year even though demand for healthcare continues to soar. Providing good care in organisations already reeling from serial austerity squeezes was challenge enough without their having the NHS tectonic plates buckling beneath them. And, in the midst of all this uncertainty (if not frank chaos), more and more healthcare will soon be shifting from costly hospitals and into the community. When this happens (just to take one

of many instances) and hospitals downsize or close, who will care for the tens of thousand of hard-to-discharge frail elderly patients with complex multiple needs and/or dementia, who now occupy so many acute hospital beds? Though community-based solutions to these and other predicaments might eventually become more human-scale and less costly, right now the fabled Big Society, hamstrung by plummeting grants, is still too thinly spread to fill the gap. The puzzle is, how do we get where we need to be from where we are right now? Not simply how to create the compassionate NHS so beloved of Whitehall directives, but how to enable whole new compassionate communities?

Do we care enough to meet these challenges? Perhaps we are only lately waking up from dreamlike denial. Maybe we feel overwhelmed by what is taking place right under our noses, or too anxious to imagine what it would be like to live with a US-style healthcare system (which costs them twice as much of their GDP as ours does) where illness can bankrupt families, over-treatment sometimes rules, and poverty shuts you out. Are we also desperately uncertain how to start engaging effectively as citizens with the national healthcare system we co-own and bear joint responsibility for?

The NHS is still truly remarkable and it can thrive again because compassion, holism and social justice are close to its heart. And most of us could take one small step toward creating better health for ourselves – and maybe for others too. The struggling charities pushing for better education, housing, elder care and food policies will be far more effective long term than any medical advance. They need our help, as do others that support mental wellbeing, or protect and redeem our damaged environment. In the NHS itself, cost-effective moves should be made to support the mental health of high-intensity users; to enable better self-care through information initiatives backed up by a new band of 'health facilitators'; to promote resilience and emotional intelligence in schools, at work and particularly among NHS staff; to mobilise retired elders who could be a precious community resource, while also developing compassionate elder care in every locality; to nurture all 'informal' carers, value the work of nurses, and raise the expectations and training of care assistants. Above all, NHS management will have to drop the belief that targets and bottom lines motivate their staff. Most people who work in the NHS made their choice because they want to care. Choking them with paperwork and bullying them to try harder and to be compassionate won't work and it misses the point: if we want a caring NHS, the culture change will have to start at the top, through leadership that lives the values of solidarity, service and healing on which the NHS was founded.

Working to create health

The College of Medicine is a new membership organisation which works to re-form the NHS into a system more fit for purpose in the 21st century. As lifespans increase, but people live for years with a variety of chronic and often avoidable diseases, it argues for the vital importance of a society which creates health, and in which illness can be managed by interventions beyond the surgery walls.

Typical chronic illness statistics include:

- in 2013, diabetes management cost 10% of the NHS budget – on current projections it will increase to 17% by 2035
- one in four or five people develop a mental illness at some point in their lives
- there are 800,000 people with dementia in the UK, likely to rise to 1 million by 2021.

These are the drivers for the growing unaffordability of the NHS. The College of Medicine, formed in 2010, argues that free healthcare in the UK is heading for breaking point unless we can find better ways of managing long-term illness, and reframing society to create health. The College, with a membership approaching 1,000 doctors, nurses, scientists, allied health professionals and patients, brings together a kaleidoscope of perspectives on how to tackle the problem.

Its underlying principle is that it's necessary to see health as a national asset to be actively nurtured. Open to any approach with an evidence base, the College does not focus on championing any single modality, but has a jigsaw puzzle approach, which allows a broader range of tools to be used, and where medicine does not stop at the surgery door.

New science

Part of that jigsaw includes using new scientific discoveries more quickly on the NHS. There is, on average, a 10-year lag between well evidenced therapies being published in journals, and their adoption in the health service. The College of Medicine's First Thursday lectures bring its members and wider public face to face with some of the scientists producing groundbreaking research, showcasing health futures which, with proper support, could be just around the corner.

In the past year the lecturers have included Professor Kieran Clarke talking about how research into ketones and insulin resistance may have an impact in treating Alzheimer's and heart disease. Professor Mark Emberton and Dr Hashim Ahmed described their work on less invasive treatment for prostate cancer using ultrasound. At the 2012 annual conference Nobel prizewinner Professor Elizabeth Blackburn talked about her work with telomeres and the ageing process itself.

The community as medicine

Equally often though, primary care providers may be constrained not by awaiting that high-tech breakthrough, but a sense that they have only narrowly medical solutions to hand for illnesses rooted in life circumstances. Dr James Fleming is a GP in Padiham, Lancashire, and one of 50 members of the College of Medicine's showcase Innovations Network. He says: 'I found I was being asked to give anti-depressants in situations where it was obvious that they weren't going to make anything any better. For some groups of patients, the problem was that they were long-term unemployed, or couldn't read, or their housing was making them sick, or they were in debt or dealing with some other crushing social situation which they were unable to escape from.'

His solution was the Green Dreams Project (see page 34) – an approach mixing counselling and multi-agency support, alongside gardening and social projects, which has helped many get back into work, or simply combat loneliness and find a purpose in their community. Tracked by the University of Lancashire, the evidence shows that the work has been more cost-effective than traditional approaches to depression and related chronic illnesses.

Other projects in the innovators network include 'sick neighbourhoods' that have seen measurable health improvement after tackling anti-social behaviour; keep fit projects involving and run by hundreds of thousands of older people; and hospital which has rejected low nutrient processed food in favour of fresh local produce.

A rebalancing of power

A theme behind these projects is to reserve hospital beds and secondary care for the illnesses that really need it, while rolling back more routine health management into communities. For this to work, the doctor/patient power balance has to be reframed, with patients more informed and more responsible for their health. The College of Medicine reflects this aspiration in its organisational structure: healthcare providers and the public belong to the College on an equal footing, and its Patient Council plays a pivotal role with patient representation in all decision-making bodies and specialist faculties.

Inspiring young healthcare professionals to break out of old tribal allegiances

One of the largest and fastest growing areas of the College is its student network. Uniquely its events and summer schools are all cross-disciplinary, bringing together doctors with podiatrists, fledgling herbalists with physiotherapists, to consider big topics like healthy ageing and self-care, to create a broad-ranging collective knowledge. Furthermore, these events allow students to learn directly from patients and their carers while working in multidisciplinary teams. The College hopes this model will be reflected as the students graduate into their professional careers.

Among the great challenges these young professionals face is compassion fatigue. Research shows that young nurses placed in a London hospital environment generally saw their high ideals deflated or crushed after only two years (Maben *et al* 2007). The College argues that the right combination of organisational support and resilience training can prevent burnout from being inevitable. By marrying the latest findings of neuroscience with simple mindfulness techniques, students can learn to retain their compassion and flourish in a supported environment.

Annual conference

The College's annual conference on 11 June at the Royal College of Obstetrics and Gynaecology, is the place where all these ideas, people and aspirations come together. The head of Diabetes UK will be talking about the best approaches to the spiralling cost of the illness, rubbing shoulders with government minister Norman Lamb MP, and scientists and patients showcasing ideas from HeartMath to telemedicine.

Many of the ideas needed to transform the NHS are already in circulation. The College hopes to focus attention on the body of evidence that underpins them and the infrastructure that will make such ideas sustainable, and also bring the political clout to allow the best ideas to flourish.

Maben J, Lattar S, Macleod Clark J (2007) The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. *Nursing Inquiry* 14 (2) 99–113.

We need a new vision to meet the new challenges of our times

David Reilly

Director, *Healing Shift Enquiry*; Consultant Physician, NHS Centre for Integrated Care, Glasgow

We face epidemic levels of chronic disease, which might be helped but won't be healed by drugs. As healthcare workers and patients, obesity, diabetes, depression and many disorders of late modernity have become our daily challenge. Yet modernity's science and technology are ill-suited to finding solutions (Hanlon and Carlisle 2012). We need a new vision.

We have searched for such shifts before in very different times. The challenges and solutions were different when the cholera epidemic in 1832 killed 3,000 in Glasgow. It took our predecessors more than 25 years, and a struggle against much opposition, to implement a change in seeing the way forward. But then Loch Katrine's clean water started to flow to the city in 1859, and when a new cholera epidemic swept Britain in 1866, Glasgow saw only 53 deaths compared with more than 4,000 in its 1848–49 epidemic.

So what would be today's equivalent shift in vision? What would transform, not merely manage, our long-term conditions epidemics? Many now consider the needed shift will be human rather than technical, relational rather than instrumental. And when it comes this shift will have to scale up from the foundational layers of self-care, via healthcare encounters and partnerships, up to whole systems, and beyond into policy and the culture itself. This vision is one we have been studying for many years in the Glasgow-based projects that constitute *The Healing Shift Enquiry* (Reilly 2001). The project (some of which is described in this issue of JHH) is charting the rich potential for the sorts of step changes and transformations in our work which begin when we supplement external interventions with a focus on enhancing the innate capacity of individuals and communities for creative change and self-healing. Such shifts – catalysed by human and relational process – would, in the long-term, mean less need for drug-based interventions.

Many of us drew lessons from CAM approaches and their more holistic perspectives. And indeed the Glasgow

enquiry in the NHS Centre for Integrative Care was seeded by earlier work in the homeopathic hospital. But we also came to see that trying to confront these epidemics with therapy-based approaches, orthodox or otherwise, would prove futile. Here then is common ground that could be explored together by those caught in an orthodox–CAM divide. Yet if creative change is to be forged in the crucible of shared human process, let's admit it – we start from a damaged place. Try this: if you have the chance to speak to an audience, ask people whether they think the human side of care is under unacceptable pressure in today's NHS. Almost every hand will go up in agreement.

What would transform, not merely manage, our long-term conditions epidemics?

The NHS system's design and core focus are far from making the fundamental shift needed to meet the current challenge. The result is a widespread inefficient, mechanised over-activity that places resources and staff under unacceptable strain as they struggle to keep the lights on. Yet ever more voices are now contributing to a growing conversation about NHS values and sustainability, and this growing concern is reflected in the ambitions underpinning Scotland's NHS Quality Strategy: for it to be safe, effective and person-centred, backed up by relationship and compassion. It would be naively optimistic to imagine that science alone will be enough to transform complex systems – people, organisations and health cultures. Therefore we must set our sights higher: more of the same thinking and doing will not help us. We need new vision to meet the huge new challenges of our times.

Hanlon P and Carlisle S (2012). *Afternoon: What next for a healthy Scotland?* Argyll: Argyll Publishing.

Reilly D (2001). Enhancing Human Healing. *BMJ* 322 (7279) pp 120–1.

Transatlantic review of the NHS at 60

Donald Berwick

President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, Cambridge, Massachusetts

President Obama appointed Donald Berwick as Administrator of the Centers for Medicare and Medicaid Services (CMS) in 2010. Small wonder then if many see him – for better or worse – as Obamacare’s number one champion; not least because CMS is the federal agency responsible for administering enormous US public sector health care programmes, including Medicare and Medicaid, crucial to the healthcare of many millions of poor and/or retired Americans. Sadly, 18 months later with Republican politicians blocking

his appointment, he resigned, but this year declared his interest in running for Massachusetts governorship; taking the political initiative back perhaps. Because, among the many Republicans who loathe and deride the NHS and all it represents, Dr Berwick’s strident views on evidence, costs, safety, wastage and invisible vested interests have made him a controversial figure (Berwick 2004); and for free-marketeters (not only in the USA) his statements about state-funded healthcare and redistributing resources from the rich to the

poor are anathema. Yet, as Dr Berwick puts it, ‘excellent healthcare is by definition redistributive’. JHH agrees. As former CEO of the Institute for Healthcare Improvement he knows the NHS well, and so it seemed appropriate in the BHMA’s 30th year, and with the NHS pushing 65, to see the National Health Service through Dr Berwick’s eyes, and remind ourselves what we too should be fighting to preserve. This speech was given to the conference celebrating 60 years of the NHS.

Let me begin with thanks for what the NHS does as an example for healthcare worldwide. I am romantic about the NHS; I love it. All I need to do to rediscover the romance is to look at health care in my own country.

A towering bridge

The National Health Service is one of the truly astounding human endeavours of modern times. Just look at what you are trying to be: comprehensive, equitable, available to all, free at the point of care, and – more and more – aiming for excellence by world class standards. And, because you have chosen to use a nation as the scale and taxation as the funding, the NHS isn’t just technical – it’s political. It is an arena where the tectonic plates of a society meet: technology, professionalism, macroeconomics, social diversity, and political ambition. It is a stage on which the polarising

debates of modern social theory play out: between market theorists and social planning, between enlightenment science and post-modern sceptics of science, between utilitarianism and individualism, between the premise that we are all responsible for each other and the premise that we are each responsible for ourselves, between those for whom government is a source of hope and those for whom government is hopeless. But, even in these debates, you have agreed hold in trust a commons. You are unified, movingly and most nobly, by your nation’s promise to make good on an idea: the idea that health care is a human right. The NHS is a bridge – a towering bridge – between the rhetoric of justice and the fact of justice.

No one in their right mind would expect *that* to be easy. No one should wonder that, as the NHS celebrates its 60th birthday this week – an age at which humans recognise maturity, it

seems still immature, adolescent, still searching.

You could have chosen an easier route. My nation did. It’s easier in the United States because we do not promise health care as human right. Most of my countrymen think that’s unrealistic. In America, they ask, ‘Who would assure such a right?’ Here, you answer, ‘We do, through our government’. In America, people ask, ‘How can health care be a human right? We can’t afford it’. We spend 17% of our Gross Domestic Product on health care – compared with your 9%. And, yet we have almost 50 million Americans, one in seven, who do not have health insurance. Here, you make it harder for yourselves, because you don’t make that excuse. You cap your health care budget, and you make the political and economic choices you need to make to keep affordability within reach. And, you leave no one out.

Fragments

In the United States, our care is in fragments. Providers of care, whether for-profit or not-for-profit, are entrepreneurs. Each seeks to increase his share of the pie, at the expense of others. And so we don't have a rational structure of inter-related components; we have a collection of pieces – a caravan site. These disconnected, self-referential pieces cost us dearly. The entrepreneurial fragments create what the great health services researchers, Elliott Fisher and Jack Wennberg, call 'supply-driven care'. In America, the best predictor of cost is supply – the more we make, the more we use – hospital beds, consultancy services, procedures, diagnostic tests. Fisher and Wennberg find absolutely no relationship – none – between the supply and use, on the one hand, and the quality and outcomes of care, on the other hand. The least expensive fifth of hospital service areas in the US have *better* care and better outcomes than the most expensive fifth. Here, you choose a harder path. You plan the supply; you aim a bit low; historically, you prefer slightly too little of a technology or service to much too much; and then you search for care bottlenecks, and try to relieve them.

In the US, we favour specialty services and hospitals over primary care and community-based services. Americans are not guaranteed a medical home, as you are, and we face a serious shortage of primary care physicians. Hospitals, on the other hand, are abundant, with many communities vastly over-bedded – an invitation to supply-driven care. Co-ordinated care – care that keeps people from having to use hospitals – is rare; so are adequate home health care, hospice services, school-based clinics. Community social services and our mental health services are undefended, isolated, and insufficient. Public health and prevention are but stepchildren. Here, in the NHS, you have historically put primary care – general practice – where it belongs: at the forefront.

In the US, we can hold no one accountable for our problems. Accountability is as fragmented as care, itself; each, separate piece tries to craft excellence, but only within its own walls. Meanwhile, patients and carers wander among the fragments. No one manages their journey, and they are too often lost, forgotten, bewildered. Here, in England, accountability for the NHS is ultimately clear. Ultimately, the buck stops in the voting booth. You place the politicians between the public served and the people serving them. That is why Tony Blair commissioned new investment and modernisation in the NHS when he took office, it is why government has repeatedly modified policies in a search for traction, and it is why your new government chartered the report by Lord Darzi. Government action on the NHS is not mere restlessness or recreation; it is accountability at work through the maddening, majestic machinery of politics.

In the United States, we fund health care through hundreds of insurance companies. Any American doctor or hospital interacts with a zoo of payment streams. Administrative costs for this zoo approach 20% of our total health care bill, at least three times as much as in England.

In the United States, those hundreds of insurance companies have a strong interest in not selling health insurance to people who are likely to need health care. Our insurance companies try to predict who will need care, and to find ways to exclude them from coverage through underwriting and selective marketing. That increases their profits. Here, you know that that isn't just crazy; it is immoral.

Equitable, civilised and humane

So, you could have had a simpler, less ambitious plan than the NHS. You could have had the American plan. You could have been spending 17% of your GDP and made health care unaffordable as a human right instead of spending 9% and guaranteeing it as a human right. You could have kept your system in fragments and encouraged supply-driven demand, instead of making tough choices and planning your supply. You could have made hospitals and specialists, not general practice, your mainstay. You could have obscured – obliterated – accountability, or left it to the invisible hand of the market, instead of holding your politicians ultimately accountable for getting the NHS sorted. You could have let an unaccountable system play out in the darkness of private enterprise instead of accepting that a politically accountable system must act in the harsh and, admittedly, sometimes unfair, daylight of the press, public debate, and political campaigning. You could have a monstrous insurance industry of claims, rules, and paper pushing, instead of using your tax base to provide a single route of finance. You could have protected the wealthy and the well, instead of recognising that sick people tend to be poorer and that poor people tend to be sicker, and that any health care funding plan that is just, equitable, civilised, and humane must – *must* – redistribute wealth from the richer among us to the poorer and less fortunate.

Britain, you chose well. As troubled as you may believe the NHS to be, as uncertain its future, as controversial its plans, as negative its press, as contentious its politics, as beleaguered as it sometimes feels, please lift your eyes and behold the mess – the far bigger, costlier, unfair mess – that a less ambitious nation could have chosen.

Is the NHS perfect? Far, far from it. I know that as well as anyone in this room. From front line to Whitehall, I have had the privilege to observe its performance and even to help to measure it. The large scale facts are most recently summarised in the magisterial report by Sheila Leatherman and Kim Sutherland sponsored by The Nuffield Trust, *The Quest for Quality: Refining the NHS Reforms*. They find some good news. For example, after 10 years of reinvestment and redesign, the NHS has more evidence-based care, lower mortality rates for major disease groups (especially cardiovascular diseases), lower waiting times for hospital, outpatient, and cancer care, more staff and technologies available, in some places better community-based mental health care, and falling rates of hospital infection. An important, large scale patient safety campaign has begun in England, as well as

among your cousins in Wales, Scotland, and Northern Ireland. There is less progress in some areas, especially by comparison with other European systems, such as in specialty access, cancer outcomes, patient-centredness, life expectancy and infant mortality for socially deprived populations. In other words, in improving its quality, two facts are true: the NHS is en route, and the NHS has a lot more work ahead.

How can you do even better? I have 10 suggestions:

- 1 **Put the patient at the centre – at the absolute centre of your system of care.** Put the patient at the centre for *everything* that you do. In its most helpful and authentic form, this rule is bold; it is subversive. It feels very risky to both professionals and managers, especially at first. It is not focus groups or surveys or token representation. It is the active presence of patients, families, and communities in the design, management, assessment, and improvement of care, itself. It means customising care literally to the level of the individual. It means asking, “How would you like this done?” It means equipping every patient for self-care as much as each wants. It means total transparency – broad daylight. It means that patients have their own medical records, and that restricted visiting hours are eliminated. It means, ‘Nothing about me without me’. It means that we who offer health care stop acting like hosts to patients and families, and start acting like guests in their lives. For professionals made anxious by this extreme image, let me simply remind you how you probably begin every encounter when you are following your best instincts; you ask, ‘How can I help you?’ and then you fall silent and you listen.
- 2 **Stop restructuring.** In good faith and with sound logic, the leaders of the NHS and government have sorted and resorted local, regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn’t make sense. It drains energy and confidence from the workforce and middle managers, who learn not to take risks, but rather to hold their breaths and wait for the next change. It is, I think, time to stop. No structure in a complex management system is ever perfect. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster, as the good, smart, committed people of the NHS – the one million wonderful people who can carry you into the future – find the confidence to try improvements without fearing the next earthquake.
- 3 **Strengthen the local health care systems – community care systems – as a whole.** What you call ‘health economies’ should become the core of design: the core of leadership, management, inter-professional co-ordination, and goals for the NHS. This should be the natural unit of action for the service, but it is as yet unrealised. The alternative, like in the US, is to have elements – hospitals, clinics, surgeries, and so on – but not a system of care. Our patients need integrated journeys; and they need us to tend and defend those journeys. I believe that the NHS has gone too far in the past decade toward optimising hospital care – a fragment – and has not yet optimised the processes of care for communities. You can do that. It is, I think, your destiny.
- 4 **To help do that, reinvest in general practice and primary care.** These, not hospital care, are the soul of a proper, community-oriented, health-preserving care system. General practice, not the hospital, is the jewel in the crown of the NHS. It always has been. Save it. Build it.
- 5 **Please don’t put your faith in market forces.** It’s a popular idea: that Adam Smith’s invisible hand would do a better job of designing care than leaders with plans can. I do not agree. I find little evidence anywhere that market forces, bluntly used, that is, consumer choice among an array of products with competitors’ fighting it out, leads to the health care system you want and need. In the US, competition has become toxic; it is a major reason for our duplicative, supply-driven, fragmented care system. Trust transparency; trust the wisdom of the informed public; but, do not trust market forces to give you the system you need. I favour total transparency, strong managerial skills, and accountability for improvement. I favour expanding choices. But, I cannot believe that the individual health care consumer can enforce through choice the proper configurations of a system as massive and complex as health care. That is for leaders to do.
- 6 **Avoid supply-driven care like the plague.** Unfettered growth and pursuit of institutional self-interest has been the engine of low value for the US health care system. It has made it unaffordable, and hasn’t helped patients at all.
- 7 **Develop an integrated approach to the assessment, assurance, and improvement of quality.** This is a major recommendation of Leatherman and Sutherland’s report, and I totally concur. England now has many governmental and quasi-governmental organisations concerned with assessing, assuring, and improving the performance of the NHS. But they do not work well with each other. The nation lacks a consistent, agreed map of roles and responsibilities that amount, in aggregate, to a coherent system of aim-setting, oversight, and assistance. Leatherman and Sutherland call this an ‘NHS National Quality Programme’, and it is one violation of my proposed rule against restructuring that I have no trouble endorsing.
- 8 **Heal the divide among the professions, the managers, and the government.** Since at least the mid-1980s, a rift developed that has not yet healed between the professions of medicine formally organised and the reform projects of government and the executive. I assume there is plenty of blame to go around, and that the rift grew despite the best efforts

of many leaders on both sides. But, the toll has been heavy: resistance, divided leadership, demoralisation, confusion, frustration, excess economic costs, and occasional technical mistakes in the design of care. The NHS and the people it serves can ill afford another decade of misunderstanding and suspicion between the professions, on the one hand, and the managers and public servants, on the other hand. It is the duty of both to set it aside.

- 9 Train your healthcare workforce for the future, not the past.** That workforce needs to master a whole new set of skills relevant to the leadership of and citizenship in the improvement of health care as a system – patient safety, continual improvement, teamwork, measurement, and patient-centred care, to name a few. Scotland announced last week that all its health professionals in training will master safety and quality improvement as part of their qualification. Far be it for me to suggest copying Scotland, but there you have it. I am pleased that Lord Darzi's Next Stage report suggests such standards for the preparation of health care professionals in England.
- 10 Aim for health.** I suppose your forebears could have called it the NHCS, the 'National Health Care Service', but they didn't. They called it the National *Health* Service. Maybe they meant it. Maybe they meant to create an enterprise whose product – whose purpose – was not care, but health. Maybe they knew then, as

we surely know now, even before Sir Douglas Black and Sir Derek Wanless and Sir Michael Marmot, that great health care, technically delimited, cannot alone produce great health. Developed nations that forget that suffer the embarrassment of growing investments in health care with declining indices of health. The charismatic epidemics of SARS, mad cow, and influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance abuse, and physical inactivity. Would it not be thrilling in the next decade for the NHS – the National *Health* Service – to live fully up to its middle name?

Those are my observations from far away – from an American fan, distant and starry-eyed about the glimpses I have had of your remarkable social project. The only sentiment that exceeds my admiration for the NHS is my hope for the NHS. I hope that you will never, never give up on what you have begun. I hope that you realise and reaffirm how badly you need, how badly the world needs, an example at scale of a health system that is universal, accessible, excellent, and free at the point of care – a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just.

Berwick DM (2004). *Escape fire. Designs for the future of health care.* San Francisco: Jossey-Bass.

This is an edited version of the speech given at NHS Live, Wembley, July 2005.



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The Healing Shift Enquiry – creating a shift in healthcare

David Reilly

Director, Healing Shift Enquiry
and WEL Programmes

I almost left medicine as a fourth-year student. Science was ascendant in a system I found de-humanising, even brutal. In staying, I resolved to change it, at least within myself. Rather than diseases and interventions, my work became centred on people, their capacity for healing change, and the conditions that affected this – within themselves and the surrounding relationships, environments and systems. Such talk was out of step with that medical era, but not with patients, then or now – and I now find myself immersed in as rich an enquiry into human healing as I dared to imagine as that foolish younger man.

Summary

The Healing Shift Enquiry addresses the impasse of today's healthcare model in the face of the long-term conditions epidemic. Its aim is to study the enhancement of individual healing change, and ask how this can be enabled, taught, and scaled up to promote wider levels of change. It asks what services would look like if they held inner capacity, and its enablement, to be central.

Introduction

Over many years of working with people with chronic complex problems that could not be 'fixed', I began to study our human potential for activating our inherent healing response, and saw how sometimes one-to-one healthcare consultations can trigger a 'healing shift'. These consultations aimed to be therapeutic in their own right; to lead not to a prescription or some other external intervention, but instead to catalyse a transformation journey in the patient's wellbeing and health. The central questions explored in my mind were: what is healing and how can it be enabled; how best to research the ways that people might better learn to enhance their own wellbeing, and how can practitioners learn to support people with this process? So behind the project stands a 25-year enquiry into creating better care by using a healing-centred and integrative approach to change, recovery and wellbeing.

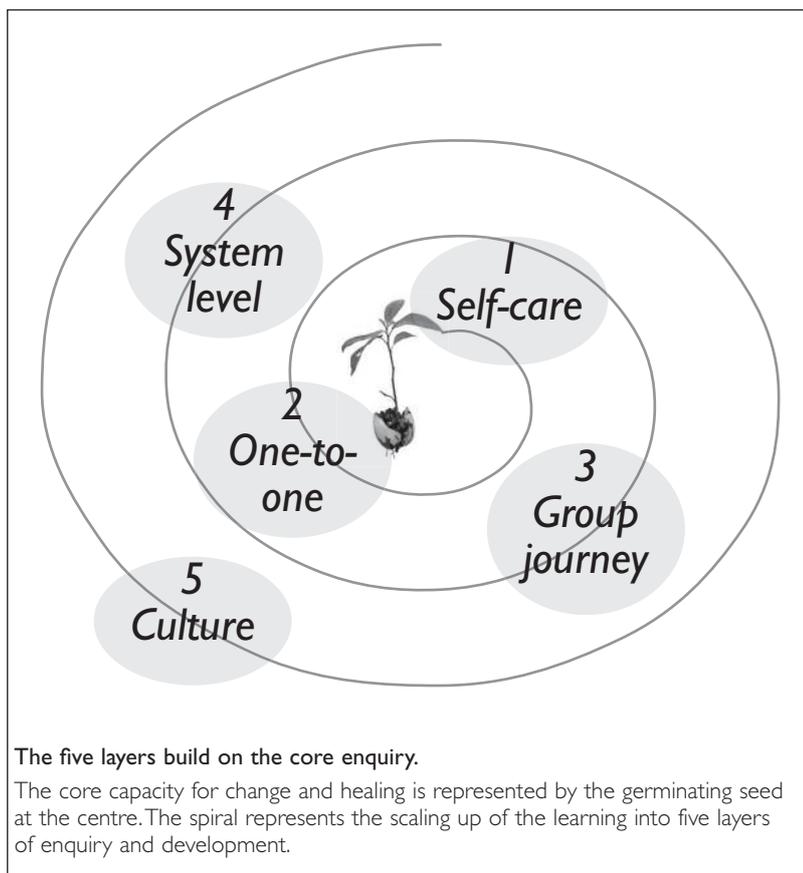
To date the work has focused on enhancing both therapeutic encounters and linked practitioner training programmes. We have explored scaling up this knowledge to new

models of clinical care including group-based work for patients and staff, and carefully tracked patient recorded outcomes. In addition we have looked into healthcare environment design, and new ways of looking at health and care. Overall, our outcomes suggest that patients and staff have benefitted.

The evaluation up to 2012 suggests that in rooting service design and wellness courses in the study of healing change processes we are on solid ground. Already good evidence is emerging that this approach yields helpful results for patients and staff, and can create more satisfying, successful and efficient ways of working. So while there is important potential here, to scale up would call for systemic shifts in our thinking about health and healthcare; cultural shifts that could unblock the current failure in preventing long-term conditions; and promoting the wellbeing of those who live with them.

The core enquiry and the five layers

The project centres on a core enquiry into people's own capacity for healing change, and how it might be



enhanced, sometimes in the form of recovery, but always in terms of better wellbeing. The enquiry explores too how this understanding can be scaled up to inform not only self-care but also the one-to-one healing encounter, and to consider them both from the patient *and* the practitioner's viewpoint. On the basis of this healing triad, The Healing Shift Enquiry explores scaling the model up to groups of people then to the wider system and policy, and finally its potential to help inform cultural change and the environment.

Point zero – the core enquiry

The core enquiry takes the phenomenon of healing change as the start and reference point for in-depth learning and development.

The focus is on studying the healing response in life and therefore people, and on understanding the individual's capacity for healing change and process. The work studies therapeutic encounters and their results, and asks what this process is, and how it can be enhanced across the spectrum of healthcare in conditions that can be cured and those which cannot.

Layer 1: Self-care

The self-care journey which is the key to sustained self-healing capacity is determined by the self-relationship. One hypothesis is that self-compassion may be of vital importance in growing the self-relationship so that it supports sustained improvement in self-care. If so, then

how might healthcare work catalyse and support self-care?

Layer 2: One-to-one meetings: therapeutic encounter

A small case series (Bikker and Reilly in press) had suggested that all participants felt stuck in their situation of being ill, due to distress or fear and their dependency on medicine. It seemed that *a transformation only took place when participants felt relaxed, found hope, could understand their situation, and saw new possibilities*. Once these changes had taken a strong hold however, people developed a sense of responsibility, learnt to cope, felt more confident and could rely on their own strengths to reduce their dependency on medicine. The therapeutic encounter has two key fields of study in the project: the individual's healing journey, and the practitioner's journey.

The patient-facing aspect of this part of the enquiry asks how a person's healing responses and self-care can be affected by one-to-one healing encounters, relationships and their own therapeutic journey. It also explores how this can be improved and measured. Support for the person's 'inner

journey' complements the current dialogue on improving the outer journey through the care system, for example through initiatives such as the NHS Scotland Quality Strategy.

The practitioner-facing aspect of this part of the enquiry asks how practitioners can be supported in learning to place greater emphasis on relationship and enhancing healing change. The project is developing and evaluating models of practitioner development and educational work. Our therapeutic encounter training synthesises and applies findings from the other layers and it also recognises that practitioner stress and the constraints of time and system design are limiting practitioners' inner development and outward improvement in practice.

Layer 3: The group journey

This part of the project asks how the core principles of human healing, self-care and therapeutic encounter can be scaled up into group work. The Wellness Enhancement Learning Project (WEL) arose out a study using the programme in a group of people diagnosed with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME). We are now implementing the approach more widely through the GeneralWEL, PrimaryWEL and StaffWEL programmes.

Layer 4: The system's journey

The project's earlier national GP survey highlighted that holism is under strain (Hasegawa *et al* 2005). So this part of the project aims to explore the scaling up of the

programme's healing principles to the level of professional practice and system design. The work to date has already made many contributions to a wide range of dialogues, conferences, and national policy development in linked areas, and it is expected that this will grow.

Layer 5: The cultural journey

The links between the concepts underpinning the Healing Shift Enquiry and new approaches in public health were first explored in the earlier 'Fifth Wave' report from the Public Health Institute of Scotland (Lyon 2003) and now in a sister enquiry on cultural influences on wellbeing (see www.afternow.co.uk).

Self-care

The practical focus is on finding better ways to support and enable a healing response; what people can do for themselves to feel better, get well and stay that way, and what helps people cope and thrive, especially in the face of long-term conditions. This orientation towards unlocking positive potential is different from, but complementary to, disease-focused care.

Therapeutic encounter training

These workshops have been run in a number of UK sites over the last decade, mainly in Scotland, and overseas principally in the USA, Japan and Canada. They aim to support professionals of any discipline, in their efforts to improve, even transform, the quality and effectiveness of their encounters and relationships with their patients or clients.

Currently they entail a standalone one-day course, with the option of a second part. New knowledge and examples of successful practice are used to help participants explore how to make the meeting therapeutic in its own right. This involves supporting what might be called 'the practitioner's shift' – moving their core purpose towards wellness-enhancing partnerships with the patient. The course takes the practitioner through an experience of addressing their own self-care and change process, and then in the second course asking how that learning can be blended with their clinical practice. Consideration is being given to subsequent support and the building of a community of practice.

Scaling-up – the Foundations of Wellness groups

The Wellness Enhancement Learning (WEL) model began with a question: Could the learning born of the study from creating enabling therapeutic encounter be scaled into a group situation? The model supports inner capacity for resilience, recovery and healing. It calls for people to be open to change and to the change journey. Participants are encouraged to reflect on their journey so far, to consider the conditions and life that may have led up to

their illness and to begin their healing journey through self-compassion, improved self-care and stress reduction. This shift is supported with cognitive skills, mindfulness, meditation and through learning about practical everyday ways of living and eating.

Specific skills introduced in the foundational part of the course include the meditative practice called 'heart-math'. This is an evidence-based biofeedback technique aimed at promoting a calm state of mind and body which can be achieved by coupling and synchronising the rhythm of breathing to the rhythm of the heart. This state of 'coherence' is known to be associated with a general sense of wellness and to have a number of health benefits.

The WEL has now grown from the early CFS/ME version into the main General WEL version for people with any long-term condition. Each WEL study cohort has about 20 men and women over the age of 18. In Nairn's first PrimaryWEL intake most of the 20 participants typically had three to five long-term conditions: nine had chronic pain, seventeen had chronic depression/anxiety, nine had CFS/ME and three had diabetes.

The course is delivered by senior clinicians with substantial experience in working in a WEL-type way, in both one-on-one practice and groups. It aims to model 'patient-centred' care and to seed ideas and practices that foster intentions towards self-care, self-compassion and ultimately, healing change. The therapeutic environment is consciously designed to be an alive and welcoming space where participants can feel safe to express themselves in their own ways.

The participant introductory leaflet explains that: 'Many of us face real challenges with our health or wellbeing. If you then add a long-term condition or stress you end up with a loss of peace, facing symptoms, loss of function and quality of life, and maybe problems like feelings of hopelessness, isolation or loss of self-esteem. The WEL is a holistic programme that aims to help you:

- develop a deeper understanding of your challenges and so achieve better self management
- develop skills in creating the best conditions for strengthening your self-healing
- increase your wellness and strengthen your ongoing commitment to self-care.

All participants attend the core WEL programme for 16 hours over four half-days at around weekly intervals, backed up with the home resource pack of a manual and DVDs. This covers:

- **Self-care:** The limits of the fix-it medical model and the need for change, a different way. Change: the why's, hows and obstacles. A Wellness Enhancement Learning approach: the underlying whole person approach, findings from mind-body medicine and self-healing.
- **Self-care relationship:** the core of the course and self-sustaining change. A model of change-practice: Meditation and mindfulness: introduced using Heartmath as a way of learning to self-care, and

supporting body harmony ('coherence') for relaxation, wellbeing and healing.

- **Food:** A guided self-reflection on what you are choosing to eat – against a backdrop of a fresh way of looking at food. Processed food and the modern epidemics – what impacts on energy, healing, resilience and wellbeing.
- **Supporting change:** What drives poor self-care and what is needed to change it for the better? Cycles of drain and cycles of healing. How thoughts, feelings, body and behaviour are linked, and what we can do with this for our wellbeing enhancement.
- **Journey skills:** Ways of reducing suffering, tension and low mood and improving inner peace and wellbeing through skills in handling thoughts and feeling. Introduction to 'The Work' as an example of questioning thoughts.

At this point participants are invited to go on to stage two a few weeks later.

PrimaryWEL and StaffWEL versions

Nairn StaffWEL, which began recruiting in May 2011, aimed to provide staff with experiential learning about helping patients make the shift towards sustainable self-care and wellness enhancement. However, our impression has been that many staff need the WEL programme at least as much as the patients do. Consequently this course had the equally important aim of helping staff address their own stress, wellbeing and self-care needs. The programme has been enthusiastically taken up.

In September 2012 around 100 NHS staff, academics, therapists and previous WEL participants took part in a LEARN meeting around TheWEL and StaffWEL courses, results and findings – with remarkable conversation and convergence of concerns and hopes for change. In the discussion that followed about staff burnout, one psychiatrist on behalf of his team said: *'Our approach is not working for most people – how can we come on this course?'*

The evaluation programme

The more recent results are confirming that the programmes have made useful impacts on people's lives and professional practice.

Ongoing end-of-course feedback is consistently and overwhelmingly positive. This is one simple current example: the end of course evaluation in November 2012 received a rating of excellent from 54% and outstanding from 46%. The people who derived most benefit report that they now want to make an impact on their own health and that the course provides the skills and strategies both to make a start on improving their wellbeing, and also to plan a longer term journey of improvement. The quotes below give a sense of this 'shift' in awareness and behaviour.

I used to burst into tears for no reason, it was terrible. Now that's improved... As time has gone on, you say 'God, I used to do that... but I am not doing it now or I'm not doing it as much now'.

I feel that I am listening to my body better than I would have done before. I think that is something the course taught me: I am worth looking after.

I have more control than I had in the past... I haven't got complete control... I still feel unwell... [It is] more in my control but I've not quite got there yet.

Many participants reported that family members had noticed change in them before they themselves were aware of any evidence of recovery.

You have given me such a wealth of advice to follow but helped me realise it's up to me to alter so many of my past thoughts and reservations about myself.

Absolutely loved it.

All the information came to life.

A further building block for me.

It's amazing how once broken into pieces and explained so well I find hope to help myself cope better with my future worries.

Found this very difficult (in a good way) as I have always resisted facing up to the fact that issues are internal.

StaffWEL course feedback

Pre-course assessments are highlighting the significant levels of stress in staff and the many challenges to their wellbeing and health.

The end of course staff feedback is excellent, with even more positive three weeks later. Staff not on the course have commented on the change in the work atmosphere and efficiency stemming from the course participants. The evaluation findings show benefits in terms of personal and professional function and wellbeing.

I have already had the confidence to make big changes in lifestyle and work, enjoying giving responsibility to others and not feeling guilty. The course has a very practical easy to understand method. I have been on other courses but this is delivered in such a beautiful way. It's the best time I've spent in many years.

I started out the course thinking about how to use if for patients but quickly realised how much I needed to do the work – that has been incredibly useful. It has introduced many new concepts and references which I will explore and, I am sure, use with patients.

This course has changed my life and the lives of my family. It opens my eyes to other possibilities

of coping and having a happier, healthier life. This will make it easier to explain to patients and help them if I am going through this myself.

This course has allowed me to think differently about how others may be viewing themselves. It has also allowed me to step back and give them the opportunity to allow them (the patient) to view their illness/condition without my input/solutions.

I feel I am on a whole new exciting journey. I have learnt the true meaning of compassion, life and it is OK to feel life, experience your map and journey, allow change, shifting the balance of self-care, nurture and love yourself as much as you love other.

It does what it says – a fresh approach that is accessible.

I feel more contentment within myself.

Definitely experiential – have seen effects of approach on changing my own behaviour – without really trying!

Has made me consider various aspects of my life. Have found natural change has occurred in various areas. Various health benefits already noticeable.

Clearly, we are addressing the tip of an iceberg since we all have a lot to explore/examine/address in our personal professional lives. Would be fantastic to have an annual immersive experience to support the process of change.

By learning to take more time for myself I am more tolerant of others.

I have never reflected on my views/feelings/self care in this manner before and I think it is going to be a long journey but it feels like a release.

I have found the whole course very interesting and have come away feeling much better about myself and I think I can cope better with bereavement.

I have started my journey but do need constant reminders to help keep me on my chosen path. Nutrition is a key element for me and this has really made me look at how I am dealing with it, albeit gently does it.

Very interesting viewing my journey and allow myself just to view and gently guide myself and not push onto others.

Changes in diet. Change in thoughts already happening able and have shared with others.

I feel so lucky to have had this opportunity to be on this journey – truly blessed! Thank you... Life changing!

Have thoroughly enjoyed all aspects of the course and will certainly help on the journey I have ahead of me.

Invaluable in keeping me well so I can continue to work in NHS.

Great concepts to use with patients – already using them.

ObjectivelyWEL – pilot biological markers

We have piloted the use of some biological measures with Nairn staff and patient participants to see if we can identify any objective measures that might prove useful in tracking the changes shown in the person-centred evaluation measures, however, we are aware the latter measures are the mainstay of meaningful evaluation of a programme of this nature.

We have begun with markers of possible future health change such as omega 3/6 ratios (a marker for future cardiovascular disease), vitamin D levels (with broad health impacts), inflammatory markers and markers of metabolic syndrome such as fasting insulin levels and blood lipids (linked for example to future diabetes).

Pre-course baseline data are showing concerning results and the staff results are not looking much different from the patients'.

A visiting learning journey to TheWEL Programme in Nairn, January 2012

In January 2012 the project was visited and independently assessed by a team of senior academics headed by Professor Phil Hanlon from the University of Glasgow (see results section of www.thewel.org). They commented:

'We visited this programme over three days in January 2012. We met senior practice staff, and 18 StaffWEL participants from a range of health-care disciplines, and 11 patients. During the course of extended and in-depth conversations with these groups, supplemented by a range of individual interviews, it became clear that we were witnessing evidence of a remarkable qualitative change in participants' capacity for self-care, resilience and wellbeing – staff and patients alike. They recognised their experience as one of a 'healing shift' and described a developing sense of compassion for themselves and for others. Staff had developed greater understanding of and empathy for their patients, and understood the importance of self-work, whilst their patients now understood the healthcare relationship as a joint enterprise, with shared responsibility. The sense of energy and purpose, enthusiasm and renewed

meaning in life and work generated by participation in this programme was readily apparent to the observing group.

‘Although the precise nature of the subtle but deep changes which had evidently taken place sometimes proved hard to articulate, these were nevertheless manifest in patients’ new acceptance of their condition and their responsibility for purposeful work on their own health and wellbeing. We also heard of the unexpected but positive effects on family life, not least in terms of healthy eating and improved family relationships. Effects also extended into the working lives of staff participants, where ‘care’ had a new, deeper meaning. The ‘healing shift’ appears to be embodied and lived, rather than simply a cognitive change. Participants at all levels were eager to see this approach transferred to the broader community, and other service sectors.

‘We are convinced that the implications of this approach for public health policy, and for the future of the NHS in Scotland, now deserve the most careful consideration...’

Moving forward

At its core this work acknowledges that the current ways of approaching health and wellbeing are falling short of what is needed and possible when facing the chronic diseases and distress common for so many of us in modern life. We are seeing inspiring progress that many people are making in finding better ways of caring for themselves and others, when they explore navigating health challenges with a fresh map – one that is predicated more on our capacity to care than on our technology, and one that more aims to enable our strengths than fix our brokenness. That may sound theoretical, but this paper shares how it is being successfully explored in a practical way, modeled in the challenging world of today’s healthcare.

Bikker AP, Reilly D (in press). *An exploration of the phenomenon of healing through interpretative phenomenological analysis.*

Hasegawa H, Reilly D, Mercer S, Bikke AP (2005). Holism in primary care: the views of Scotland’s general practitioners. *Primary Health Care Research and Development* 6 (4) 320–28.

Lyon A (2003). *The fifth wave – searching for health in Scotland.* Edinburgh: Scottish Council Foundation. Available at www.davidreilly.net/HealingShift/5th_wave_files/TheFifthWave.pdf (accessed on 24 April 2013).

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Biomedicine has been locked in a century-long arms race against ever more complex forms of chronic disease. And now, as we live longer less healthy lives and the flow of new magic bullets dries up, its weaponry costs are spiraling out of control. Though the problems of cure and cost are two sides of one coin, biomedicine could be facing an even deeper crisis of care and commitment as its mechanistic culture and obsession with cure downgrade timeless virtues of caring and compassion. A perfect storm could be brewing as crises of cure and cost, compassion and commitment interact, and yet in emerging psychology and neurobiology there are glimmers of a scientific foundation for a renewed Art of Medicine. Perhaps, if medical science can spread these new wings, and healthcare become less impersonal, practitioners’ wisdom and compassion will be seen not as something marginal and non-specific, but once again as the very heart of healthcare.



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Institutional atrocities

The malign vacuum from industrialised healthcare

David Zigmond

GP, Bermondsey; Physician in Psychological Medicine, Hammersmith Hospital

I trained in medicine in the 1960s: a feral and fertile period in academia and healthcare – long since tamed. I have pursued, over the decades, person-centred and holistic approaches to our encounters with others in understanding ('diagnosis') and influence ('treatment'). I have been able to study, write and teach about these from my NHS work in psychiatry, psychotherapy and general practice. From all of these I offer a soundbite-slogan: 'Healthcare is a humanity guided by science'.

Summary

Flagrant neglect or abuse in our care of the vulnerable within our advanced welfare state seems shockingly perverse. How and why does this happen? This article argues that excessive industrialisation and schematisation are speciously alluring, but then alienating. Restitution of any culture of more compassionate care is like an organic process: it must develop from milieux that have receptive space for attachment, affections, and containment.

So, from the tide of depersonalised healthcare we have netted a flagrant and demonic example at Mid Staffs and, now alarmed, subjected it to forensic analysis. Understandably we want to know: how could this happen? Who is responsible? Who can we blame? Government? Inspectors? Policymakers? Regulators? Practitioners? Administrative managers? Clinical managers? Almost immediately we have rhetorical cries for justice and resolution: more trainings/inspections/management! Professional eliminations! Clear and strong leadership! Show trials for public pillory!

All of these responses have relevance or truth yet seem, to me, to miss some deeper understandings about how advancing technology is changing not just our thinking, but also our configurations of human connection. Like our banking and economic systems, our problems extend far before and beyond our crises, or our judgements of villainy or technical incompetence. These events are grotesque aspects of Zeitgeist: we are all in this together. We are all easily, unwittingly, victims or perpetrators; we have much to understand.

In my exploration I have come to some different, though contiguous, ideas. At their centre is this: that healthcare has become too beholden to the objective, technical, systemic and informatic; that the unmindful excesses of these have driven out interpersonal understanding, attachment and, thus, instinctive and

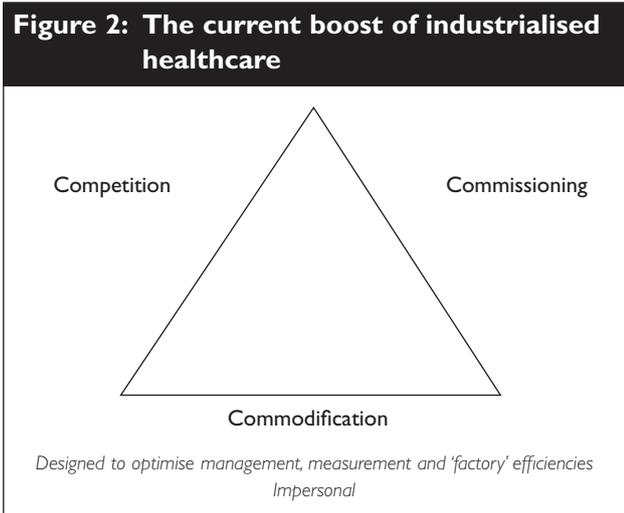
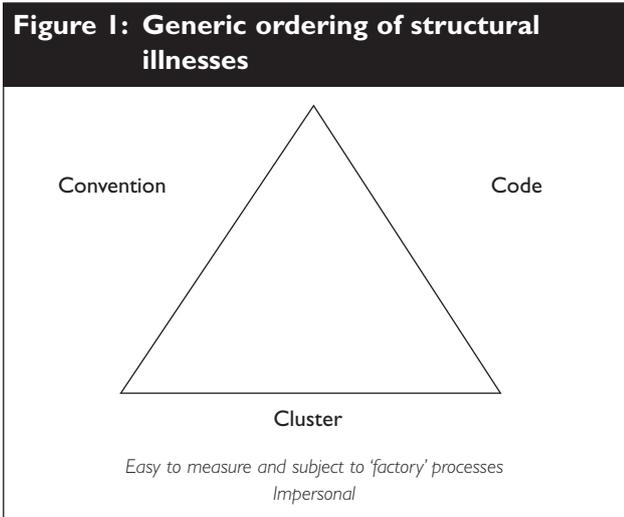
gratifying caring. We have ignored – at great cost – an omnipresent paradox in our care of others: that is, impersonal treatments and formulations (science) tend to countervailance with personal engagements and holistic understandings (art). Our contemporary healthcare thus requires a vigilant balance: to offer our best skill, effectiveness and humanity, we must be able to combine these opposing principles – to weave and titrate them – differently with each encounter.

Four decades ago I was mentored by doctors who, generally, had a canny awareness of the importance of such complex balances. Successive generations have lost this sentience in our cultural rush and thrall to the impersonally managed, measured and procedural. In our increasingly push-buttoned world we are increasingly uncomprehending or intolerant of anything else.

I recently watched a BBC *Newsnight* programme: graphic descriptions of cowered, helpless people dying of dehydration on soiled sheets exemplified our problems. The fractious lobbyists and pundits exchanged recriminations and accusations and never-again contritions. Several talked of inadequate or incorrect training, assuming that it is training that prevents a gravitational drift to blatant inhumanity. My view is different. Such omissions of care and connection are not a matter for adding specialist *training*, but of retaining or

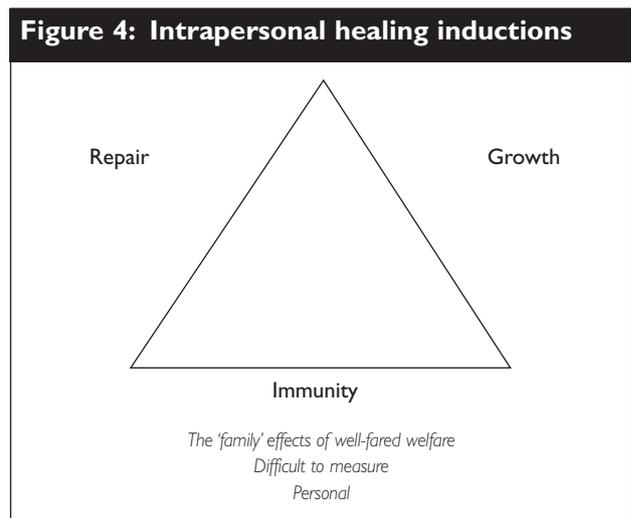
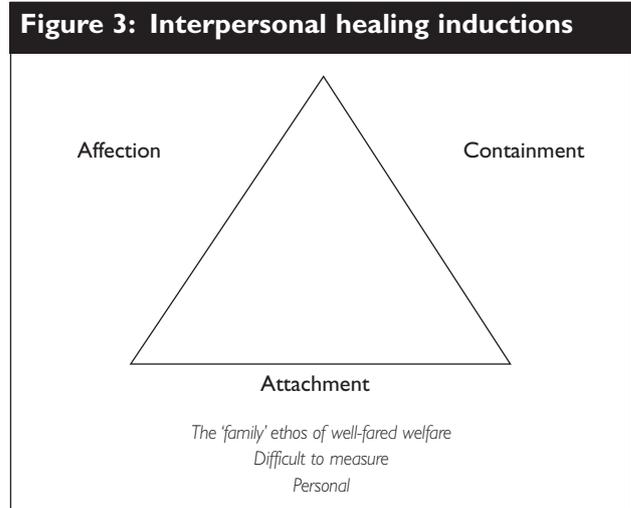
reclaiming our common *humanity*. How have we lost this, and on such a massive scale? How do we repair this, and in a way that will be sustainable?

In answering these questions it is important that we first acknowledge the blessings from our accelerated industrialisation of healthcare, for these have certainly brought us dramatic benefits alongside the insidious losses we are exploring here. The benefits are greatest for complaints that are primarily physically localised, and then are speedily and decisively resolved by procedural expertise. Clear examples are timely interventions in cardiovascular disease and some cancers. The way we systematise deliveries of such blessed interventions can be thought of as being like a *factory*.



Yet the modelling of healthcare solely on this illness/procedural intervention paradigm is hazardous: when our suffering or its causes are not easily despatched, we need a culture that encourages something very different – attachments, affections and containments that develop *between* people. This enables personally anchored understanding and care: these offer not only comfort, but also the subtle inductions of *healing within* the person: of immunity, growth and repair. These activities cannot

be schematic, but they are vital and vitalising. Notably attachments, affections and containments are at the heart of any healthy kind of *family*.



While factory and family healthcare paradigms both have irreplaceable functions, their co-existence is not straightforward: for our best benefit can come only from ceaseless and careful choreography between them. Failure to understand, respect and achieve this delicate balance leads not just to ineffectiveness, but then to inhumanity or hazard. This is our current nemesis: our healthcare has become factory-rich but family-poor; informatics and scanner-sighted, but humankind-blind.

We have erred through our indiscriminate and thus excessive use of systematics: objectification, coding, planning and atomisation into managerially proliferated and bounded specialisms. This may be a good way to run a robotic factory; it is definitely not a good way to raise a (healthcare) family.

Many will regard the Mid Staffs debacle as criminal; I think it is more true, and more instructive, to think of it as *cultural* – Mid Staffs is thus a severe symptom, a warning sign, of our collective and collected errors. It is, of course,



a severe event, but also one of many (now everyday) examples of our healthcare anomie and human disconnection. This has happened both despite, and because of, our ever-increasing welter of commissioners, statutory bodies, dividing and divisive specialisms and competing autarkic Trusts – all these have led to a kind of healthcare that may look good as an architectural model, but is not good to live in. The worse the economy, the more impressive the economists.

I used to work in a much more heterogeneous NHS: the worse was worse, and the better much better. What was that ‘better’? For the professionals working hours were longer, but morale was higher. Official regulation was less, but vocational conscientiousness greater. Physical treatments were simpler and cruder, but personal care more sustained and sensitive. Electronic signalling non-existent, but conversational dialogue much easier. The pay was less, but the human reward was more. Didactic training facilities were meagre, but educational discourse richer. Most of my older mentors passed on loving care for their work; now my younger colleagues attempt to control others by formalistic personal development plans.

And what of the patients? In the earlier, less technocratic NHS the better clinicians understood the importance of attachment, affection and containment in *healing*: we assured time, flexibility and imaginative space for these. We knew that such subtle interactions were often our best offerings of care for those conditions not easily cured – probably the larger part of our healthcare (yes!): our ageing, our mental distress, our tangled, troubled reactions to life’s vicissitudes. For these our best efforts are more imaginatively pastoral than procedurally technical. Here the professional’s integrity and judgement need *personal* enlightenment and nourishment, yet these are now often driven out by further *technical* management and training. The stark inhumanity at Mid Staffs is what happens if we do not understand and then neglect this delicate ethos of human connection; it is not about the kind of competencies that can be quickly and easily trained and regulated. The realisation of this may be an awakening, to re-open our eyes, hearts and minds.

This schematic desiccation of human connection in NHS healthcare is thus seminal to many of our serious and widespread problems. Over the decades I have observed this previously humanity-rich but imperfect organisation become more and more machine-like. People in the NHS I now work in have a steadily declining personal knowledge or understanding of one another. In this ex-human vacuum the computer now sits, like a glowering, increasingly obese and enthroned emperor, appropriating the impersonal hub and frontline of administrative and informatic continuity.

What does this lead to? Anomie and depersonalisation. Few people can now name their GP, hospital consultant, or even the name of the specialist clinic they attend – mostly the computer will bid and book them, and mostly they will comply. GPs are increasingly working in large conglomerate practices where they offer little personal continuity of care, do not know families, neighbourhoods or even the names of their own receptionists. The receptionists, in turn, are disconnected from their (many) doctors and increasingly from the patients – ‘reception’ is now often done by a computer screen, leaving the receptionist ‘free’ to tend the computer with other tasks. Those other tasks often involve some kind of electronic data collation, which will be necessary for the doctor to have on the screen, when he is having a procedural (non) contact with a patient he will never really get to know, and does not look at (because he is instead looking at the computer screen)... Get it?

In hospitals this anomic haze is even worse. In my local airport-like hospital I have seen consultants doing ward rounds with rota-directed junior doctors they have never met before, attended by nurses who do not know their own colleagues, the patients or any other ward staff. This consultant, clustered with strangers, then attempts quickly to evaluate a complex (for we are) human/technical problem in a patient they are seeing for a first and (often) only time. Such a symphony of fragmented depersonalisations has been orchestrated by successive layers of ‘improvements’ to logistics and efficiencies of healthcare’s training, standardisation, procurement and delivery. Examples? Amalgamation of medical schools, the dispersal of hospital nursing schools to universities, standardised modular trainings (rather than apprenticeship-type education), the encouragement of subcontracting, the abolition of GP personal lists, autarkic powers of NHS Trusts, payment by results, the fragmentation of psychological and psychiatric care into complex speciality-based streams, the European Working Time Directive, and, of course, the three Cs – commissioning, competition and commodification – all of these exemplified initiatives, plotted and hatched by experts, have added to the remote-control complexity of our healthcare machine and the human inaccessibility for its operators and operatees.

* * *

Authentic caring is not a commodity to be traded or a skillset to be instructed. It is an ethos, a metaphorical

effusion of the heart. It is a benign, often relayed, human transmission that tends to mirror, then amplify, the incoming signal. It is a similar, but opposite, process to the contagious relay of cruelty, bullying or intimidation. For caring we need holistic imagination – to perceive or conceive *more* than is explicit or apparent. In contrast, cruelty requires us to see in a person or situation *less* than is clearly there. Cruelty is a kind of reductionism. Yet out current systems of management will urge us to the simplistic formulaic and formalistic. Trust-employed healthdroids are now paid to look only at one prescribed part of complex problems, and in the Trust's officially prescribed manner. This is usually determined by the Trust's interests of autarky or economy.



Caring for others also depends on our own morale: whether *we* feel cared for, embraced by human connection and value. This, of course, will depend much upon our milieu: as health carers how do we perceive our working and employing culture? What kind of 'factory' or 'family' do these represent for us, and in what kind of ratios?

The quality of how we care about our care of others depends on ensuring receptive and imaginative mental space and time to make possible personal *attachments*. From these may develop *affections*: the investment of bonds with discernable feelings – for now we become significant, then important, for one another. This establishment of affectionate attachments then makes possible another and essential aspect of compassionate care: *containment* – we bring comfort, calm and often understanding to others when we receive, hold and share what they can no longer bear alone. Again, this is often a relay effect: the sufferer is helped to contain their suffering by feeling contained by the helper, who can do this much more readily if he himself feels an equivalent caring containment in his environment. Caring containment is thus passed on in successive relationships, like Russian dolls, one within the other. It is important, so reiterated, that the opposite experiences and effects – of indifference, fear, cruelty etc – are passed on in a similar way. Thence come our dysfunctional or hostile families and institutions. Was Mid Staffs such an example of discontainment?

So, caring and containment can be best assured where attachment and affection can develop. As we have seen, this is unlikely in an NHS in which the ethos of the 'factory' has largely driven out the 'family'. Consider, for example, an undramatic and very common scenario: the process of a hip replacement in 1983 and again in the more industrialised/schematised 2013.

1983. A technical task: personal continuity

Ali is 65-years-old and already disabled and housebound by his hip arthritis. He goes to see Mr O, an orthopaedic surgeon. Mr O hears Ali's story and complaint: Ali tells Mr O of how his life has been diminished and disempowered by his infirmity. Mr O recommends a standard hip replacement and sees Ali several times before and soon after the successful procedure, and then for longer term follow up. The two men develop a low-key but cordial and discernable affection. Ali expresses his gratitude for a much restored life and feels encouraged by Mr O's interest and advice early in his recovery: he talks of him warmly as 'my surgeon' – this is affectionate, not presumptuous or possessive. Mr O is grateful, too. It is good for him to see the human effects of his technical intervention, to hear from Ali about a life restored. Mr O's work is often difficult and stressful: such human contacts nourish and sustain him. One of his young and idealistic students once tried to interest him in a conversation about holistic medicine. Mr O had replied that he'd never really understood what the term means; he was 'just a surgeon'. For Ali he was more: Mr O knew this, but did not speak of it.

2013. A technical task: a production line

Ali is Ali's son: he, too, has succumbed to a similar disability at a similar age. Ali attends the same hospital as his father had, but its inner workings are now very different and Mr O has long retired. There seems to Ali no equivalent or replacement for his father's surgeon, for he sees someone different each time he goes to the hospital. He does not know if the stranger he is talking to is a nurse, a doctor or a physiotherapist and he does not feel he should ask. Nor does he remember the names of the different clinics, but takes the appointment letter with him to ensure his accurate destination. He is seen by different practitioners for orthopaedic assessment, preoperative assessment, surgical admission, surgery, surgical recovery, and post-surgical follow up. He does not know the name of any of his attending clinicians or who replaced his hip. Ali thinks his technical care was 'probably alright', but confusing. He was afraid in hospital, but told no one. He found recovery painful, lonely and difficult: he had no quietly affectionate professional relationships to encourage him, and no smile of gratitude to bestow. 'Job done', true enough, but no human connection or deeper satisfactions for Ali or the anonymous 'teams'. And the innumerate, unknown hip surgeon – Mr or Ms O2 – what sustains them? What gives their tiring job human value and meaning?

Figure 5: Imaginatively compassionate healthcare – some guiding caveats and principles

- If we like our work and find it interesting, we will do it well and willingly.
- Such liking and interest often involves the gratification of seeing our work's longer-term evolution and personal effects. Deeper satisfactions, too, are often personal and holistic: conversely, fragmented, short-term work offers little of these.
- Encouragement to draw on our experience to make intelligent creative decisions is likely to engage and develop our best qualities. Submitting to endless committee-designated diktats does not.
- We thus prefer flexible and collaborative working arrangements rather than those that are rigid, competitive and divisive.
- If we get know people well, we will be well-motivated to care for them. The more you see of someone, the more of someone you see.
- If we do not know people it is far easier not to care, or even to collude with harm: history has innumerable examples before Mid Staffs.
- People who feel attached, interested and positively personally engaged need relatively little disciplinary or motivational management.
- In contrast, it is very difficult to get good work from people who do not enjoy their work, feel attached or positively, personally engaged: these are primary deficits, and no amount of regulation, management, training or financial incentive will rectify them.

Vernacular maxims: no statistics

After more than four decades as a frontline NHS doctor I have mounting sadness and fear for the human and philosophical impoverishment of my profession. If I live long enough I, too, will have a serious role as a patient. The Mid Staffs exposure may shock many: for me it is merely another shard of disheartenment. Every working day I encounter similar, if lesser, systemic human disconnections. I look back over the rolling eras of errors, and management ideologies, and the hundreds of colleagueial conversations I had trying to make sense of them. In all of these I am searching for general caveats and motivational principles – the kind that might better guide institutions to enable, rather than stifle, imaginatively compassionate healthcare. Like the work itself, my compilation is flawed, never complete, and must always be revised.

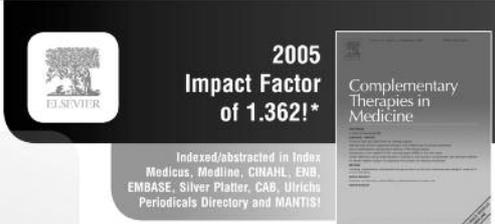
If large organisations, like individuals, can have breakdowns of spiritual and emotional integrity, then the NHS is set for an epidemic. This is largely due to our disinvestment of natural and positive attachments. Mid Staffs is but one early, now publicly flaunted, casualty.

*The whole is more than, and different from,
the sum of its parts.*

Healthcare is a humanity guided by science.

That humanity is an art and an ethos.

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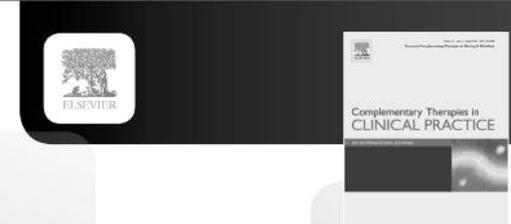
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Responding to the Francis Report

Some simple but radical suggestions

Paquita de Zulueta

*Chair, Human Values in Healthcare Forum;
Honorary Clinical Senior Lecturer,
Department of Primary Care & Public
Health, Imperial College*

As a GP I have been involved for many years in the professional and personal development of doctors in a variety of roles – mentor, appraiser, educationalist and ethicist. More recently I have qualified in cognitive behavioural therapy and this, with mindfulness and compassion focused therapy, has enhanced my understanding of the role of emotions in our moral lives and for our wellbeing. My key themes have been enablement and humanity in clinical practice. I joined the Human Values in Healthcare Forum in the 90s and I am in the process of reviving it in order to work with others to share ideas, strategies and practices that enable ethical and compassionate healthcare – something that seems to be under greater threat in the 21st century.

Summary

How can we learn from the events in Mid-Staffordshire in a way that avoids the blame culture and builds an organic improvement? The fundamental changes that are needed have not been made – a real cultural shift is called for. Simple but radical suggestions are made for compassionate, humane and ethical healthcare.

Introduction

Both the Independent Francis Inquiry (Francis 2010) and the Francis Public Inquiry (Francis 2012) published this year make for distressing and disturbing reading. One can barely believe that healthcare professionals could have allowed this to happen – so comprehensively losing their moral compass and eschewing their fundamental duty to care for and protect their patients from harm and unnecessary suffering. The statistics – up to 1,200 preventable deaths – are shameful, but it is the personal stories that truly shock us. The relatives' accounts of the degradation, neglect, callousness and even cruelty experienced by patients create a picture of a living hell.

How on earth can we make sense of it all? Above all, how can we learn from this, such that the words 'never again' do not ring hollow in a few years time?

The temptation is to assign blame to the visible perpetrators, but we need to recognise that the reasons for these egregious failures are complex and require a wise, resourceful and creative response. We need to understand the science of compassion.

We also need to acknowledge that health professionals did attempt on several occasions to raise concerns, but were ignored or silenced. Although necessary to take appropriate disciplinary action, it would simply be inadequate to punish the foot soldiers and move on without really grasping the nettle. Before we consider how the profession should respond, we need to look at the bigger picture and recognise how coercive leadership and narrow organisational imperatives can set the moral climate and engender a toxic culture.

The implementation of targets and efficiency drives, led by the Department of Health, were accompanied in Mid-Staffordshire by a drastic reduction in staff and resources without due consideration of the impact on staff and patients. This was key, as was the culture of defensiveness and secrecy. Clearly, managerial systems and organisational priorities in the NHS need to change, particularly as we face years of unprecedented financial stringency and yet more reorganisation, which threaten to destabilise existing systems of care. The Royal Bristol Public Inquiry report led by Sir Ian Kennedy made similar criticisms of a target-focused

command and control management and mandated a shift to a no-blame open culture, with patients at the centre of the service (Kennedy 2001). Yet, despite the introduction of a number of regulatory changes, little appears to have changed at the fundamental level.

Clearly, managerial systems and organisational priorities in the NHS need to change

Before the publication of the public inquiry, I was asked by an individual in the Department of Health to make suggestions for how to respond. I set out this brief list of suggestions. It is by no means comprehensive but I think does tackle most of the key factors. It is based on reading extensively the literature and follows reflection, discussion with colleagues as well as personal experience. Some of these did emerge in the public inquiry report's 192 recommendations. The government's initial response does make some useful proposals but alas many that would create a real cultural shift are missing (DoH 2013). In particular, leadership issues, staff shortages, funding for healthcare assistant training, and reduction of targets are not adequately addressed. Superficial methods of measuring quality and financial incentives for good care could be counterproductive. Furthermore it seems hard to see how bureaucracy can be reduced (the government pledge is to reduce it by 30%) in the wake of the reforms that will lead to multiple contracts and fragmented care. Nor does the relentless marketisation and commercialisation of the NHS accompanied by austerity cuts augur well for a compassionate, humane and ethical healthcare.

Leadership

- This must be **emotionally intelligent** (resonant) leadership, with built-in coaching and training for emotional intelligence at all level of leadership – clinical and managerial. There are far too many pacesetters in the NHS.
- Leaders must be seen as **competent, trustworthy, compassionate and without conflicts of interest** or a past history of responsibility for Trusts such as Mid-Staffordshire at the time of their unravelling.
- **Excellent role models** should be supported and rewarded and poor role models removed from teaching, supervisory and managerial roles.

Education and training

- **Nursing** – Invest more in healthcare assistants (HCAs). Currently they represent 40% of the nursing workforce but attract only 4% of the educational budget. HCAs need to be properly remunerated and professionalised. Nurses must be adequately supported and shift work reassessed.

- Education must be aimed at building **emotional resilience** in work that demands considerable emotional labour e.g. that of nurses and doctors. There are several evidence-based methods for this such as mindfulness training, CBT skills, fostering self care, Schwartz centre rounds, mentoring, appreciative inquiry etc. Teaching ethics and instigating codes of conduct by itself is insufficient.
- **Teaching excellence** should carry a high status and attract rewards commensurate to research ratings (a perennial issue).
- Additional training and resources for **care of the elderly** in hospitals.

Management and person-centredness

- Many targets, financial incentives, and tariffs create perverse incentives, encourage 'gaming', distort healthcare priorities and squeeze out the human aspects of care. These should be jettisoned. The Francis report of 2010 has already made this point. Privileging the readily measurable and tick-boxing competencies should not serve as methods for ascertaining quality and value. The 'non measurable' such as caregiving and compassionate care become devalued and lost in this system. Focus should be on real outcomes not procedures or surrogate markers.
- Management must be founded on the premise that organisations are **living human systems**, not machines. Hospitals and primary health care centres are not factories or retail outlets and people are not cogs. The assumption that patients are 'rational consumers', that health and healthcare are commodities and the adherence to the flawed 'expected utility theory' (jettisoned by many economists) have been deeply damaging. The inherent power imbalances and the lived realities of being ill and vulnerable should be recognised and woven into policies and practices.
- NHS trusts and GP practices should involve input from all those who work in it and build on strengths rather than focus endlessly on weaknesses.
- Patients should be properly consulted and involved in care design and implementation. In-depth feedback should be implemented to foster patient centred care (not yet more box-ticking).
- Valuing and fostering **covenantal/relational care** rather than just focussing on transactional care. A great deal of care is complex and iterative. It will not fit linear simplistic models of care. You cannot coerce or pay people to be compassionate. End of life care is particularly sensitive and should not be monetised.
- Separating policy from implementation and allowing creative solutions from those at the coalface. Care pathways must be flexible and co-ordinated to accommodate the unpredictability and complexity of illness.

- Abolish mixed sex wards except CCU, ICU etc and limit maximal bed occupancy.

Workforce flourishing

- Ensure that **wellbeing strategies** are in place for all the workforce, including availability of stress reduction programmes, psychological services, facilities for exercise, time/facilitation for individual and group reflection, and a hospitable environment. (Flowers and plants can make an environment more welcoming. There is no evidence they transmit infection.) There should be comfortable common rooms (often absent) for doctors and nurses and access to healthy food and refreshments at all times. The evidence shows that if healthcare professionals feel valued and are happy, patient outcomes are improved and absenteeism reduced.
- Encouraging **team building, multidisciplinary working**, time for proper handovers, educational ward rounds and real dialogue. Much of this has been eroded.

Workforce planning

- Adequate numbers to do the work. Shortages of nurses and midwives and experienced staff needs to be addressed. Expensive agency nurses reduced.
- Co-designing patient care. Using existing human resources imaginatively such as creating clearly identifiable 'companions' with responsibility for welcoming vulnerable patients, ensuring they have food and drink, and accompanying them along their journeys from ward to X-ray to clinic and to next ward etc. They could carry pagers that patients could call them on when ready to move on. The role could be fulfilled by trained students, porters, volunteers etc and would be inexpensive.

'Culture' and patient safety

- Open, no blame culture. Constructive criticism encouraged. Patient complaints attended to promptly and appropriately. Statutory duty of candour?
- Get rid of bullies and protect whistle-blowers. Currently the latter are heavily penalised and intimidated. No 'gagging clauses' legally permitted.
- Robust safety systems in place that involve/engage all staff, including cleaners.
- Adequate resources and training for regulatory bodies.
- Clear lines of accountability.
- Pro-active versus reactive approach.

Other wider issues including fairness and equity

- Integration of health and social care, and valuing both mental and physical health.

- Sufficient nursing homes and community facilities including cottage hospitals to (often the very organisations that keep people out of hospital are those that are axed first).

• Commissioning for compassionate care.

- Any qualified provider, including out-of-hours care, social care has to be a **non-profit-making organisation** to avoid greater allegiance to shareholders versus patients.
- Factoring in ease of access for local populations when designing care.
- Greatly reducing the scope for 49% private beds in hospital trusts. This will inevitably exacerbate a two-tiered system.
- Encouraging collaboration versus wasteful competition particularly for primary and secondary care working. Discouraging monopolies. Provider purchaser split has to be proven to improve care before implementation. Reducing bureaucracy. *Is the quasi market for the NHS really fit for purpose? Is a total rethink in order?*

In November 2012 The Human Values in Healthcare Forum (HVHF) and the Open Section of the RSM held a highly successful (and sold out) multidisciplinary conference on compassion in healthcare (see page 42). Much of the content of this conference is highly relevant to enabling compassionate care and changing the culture of the NHS.

The HVHF (www.humanvaluesinhealthcare.com) has the following aims. To:

- form a network of individuals and organisations that cultivate compassionate healthcare
- raise awareness of norms, assumptions and practices that threaten or erode human values in healthcare
- offer a forum where professionals, patients, students, academics, spiritual and healthcare leaders, managers and members of the general public can engage in creative conversations and share ideas, projects and ethical concerns
- share and disseminate examples of good practice, relevant training, education, and research
- critically appraise the impact that policy and organisation have on patient-centred practice
- provide hope and inspiration to those who care about flourishing and humanity in healthcare.

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HeartMath in UK healthcare: Does it add up?

Kay Riley

Chief Nurse, Barts Health NHS Trust

Deanna Gibbs

Research Consultant, Barts Health NHS Trust

A career-long interest in compassionate care and compassion fatigue in healthcare staff led me to an interesting discovery while visiting a Magnet Hospital in the USA. Every aspect of the hospital felt 'compassionate', the emotional capacity and care of the staff for their patients and each other was overwhelming. The difference was HeartMath, and so our journey to bring HeartMath to the NHS in England began. My own personal experience and the results of our pilot project further supports that if we look after our staff they will be better equipped to look after our patients.

Kay Riley

With a professional background in occupational therapy, I realised the benefits of including a variety of stress management techniques in working with people with acute and chronic illness. When Kay asked me to be involved in delivering the HeartMath pilot project I was originally intrigued by the scientific research that supports the benefits of the programme. However, as I delivered the programme to our staff I not only directly benefited from implementing the techniques into my own life as a means of supporting my wellbeing, but also believe that HeartMath has significant potential to support our delivery of compassionate care.

Deanna Gibbs

Summary

Stress and burnout have been identified as key barriers to the provision of compassionate care. This paper describes a pilot project that evaluated the delivery of an innovative approach to improving staff wellbeing. Detailing the experience of providing the HeartMath Revitalising Care programme for the first time in an NHS Trust in England, we describe the delivery of the programme, the evaluation of the impact on staff wellbeing, and recommendations for future provision.

Introduction

Stress, depression and burnout among hospital staff have been identified consistently as key barriers to the provision of compassionate care (Firth-Cozens and Cornwell, 2009). In 2010, Barts Health NHS Trust identified the provision of compassionate care as a key objective for the coming year.

The issue of stress and burnout among healthcare providers has been extensively researched (Aiken *et al*, 2002; Vahey *et al*, 2004; Balogun *et al*, 2002; Reader *et al*, 2008). Burnout is a colloquial term commonly used to describe a state of mental and emotional exhaustion in the workplace. Burnout results from high levels of occupational stress, and is associated with negative attitudes, emotions and behaviours towards one's work. Associations have been made between levels of burnout and staff turnover;

absenteeism, poor organisational commitment, low job satisfaction and coronary heart disease. Burnout among healthcare professionals has also been shown to affect the quality of care provided to patients (Reader *et al* 2008).

Stress and burnout among healthcare providers has been attributed to:

- individual causes (eg high self-criticism, making errors, decreased empathy, and the emotional labour of healthcare)
- quality of team working (eg clarity of team objectives, role delineation, communication styles, mutual respect)
- organisational causes (eg high workload, time pressures, low autonomy and participation in decision-making, role conflict, lack of social support and lack of feedback).

(Firth-Cozens and Cornwall 2009).

The aim of this pilot project was to introduce a programme aimed at improving staff wellbeing using an education model that would equip staff to manage their work and personal stress more effectively. It was envisaged that improving staff wellbeing would be a key contributor to the objective of embedding compassionate care within Barts and the London NHS Trust.

Project details

The HeartMath Transforming Stress/Revitalising Care Programme is a well-researched intervention with a track record of providing hospital leaders, nurses, doctors and staff with a set of ideas and techniques which have been scientifically validated. The techniques are easily learnt and implemented and have proven effective and popular with staff in healthcare settings.

Burnout among healthcare professionals has been shown to affect the quality of care provided

The project provided staff education on HeartMath techniques which have been found to assist the self-regulation of emotional responses and increase 'personal coherence'. The HeartMath technology provides real-time feedback on heart rate variability (HRV). HRV is a reliable indicator of the balance between sympathetic and parasympathetic nervous system activity. The HeartMath programme provides biofeedback on HRV through a handheld emWave device which picks up the user's pulse, and processes the data to provide immediate visual biofeedback on HRV. In this way the emWave makes visible the moment-to-moment physiological impact of a simple cognitive and breathing technique designed to regulate HRV, by reducing sympathetic nervous system over-arousal and boosting parasympathetic activity. With regular practice these techniques appear to build 'personal coherence' and support greater autonomic stability. This shift is associated with positive change in nervous, cardiovascular, hormonal and immune function, performance, perceived stress, emotional stability, sleep health and wellbeing (McCraty and Childre 2010). When implemented widely in healthcare and other corporate settings the programme has been shown to increase overall staff resilience (McCraty and Childre 2010). In addition to resilience, HeartMath interventions in hospital settings have achieved results by:

- increasing staff retention
- improving patient satisfaction
- enhancing communications
- boosting employee morale
- enhancing team performance at both staff and leadership levels
- reducing costs significantly (HeartMath LLC 2011)

The HeartMath Revitalising Care programme has been used in a variety of hospital settings in the USA, including

Duke University Health System, Kaiser Permanente Medical Centres, and the Mayo Clinic. In the UK HeartMath has been introduced into large companies including GlaxoSmithKline. However, the HeartMath Revitalising Care programme at Barts and the London NHS Trust was the first time that this programme has been piloted in an acute hospital setting in England. Evaluation of this pilot aimed to give the Trust information sufficiently robust to establish the feasibility of providing the programme across the whole organisation.

Project objectives

The objectives of the pilot project were:

- to implement the HeartMath Revitalising Care Programme in four pilot sites within Barts and The London NHS Trust
- to objectively evaluate the impact of participation in the project on individuals in relation to the reporting/measurement of emotional vitality, organisational stress, emotional stress, physical stress, and blood pressure
- to objectively evaluate the impact of the project on organisational factors including staff retention and turnover, absenteeism and service user complaints.

Project design

Education provision

In order to deliver the HeartMath Revitalising Care programme, seven Trust staff participated in a one week train-the-trainer programme which provided the elements required to deliver the programme as per the licensed agreements. The training team incorporated both clinical (three matrons) and non-clinical (four HR/corporate nursing) staff as trainers.

Pilot areas

The programme was offered to staff in four discrete areas of Barts and The London NHS Trust:

- cardiac ward, St Bartholomew's Hospital
- medical and surgical oncology ward, St Bartholomew's Hospital
- acute admissions unit, Royal London Hospital
- outpatient reception staff, Royal London Hospital.

Staff working in each of these areas were invited to participate in the programme. Senior sisters/charge nurses for each area facilitated this by managing their rostering requirements to help release staff from the ward to attend.

Participation involved attending a one-day training programme where staff were shown the scientific background to HeartMath, and taught self-regulatory strategies and techniques. All of the staff who participated in the project also received training on how to use the emWAVE2 – a handheld instrument that provides feedback on heart rate variability. Two weeks after completing the initial

training, staff were invited to attend a two-hour follow-up workshop to review their experiences of using the techniques, and explore ways of integrating the techniques into work and home lives. In addition a final technique was taught. So they could better support staff-engagement within their areas, key members of the leadership teams for each pilot area were invited to attend a one-day workshop introducing the HeartMath intervention.

Staff involvement

All staff in each of the pilot areas were encouraged to participate in the programme. It was envisaged that as each area involved between 30–50 people the pilot might engage with 150–200 in total. However numbers recruited were lower than anticipated (due to a number of vacancies in staff establishments) and only 103 staff enrolled into part one workshops. A further 16 staff attended the leadership workshop.

A series of 11 part one and part two workshops were provided throughout August–October 2011. Of the 103 staff initially enrolled in the workshops, 97 staff attended a part one workshop, and 52 attended a part two workshop.

Project evaluation

Evaluation procedures

Evaluation of the project was conducted using pre- and post-measures. Individual performance measures were recorded at two time points:

- T1: Initial attendance at the part-one HeartMath training workshop
- T2: Attendance at the part-two workshop (two weeks later).

Individuals completed the Personal and Organisational Quality Assessment – Revised 4 Scale (POQA-R4), which is a written questionnaire with four subscales (emotional vitality, organisational stress, emotional stress and physical stress). POQA-R4 has been used this way in a range of studies evaluating the effectiveness of the HeartMath programme. Returned questionnaires were anonymised before analysis was undertaken.

Previous research with hypertensive employees suggests HeartMath self-regulatory techniques may reduce blood pressure (McCarty *et al* 2003). So in this study participants known to have elevated blood pressure were able to have their blood pressure recorded at the part one workshop. Individuals were responsible for scheduling a follow-up OH clinic appointment for a repeat measure six weeks later and for confirming whether they wished their anonymised readings to be included in the overall project evaluation.

The study was able to access existing standard Trust reporting mechanisms and dashboards to obtain data relating to certain organisational factors.

The timeframes and tools for evaluation are summarised in Table 1.

POQA Pre-post test results

Personal and organisational quality assessment – revised (POQA-R)

The POQA-R is a self-report inventory designed to reflect certain key psychological and workplace elements that contribute to the overall quality of an organisation’s work. The instrument provides a concentrated yet comprehensive assessment in the two main topic areas listed in Table 2.

Stress has a significant negative impact on employee health and work performance. The personal quality scales directly reflect employees’ day-to-day moods, attitudes and stress related symptoms. The stress symptom items in the POQA-R have been validated as clinically significant correlates of stress. The POQA-R’s organisational quality scales on the other hand are concerned with key organisational factors that influence employee

Table 1: Evaluation tools

Assessment	T1 (prior to participation in programme)	T2 (2–6 weeks after completion of programme)	T3 (6 months after completion of programme)
Individual			
POQA-R4	×	×	
Blood pressure*	×	×	
Organisational			
Turnover	×		×
Sickness absence	×		×
Complaints	×		×

*Blood pressure recordings will only be taken for staff who elect to attend the Trust’s occupational health services

Table 2: POQA-R personal and organisational qualities

Personal qualities	Organisational qualities
<ul style="list-style-type: none"> • Positive outlook • Gratitude • Motivation • Calmness • Fatigue • Anxiety • Depression • Anger management • Resentfulness • Stress symptoms 	<ul style="list-style-type: none"> • Strategic understanding • Value of contribution • Manager support • Goal clarity • Job challenge • Work intensity • Time pressure • Freedom of expression • Communication effectiveness • Confidence in the organisation • Work attitude • Morale issues • Productivity • Intention to quit

engagement, performance and behaviour, as well as attitudes toward work, and the ability to perform well.

The pre-post POQA-R test results are displayed in Figures 1 and 2.

Figure 1: Pre-post results: personal qualities (POQA-R normative summary)

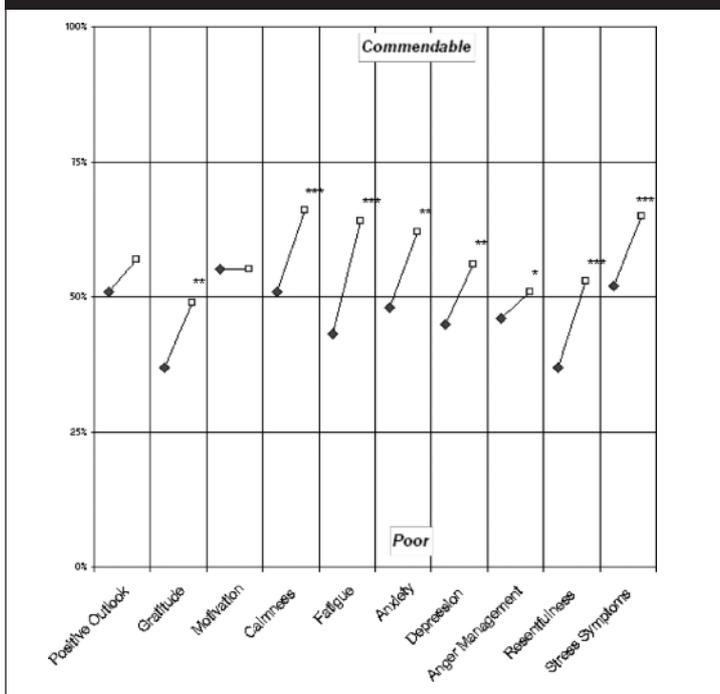
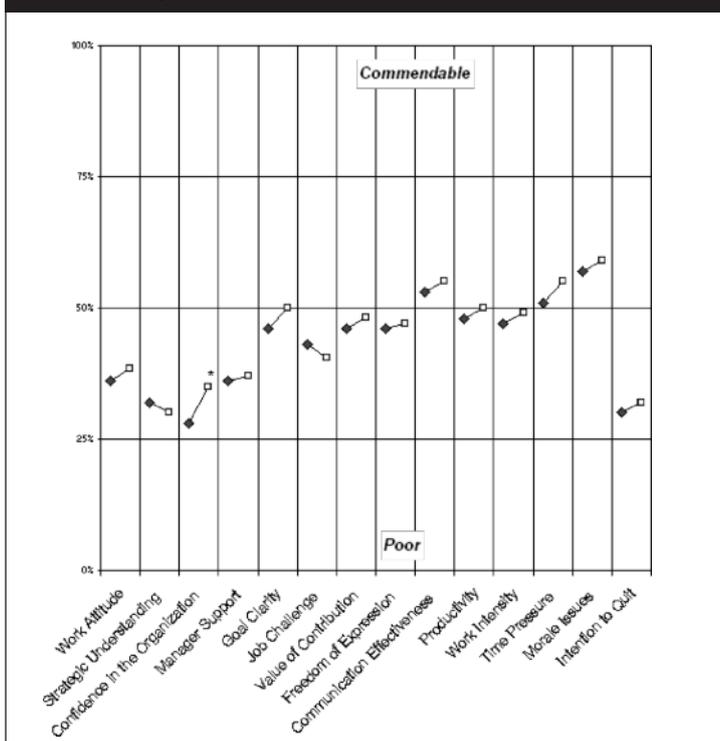


Figure 2: Pre-post results: organisational qualities (POQA-R normative summary)



Summary and interpretation of POQA-R results

Personal qualities

The summary results for the pre- and post-test POQA-R results showed improvements in all of the personal qualities categories. Motivation was the single exception, but this had the highest pre-test score. In eight of the ten categories these changes were statistically significant, with fatigue and calmness showing the greatest evidence of change.

Table 3 extracts personal qualities scoring items that evidenced the greatest change:

Previous HeartMath intervention studies have demonstrated improvements in personal stress and energy factors, especially so once the program has been implemented more broadly across an organisation. Yet, even in this small scale intervention the significant changes in all areas of this table suggest improvement in participants' well-being, quality of life and potential effectiveness. Such measurable changes occur more quickly for the individual than for the organisation as a whole, and changes in the organisational quality categories are often not evident for several months (Institute of HeartMath, 2011).

Organisational qualities

However, in larger scale, longer studies of the intervention, additional associated improvements have been found in increased patient satisfaction, improved patient safety, and reduced sickness/absence. It seems that in time, individual improvements in resiliency have a carry-over effect on the organisation, but in the short term the scale of change between the pre-and post-test results for the organisational qualities is smaller than that for personal qualities.

This section of the POQA-R analysis indicates the health of the organisation as perceived by the staff participants. In the pre-test data, 11 of the 14 organisational metrics began in the below average range. These were: work attitude, strategic understanding, confidence in the organisation, manager support, goal clarity, job challenge, value of contribution, freedom of expression, productivity, work intensity, and intention to quit. Only one category, confidence in the organisation (one of the lowest rated in the pre-data) showed a statistically significant improvement ($p < 0.05$).

The starting points of the remaining metrics were in the average to above average range.

in the post-test data, three of the metrics moved into the above average range – communication effectiveness, time pressure, and morale issues. The end points of the remaining metrics are gathered around the average to below average range.

Table 3

Personal quality	% pre workshop	% post workshop	% change
I feel optimistic about the future	68	73	5
My life is deeply fulfilling	44	58	14
Appreciative	35	56	21
Peaceful	28	57	29
Calm	38	47	9
Tired	58	27	29
Exhausted	42	19	23
Worried	25	16	9
Depressed	11	4	7
Annoyed	32	19	13
Angry	19	12	7
My sleep is inadequate	40	22	18
Body aches	30	19	11
How stressed have you been in the past month (100-point sliding scale)	41	27	14

Some individual scoring items further illuminates the impact of the HeartMath intervention, showing a difference in the perception of the participants in terms of their alignment with the organisation as a whole, enjoyment of their jobs, feeling supported by management and their co-workers and achieving balance between their work and personal lives (Table 4).

However, some of the individual scoring items also clearly demonstrate areas where staff wellbeing is influencing/being influenced by the organisational culture:

- people feel a sense of appreciation for one another – 25% (75% disagree)
- their work is often recognised or appreciated by their superiors – 38% (62% disagree)
- people are free to express their opinions – 35% (65% disagree)
- they are able to speak without fear of consequences – 46% (54% disagree)
- people listen carefully to each other at work – 54% (46% disagree)
- most of the current talk about the organisation is good news – 14% (86% disagree)
- I always know how my supervisor wants me to utilise my time – 56% (44% disagree)

- people's roles and responsibilities are made clear – 44% (56% disagree)

In summary, the formal POQA-R evaluation clearly shows significant individual benefits for the participants in relation to their well-being. Further, we may infer at least tentatively that the results imply improvements not only in individual wellbeing, resilience and personal effectiveness but also in attitude to and appreciation of organisational qualities.

Organisational data evaluation

The final part of the evaluation reviewed changes in turnover rates, sickness absence and complaints. In order to take account of seasonal bias, two time periods were reviewed: Jan–March 2011 (pre-programme) and Jan–March 2012 (post-programme). Although there were some marked differences between pre-post test data and between wards/departments, the organisational changes occurring at the time of this data subset make it impossible to attribute any of the changes observed (positively or negatively) to the HeartMath intervention.

Complaints

The full list of complaints from each pilot area was reviewed, and only those specifically relating to the

Table 4

Organisational quality	Pre workshop	Post #2 workshop	% change
Question	%	%	
I am proud of the company I work for	48	54	6
My efforts make a big difference in my organisation	50	60	10
People where I work feel free to express their opinions	24	38	14
I am always highly productive	52	64	12
I feel pressed for time	65	45	20
I feel like leaving this organisation	28	12	16

professions of Trust staff who had attended the HeartMath programme were included (eg in relation to outpatient department complaints, only those specific to outpatient reception staff were considered). No significant differences in frequency/type of complaint from service users were noted across the two time periods.

Blood pressure

The Trust's occupational health service had made a nurse available to take blood pressure readings for staff attending the training. However, no formal follow-up data is available, mainly because too few staff attended for a follow-up appointment. There are, however, some anecdotal reports from a small number of staff who rechecked their own blood pressure in ward areas and noted a decrease.

Summary and recommendations

The HeartMath Revitalising Care programme in the Barts and The London NHS Trust resulted in some significant benefits for staff who participated. There was a strong trend of improvement between pre- and post-programme measures on a range of personal health and well-being factors including fatigue, anxiety and depression. The slight trend of improvement in some organisational factors was not significant, possibly because evidence for such changes is not typically evident until there have been several months of sustained programme provision.

There were no positive or negative trends attributable to the HeartMath programme in other internal measures (eg sickness absence, turnover and complaints).

On the basis of the project evaluation, the following recommendations were suggested:

- continued provision of the HeartMath Revitalising Care Programme
- considering ways of targeting staff and developing optimal approaches for delivery of the programme, including:
 - embed the course into the Trust's overall staff learning and development programme rather than using a ward-focused model
 - target groups for particular staff (eg staff in leadership roles, staff providing direct clinical care)
 - further adjust the content of the HeartMath Revitalising Care programme (in collaboration with HeartMath) to make it more resonant for a UK staff population
 - manage internal resources to support further training opportunities
 - position the HeartMath Revitalising Care programme in a broader context of initiatives aimed both at improving staff health and wellbeing, and progressing organisational development.

Further discussions are now underway in the recently merged organisation to consider implementing these

recommendations. In view of the Francis Report's recommendations the NHS as a whole will be considering how best to support staff resilience and underpin the provision of compassionate care.

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BHMA Student Essay Prize £250



The British Holistic Medical Association prize of £250 will be awarded to the undergraduate health-care student who submits the best 1,500 word essay entitled:

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Coherence, care and inspiration: The power to heal organisations and ourselves

Bruce Cryer

Global Director, HeartMath Healthcare;
Director, HeartMath UK

I have had an interest in complementary approaches to health for 40 years and have worked extensively in the fields of resilience, stress reduction and emotional wellbeing through the US-based Institute of HeartMath, where I was a founding director in 1991. I have consulted to the NHS in both London and Glasgow implementing research-based programmes to not only utilise innovative stress reduction techniques and technology to improve cardiovascular and cognitive function, but also to improve the quality of patient care. My own resilience skills were put to the test in 2009 when I was diagnosed with Stage I bladder cancer, and later had to overcome MRSA and recover from double hip replacement. Now healthy again and thriving, I hope to inspire people to live fully in spite of the difficult challenges life can bring.

Summary

Organisations are asked to change like never before. Simultaneously the stress on many individuals is higher than ever. How can we expect to create sustainable compassionate organisations, particularly in the NHS, when the frontline providers remain under excessive pressure? New research, tools, technology and a promising pilot programme provide hope and inspiration.

Through my teenage years and well into my 20s, my deepest interests were in fostering social cohesion, peace, health, wellbeing, personal and spiritual development, and optimal performance. Some of these interests became a vocation in 1980 when I joined the executive team of a biotech company. But the overriding interest I held was in the power of one's emotional life to create joy or sorrow, happiness or pain, optimism or depression in all dimensions of our life. This interest inspired me in 1991 to join the founding team of the non-profit Institute of HeartMath when it was launched in the hills above Silicon Valley in California. Since then I have been privileged to help build programmes leveraging new understandings of human physiology, heart-brain interactions, positive emotion, and mind-body medicine.

I have found that being inspired by beauty in nature, music, poetry, acts of heroism, or a deep conversation, always gave me new energy and

fortitude to heal and to grow. Indeed over the past 20 years, the idea that positive emotions can play a significant role in health and wellbeing has gained widespread acceptance (see www.authentic happiness.sas.upenn.edu/Default.aspx). Research into the impact of cognitive behavioral therapy, mindfulness practise, positive psychology and the emotional intelligence asserts our emotional life plays an active part in the regulation of biological processes. The neurobiology of emotions and how they arise in the body and brain is being widely studied, and their effect on our risk of developing chronic disease, our longevity, our social support, our cognitive health, even our fundamental quality of life is increasingly understood.

The concept of coherence

Coherence implies orderly structure. It stands alongside other metaphors

like harmony and alignment. Coherence is something we seem to sense within and among systems – whether in atoms, organisms, organisations, or social networks. As a subjective experience, most people know what a ‘harmonious’ state feels like: moments where our hearts, minds and bodies are united in a sensing of wholeness. This state has been called ‘the zone’, ‘flow’, ‘oneness’ etc, and typically when we are in such states we feel connected not only to our deepest selves but also to others, even to the Earth itself. We may feel inspired. At HeartMath we have come to call this state of internal and external connectedness *coherence*.

Programmes aimed at enhancing staff resilience can increase patient satisfaction

The coherent heart rhythm of positive emotions

Yet coherence, we have learned, is more than just an apt metaphor; for we have found it to be something measurable, and that its effects can be gauged for instance in terms of how it impacts on organisational efficiency and patient care, as well as individual self-care and health. The Institute of HeartMath introduced the terms *cardiac coherence* and *psychophysiological coherence* in the early 1990s to describe the degree of order, harmony and stability in the various rhythmic activities within the human system over a given time period (Tiller *et al* 1996). This harmonious order signifies a *coherent system*, whose efficient, optimal function is directly related to the ease and flow in life processes. By contrast, an erratic, discordant pattern of activity denotes an *incoherent system* whose function will reflect stressful and inefficient utilisation of energy in life processes. Testing our early theories that positive emotions would lead to measurably more coherent internal processes for people, we learned that positive emotions such as appreciation and compassion are indeed reflected in a heart rhythm pattern that is more coherent (McCraty and Childre 2004) (see Figure 1).

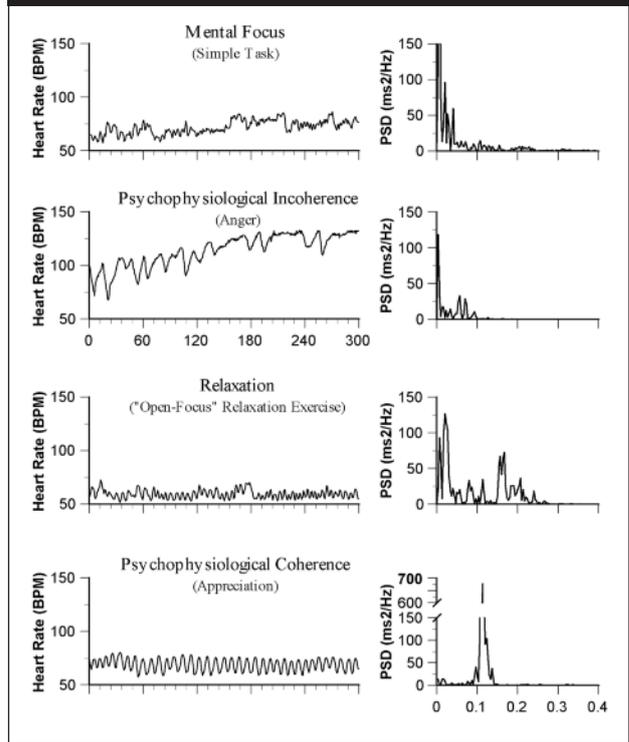
The left-hand graphs are heart rate tachograms which show beat-to-beat changes in heart rate. To the right are the heart rate variability (HRV) power spectral density (PSD) plots of the tachograms.

Mental focus is characterised by reduced HRV activity in all three frequency bands of the HRV power spectrum.

Anger, an example of psychophysiological Incoherence, is characterised by lower frequencies in the PSD plots, more disordered heart rhythm pattern and an increasing mean heart rate. As can be seen in the corresponding power spectrum, the PSD plot during anger is primarily in the very low frequency region associated with increased sympathetic nervous system activity.

Relaxation on the other hand results in less higher frequency lower amplitude activity, indicating reduced sympathetic autonomic outflow. And in this case, there is

Figure 1: Emotions are reflected in heart rhythm patterns



also increased power in the high frequency region of the power spectrum, reflecting increased parasympathetic activity. (This is a typical PSD plot for the relaxation response).

Psychophysiological coherence is a functional mode measured by heart rate variability (HRV) analysis wherein a person’s heart rhythm pattern becomes more ordered and sine-wave-like at a frequency of around 0.1 Hz (1 cycle every 10 seconds). This state can be maintained by a combination of slow breathing and sustained positive emotion (in this example ‘appreciation’). This results in a highly ordered tachogram with a sine-wave-like heart rate variability pattern and, in the corresponding power spectrum, a large, narrow peak in the low frequency region, centred around 0.1 Hz. (Note the scale difference in the amplitude of the spectral peak during the coherence mode). This PSD pattern indicates increased synchronisation of the sympathetic and parasympathetic nervous system, and system-wide resonance due to entrainment between the heart rhythm pattern, respiration, and blood pressure rhythms. Though the coherence mode is also associated with increased parasympathetic activity – a key element of the relaxation response – it is physiologically distinct from relaxation in that the system is oscillating at its resonant frequency. In this coherent state there is increased harmony in heart–brain dynamics with enhanced synchrony of higher-level brain function and of the two branches of the autonomic nervous system (ANS). Simply put, coherence feels good, at least in part because our entire system becomes calmer and begins operating more efficiently.

Resilience

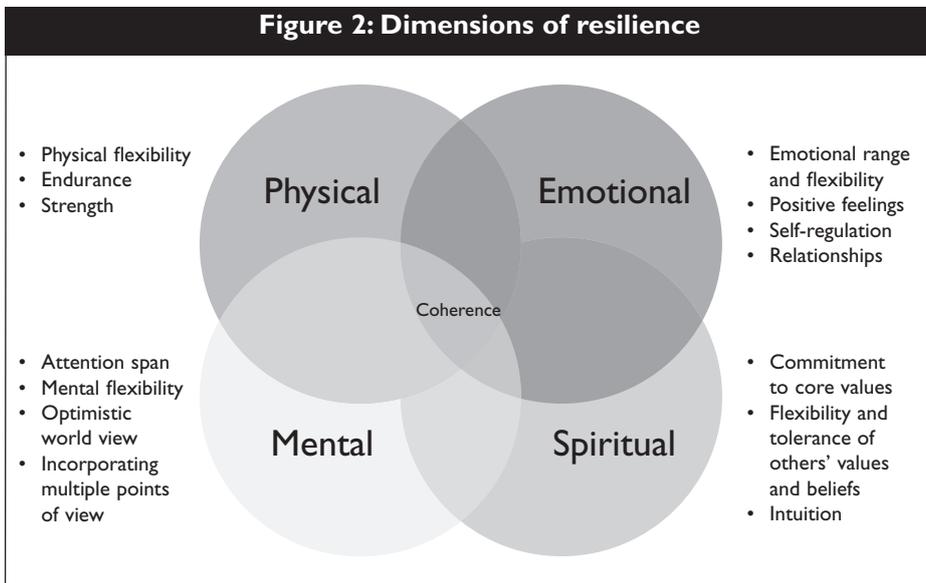
Some people apparently thrive even when conditions are harsh and pressures are high; though their life might be full of personal and professional change and difficulty, they seem to cope and recover more quickly. A considerable amount of research into stress suggests that such resilience is linked with a certain balance in the nervous system and with positive emotional wellbeing. Together these qualities sustain high performance at work and play, and so as stress and pressure mount in organisations, this capacity for resilience has become increasingly relevant; and crucially they want to know what erodes it and how it can be enhanced not only within individuals but across whole organisations. It is now clear that resilience is largely dependent on individuals' self-management, in the sense of their efficient use of energy resources across four domains; physical, emotional, mental and spiritual (see Figure 2).

resilience is characterised by a more rapid recovery after challenging situations, and a damping down of unnecessary or excessive stress reactions (eg frustration, impatience, anxiety) that would otherwise deplete our resources across all these domains.

Heart rate variability coherence

The naturally occurring changes in beat-to-beat heart rate reflect especially the functioning of the ANS, whose flexibility and adapt-ability exert a fundamental regulatory effect on all body-systems. It is well understood that too much ANS instability is detrimental to efficient physiological functioning and energy use but also that too little variation indicates depletion or even, pathology. Heart rate variability (HRV) analysis is now recognised as an excellent tool for assessing wellbeing, because neurocardiac function accurately reflects heart-brain interactions and ANS dynamics. The amount or range of overall HRV correlates

to a degree with age, younger people having higher levels than older ones. Low HRV is a strong and independent predictor of future health problems, including all causes of mortality, and it is associated with numerous medical conditions (May and Arildsen 2011). HRV is also an important indicator of psychological resiliency and behavioural flexibility as well as the ability to effectively adapt to changing social or environmental demands (McCraty *et al* 2009a). Hence HRV is in some sense a complex measure of the heart's interactions with multiple body systems. HeartMath sees this heart-brain relationship as



- *Physical resilience* is reflected in physical flexibility, adaptability, endurance and strength.
- *Emotional resilience* is reflected in one's ability to be inspired, to self-regulate emotions, along with building and sustaining relationships.
- *Mental resilience* is reflected in our attention span, mental flexibility, an optimistic worldview and ability to integrate multiple points of view.
- *Spiritual resilience* is associated with our commitment to core values, intuition, and tolerance of others' values and beliefs.

I would say that for myself, the fuel which creates and sustains my own resilience is *inspiration*. And in the HeartMath model this combination of coherence and feeling inspired, by increasing physiological efficiency and favouring the alignment of mental and emotional systems in turn supports further accumulation of resilience across all four domains. We have found that a high level of

critical to healthy mind-body functioning and so to overall wellbeing.

Heart rate variability coherence feedback

Heart rate variability coherence feedback can be used to learn self-regulation skills. Several HRV coherence training systems are increasingly used in healthcare, law enforcement, corporate, military and educational settings. Four systems – the three emWave and Inner Balance (iOS app) technologies available from HeartMath and another system from Wild Divine – can display heart rhythm in real time and record the levels of coherence achieved in real-time. Effective HRV coherence feedback has been shown to significantly improve outcomes in clinical populations with PTSD, depression, asthma, congestive heart failure, hypertension, anxiety, fibromyalgia, and insomnia (McCraty and Tomasino 2006a).

Research studies on coherence, cognitive performance, wellbeing, and safety

Coherence training also improves performance in a wide range of cognitive capacities, both short- and long-term. Examples include eye–hand co-ordination, speed and accuracy, and co-ordination in various sports as well as in tasks involving executive functions, focus and concentration, problem-solving, self-regulation, and abstract thinking (Bradley *et al* 2010). Coherence training has also been shown to improve overall health (including cardiovascular function) and well-being (McCraty and Tomasino 2006b).

- **ADHD and cognitive performance:** A UK study directly assessed cognitive performance in middle school students with clinically diagnosed attention deficit hyperactivity disorder and found a wide range of significant improvements (Lloyd *et al* 2010).
- **PTSD:** A US study conducted at a Veterans Affairs facility with soldiers who had recently returned from Iraq and had been diagnosed with PTSD found that a relatively short period of coherence biofeedback training resulted in significant improvements in cognitive functions, especially in the ability to self-regulate and inhibit negative responses, which correlated with coherence measures (Ginsberg *et al* 2010).
- **Stress and health care costs:** A US study of correctional officers with high workplace stress found reductions in total cholesterol, glucose, and both systolic and diastolic blood pressure, as well as significant reductions in overall stress, anger, fatigue and hostility with projected savings in annual health care costs of \$1,179 per employee (McCraty *et al* 2009). (Numerous additional employer-led studies in the US have shown similar health cost reduction benefits.)
- **Congestive heart failure:** A Stanford University study of patients with congestive heart failure showed significantly improved functional capacity and reduced stress and depression (Luskin *et al* 2002).
- **Diabetes:** A study of diabetes patients found improved overall quality of life and glycemic regulation, which correlated with use of the self-regulation techniques (McCraty *et al* 2000).
- **Lowering negative mood:** An analysis of the combined psychometric data from 3,129 matched pre-post coherence trainings found that fatigue, anxiety, depression and anger were reduced by almost half (McCraty and Childre 2010).
- **Medical safety:** A US workplace study conducted with 220 pharmacists across multiple locations found a reduction in medical errors ranging from 40% to 71% (HeartMath 2009).

Pilot results within the NHS

The Institute made the significant discovery that coherence associated with positive feelings such as appreciation, compassion, care and love has an impact beyond the individual experiencing them. It appears to entrain coherence in the object of these feelings too (Morris 2010). If this can be corroborated in further studies it would have obvious importance in any healing context: perhaps this might even be a physiological basis for the common experience that the presence of a genuinely caring and attentive caregiver feels much more ‘healing’ than dealing with a stressed caregiver who is under pressure, or who though well-intentioned is simply following a script for ‘patient care’. In my own two-year healing journey, I experienced the full spectrum of patient care and human emotions: some of the caregivers were extremely coherent, and therefore comforting and reassuring to me through each phase of surgery, testing, diagnoses, waiting, treatment, and healing. Unfortunately the presence of some others, who seemed less well-aligned with their career choice, only increased my anxiety. It would come as no surprise, given that stress can slow healing processes, if stressed caregivers exerted a similar effect by triggering stress responses in their patients. Likely as this seems, more research is yet to confirm this notion.

What is already established however is that programmes aimed at enhancing staff resilience can increase patient satisfaction and reduce medical error. The HeartMath Revitalising Care Programme has been used in a variety of hospital settings in the US, including the Mayo Clinic, Stanford University Health System, Duke University Health System, and Kaiser Permanente Medical centres. In the UK HeartMath has been introduced into large companies including Shell, Unilever, and GlaxoSmithKline. However, the HeartMath Revitalising Care Programme at Barts and the London NHS Trust, sponsored by chief nurse Kay Riley, was the first time that this programme has been piloted in an acute hospital setting in England. Evaluation of this pilot (which is summarised elsewhere in the issue of *JHH* – see page 23) showed improvements in all of the categories around personal stress and wellbeing. In eight of the ten categories these changes were statistically significant, with *fatigue* and *calmness* showing the greatest evidence of change. (The potential implications of these last two items on patient care should be noted.)

Previous HeartMath intervention studies have demonstrated improvements in personal stress and energy factors, especially so once the programme has been implemented more broadly across an organisation. Yet even on this small scale the significant changes made in all areas of this table suggest improvement not just to participants’ wellbeing and quality of life but also to their potential effectiveness.

Kay Riley had this comment about the programme: ‘I have always believed that to care for our patients to the highest standards, we must first properly care for our staff. The results of our HeartMath pilot strongly support this

concept; the outcomes are more impressive than any staff stress management or self-care programme that I have previously come across.’

A second pilot programme using HeartMath has already begun to build on the success of the first. It was completed in several NHS facilities in Scotland, through the sponsorship of chief nurse Ros Moore, and chief health professions officer Jacqui Lunday, and led by Choice Dynamics International. Results are not yet available.

We have found that HeartMath techniques and technology help enhance positive emotion, inspiration and coherence. These methods can bring significant benefit to individuals and perhaps especially to those providing frontline care, and both directly and indirectly to their patients. At a time when our organisations and indeed our entire society need to nurture caring in ways that are practical and sustainable, the HeartMath approach deserves serious consideration.

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An idea

James Fleming

The Green Dreams Project

After working as a GP in Padiham near Burnley for some years I set up The Green Dreams Project to help patients who need multi-agency support for long-term unemployment, isolation and reduced life skills, but who are unable to co-ordinate this help themselves. As part of our work we also try to develop the community to increase the number of social assets available for residents. We take referrals now from around 50 GPs in seven towns after joining with Lancashire Care Foundation Trust and receiving support from The Prince's Charities.

Summary

This is the story of how a moderately sized social enterprise has been set up by a GP who saw a gap in service provision for his patients who were isolated, unemployed or needed support with life skills. It is this GP's life's work. He is fascinated by how much more than the contractual requirements a GP practice can add to its community. The work of the social enterprise is explained along with the outcomes and plans for the future.

Introduction

Once upon a time I had an idea during afternoon surgery. This idea is now a social enterprise with five full-time employees, a larger team of around 12, and coverage of seven towns across East Lancashire. We are the Green Dreams Project Community Interest Company (CIC).

Realising this idea has been brilliant. I have had to learn how to create appropriate governance and safety procedures, how to train staff to do something new, how to do payroll, accounts, contracts, website creation and management, and how to procure funding. As well as more than 50 stakeholders, I have developed working relationships with the College of Medicine, The Prince's Charities, the Department of Health, representatives from the Cabinet Office and the local CCG, merged with a Trust, and undergone an evaluation of our service from the University of Central Lancashire.

The team at Green Dreams has seen hundreds of patients who other agencies were unable to help. We have got people back to work, into volunteering and re-integrated into society; firmly linked GP surgeries to their local communities; caused reductions in GP appointments, anti-depressant and anxiolytic prescribing; built an open-air theatre, gardens for eco-therapy and groups for the elderly and isolated. We have developed referral routes from GPs, persuaded them to evaluate the service at their surgery themselves to remove bias, linked with local job centres and

developed a way of using and creating social assets without creating dependency.

Whatever I was doing, it was not working

Six years ago I had not heard of things like this. I did not properly understand the terms social asset, integrative medicine, dependency, identity or resilience, nor had I any appreciation of why unhappiness was different to depression. I had never heard of a Community Interest Company and with hindsight, despite being a GP I realise that back then I knew very little about my local community.

What I did know was that whatever I was doing, it was not working. I saw patient after patient who required a sick note as a means to survive and I was unable to work out what else to do other than give one. Before everyone writes in with suggestions, forgive my then ignorance – I was young. Typical presentations that left me feeling redundant and uneasy would be 'I've come for my sick note' or 'The Job Centre's told me to get a sick note'. Usually this would be for depression, at which point I would attempt to treat the depression with either medication or counselling. What occurred to me very early on was that if your life is terrible, it will still be terrible after you are on the medication. You can talk about it all you want at counselling but it will still be terrible.

It is well-recognised that psychosocial problems are common in the GP setting, affecting the health of

34% of patients in some studies (Gulbrandsen *et al* 1997). They can manifest as chronic pain or mood disorder (Cawston, 2011) or other physical or psychological complaints in over two-thirds of those social problems (Popay *et al* 2007), particularly concerning welfare benefit and housing problems. Because of factors like time constraints studies show that a lot of social problems would be better dealt with by voluntary and community sector organisations (Cawston 2011). As well as providing further support for patients this also strengthens the relationship that the GP practice has with the local voluntary sector. This is one of the central themes of Green Dreams; if we all work together, appropriate help is easier to find and resources for patients are widened in their scope.

First steps

This was the point where I started to use the influence I discovered I had as a GP to change things. If someone could not read or write and did not have the confidence to attend a course, I began ringing round to find someone to teach them locally. If someone was living in a squalid rental property and it was affecting their and their children's health, I tried to change this. Very quickly I discovered how much there is out there for people if you know where to look. There is still a gap in services, and it is that gap we attempt to fill by helping those who need multi-agency care but who cannot engage with all the different agencies needed to enact change.

Inspiration

The transformation of the idea into reality began with a tour of innovative surgeries around the UK like Bromley by Bow to see what others had done in their surgeries in addition to normal duties, and work out if it was possible to do more than the work we as GPs are contracted to do. The answer is yes it is, if you are one of those people lucky enough to have a lot of energy. At this point I settled down a bit with the realisation that I had only been a GP for a relatively short time, and embarked on a long period of study in the area that so interested me. At the time I could not even define what it was that perplexed me, so I began an MSc in Primary Care at the University of Central Lancashire (UCLAN). This helped me to define the phenomena that I was seeing but could not put into words and there began the introduction to existentialism, identity, resilience, methodology and most importantly salutogenesis.

After the MSc I submitted a proposal for a PhD. I wanted to work out whether it was possible to introduce my ideas into a consultation model. The watershed moment for me was the preliminary meeting with Professor Tim Thornton. He became the catalyst. He said that my PhD proposal was too broad. After getting to know me he said 'why don't you just do it, instead of writing about it?' So I did.

Turning theory into reality

I applied for an award from Innovate Now North West based on an idea to employ someone as a co-ordinator in the practice. If I saw a patient who needed multi-agency help, but who was unable to co-ordinate that help themselves and was resistant to existing agencies, I would be able to send them to this new employee for help in life skills and pre-employment. The first employee, Polly Moore, is now the team leader at our offices in the town hall, which is directly next door to my practice.

In that first year Polly had about 180 referrals. We had to create her role from nothing and design every protocol and procedure from scratch because there were no precedents to follow. The success of this led to a merger with Lancashire Care Foundation Trust (LCFT) who seconded four people to Green Dreams, making up a team of five. Now Green Dreams employs three, LCFT seconds two, and there is a wider team of board directors, clinical supervision (LCFT) and teams for specific bids.

Service description

Now of course definitions and procedures are a lot tighter. Protocols are well defined, referral routes are clear, evaluations are uniform. Here's the detail:

The Green Dreams Project is accessible only via GP referral. The project is specifically for those patients who existing organisations are struggling to help. It exists to support those who are unemployed, those who are isolated, particularly the elderly, and those whose quality of life is so poor it has impacted on their health. This is particularly relevant for those who need multi-agency help but who are unable to self-refer to all the different agencies. The project also helps to develop the community as a whole, while integrating this work with primary care.

Our uniqueness is the triad of support that we have to offer:

- A programme specific to each patient can be designed to address need – this is **tailored co-ordinated care**.
- Because the patient has been sent to Green Dreams through their GP, we can then **marry health and social needs together**, and also measure the effect of what we do.
- We can also develop **new activities** using existing social capital and our own resources to support that patient. This contributes to community development.

Areas where we offer help

Examples of issues we might help with to improve a patient's medical status are:

- unemployment
- benefit issues
- help with documents
- isolation
- education and training
- debt

- low self-esteem/confidence
- housing
- reduced life skills
- information on community resources
- volunteering to provide a reference.

Outcomes

Monitoring

We monitor our progress very carefully using a wide range of parameters. We measure demographics, social health outcomes, GP reported health outcomes, and client feedback. What we ask referring GPs to look for in their own patient medical notes, independently of us, is evidence, in various formats, that Green Dreams will give: a perceived benefit to the patient, markedly decreased appointments at the GP, decreased appointments with mental health services, reduced anxiety, stopped or reduced use of benzodiazepines, stopped or reduced use of anti-anxiolytics, stopped or reduced use of anti-depressants, actively seeking of employment, better mental health. As you can appreciate, evidence of this kind is very hard to find, and we do ask for justification from the GPs sending in data.

Reducing bias

Recently we have received our first university evaluation from UCLAN, looking at our work over the last few months. This has been a very important moment for me because I do not want anyone to think we are modifying our figures to make them look good, and this report removes a great deal of perceived bias while confirming the validity of our existing figures.

Who gains?

The benefits of the Green Dreams approach to patients are defined by us in separate categories.

Gains for the patient are in the form of support to realise aspirations, the preparation for and transition to paid work if this is appropriate and particularly if this will contribute to better self-esteem, better engagement in the community (particularly important when identity issues are prevalent), better family relationships, a perceived 'way out' of a lifestyle that is not favoured by the client, improved life skills, and less medication. The solutions that we offer are local. This leads to better engagement due to trust and travel issues, and because by using local social assets the variety of help can be increased for less cost.

Gains for the community are that we bring together voluntary and non-voluntary caregivers to widen the scope of what the practice and the community can offer to residents, we integrate the trusted GP practice with all other caregivers which betters engagement and we set projects up to develop and enhance the community. The example of this of which I am most proud has been linking with the local Unitarian church and park to create

a garden for eco-therapy and an outdoor theatre, in an attempt to provide volunteering work for long-term unemployed people which can help them get paid employment. This has been supported by the Prince's Charities. The health benefits of community gardens and horticulture have been shown in numerous studies. They improve physical activity and nutrition, reduce depression and improve self-esteem and thereby contribute to social wellbeing (Wakefield *et al* 2007; Zoellner *et al* 2012).

Gains for the practice are less strain on appointments dealing with the reason for referral; we may see a twelve-fold drop in appointments with the doctor once the source of the problem is being tackled. We also see less anti-depressant and anti-anxiolytic prescribing which is important because it means clients are not being medicated unnecessarily and also because this is appropriate help for a social problem when medication is not necessarily the answer. Our work is an aid to a fit note when the GP thinks a patient might benefit from doing more. This can lead to less mental health problems.

Gains for the consortium are in meeting aims in *Healthy Lives Healthy People* (DoH 2010) the Coalition Government's White Paper response to Sir Michael Marmot's independent review *Fair Society, Healthy Lives* (Marmot 2010). The review set out how material circumstance, social environment, psychosocial factors, behaviours and biological factors must all be taken into consideration for health. *Healthy Lives Healthy People* asks for contributions to resilience, wellbeing and health inequalities and communities by tackling the wider social determinants of health. It encourages empowerment of individuals and communities.

Further benefits

It is useful to bear in mind that our clientele represents a group who are struggling to make use of existing agencies. Of the last 170 patient we evaluated, 7 people got back to work and off benefits, 13 became work ready, 18 started volunteering; 56 received on-going weekly support from our groups; 73 became financially more stable; 46 (27%) had demonstrable benefits recorded in their GP medical notes after our intervention. This type of GP data was submitted by their own GP independently of us. 34 (20%) had markedly decreased appointments after our intervention; 15 had better mental health; 2 had an intention to self-harm prevented by our intervention.

Comments in the patients' medical notes written by the GP after our intervention are:

- increased self-esteem through Green Dreams
- Green Dreams has kept [the patient] going
- generally a lot more positive
- Green Dreams is an amazing idea and a much needed support service.

Comments from beneficiaries are:

- I feel invigorated after much disappointment, especially in terms of earning a living again

- I can now see a future
- I have the support to face the challenges and obstacles that I have to overcome. You have identified my needs and supported me to achieve them. This has given me hope, reassurance and courage.

Next steps

A group containing the Green Dreams Project, Lancashire Care Foundation Trust, The Prince's Charities and local partnerships is working together to create a payment by results scheme to finance Green Dreams from 2014 onward. It is our hope that this will lead to expansion of the project over a wider area.

The other important step for Green Dreams has been the creation of separate projects allied to our main work that support the organisation as a whole. An example of this is the creation of elearning modules which we intend to present to the Royal College of General Practitioners and the local medical school to try to introduce our work into both curriculums. Being GP-led we hope that the modules will be appropriate for use in these settings. This will hopefully help to fill the gap in service that we spend all our time trying to fill.

Conclusion

It is difficult pushing the boundaries. You have to have a fairly thick skin, but the rewards of innovation are immense.

With planning and energy, it is possible to create a new service to support patients if there is a perceived need. Support is out there, and once the ball is rolling it becomes easier and easier to continue the work.

I have been particularly lucky to work in an area of the country – East Lancashire – where the CCG is innovative and supportive of new work. Without its support Green Dreams would not have been possible. I have also been lucky to have the support of The Prince's Charities whose unique convening power has enabled me to meet people and organisations I would otherwise have never been able to.

In my opinion the key to any new work is creating a large team to work with you and basing your work on evidence of need and evidence of effect.

Glossary

Wellbeing: 'Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, security, rewarding employment and a healthy and attractive environment' (Steuer and Marks, 2008).

Social enterprise: a business with a social or environmental purpose.

Community Interest Company: one type of social enterprise where any profits must be re-invested into the community. They are created with an 'asset lock' which states for example that any assets left over if the company ceases trading cannot be taken by Directors.

Social asset: something in the community that has a value that is not monetary, like support from neighbours.

Dependency: in the context of this work, it is providing support to a client to the degree that they begin to rely on it. The client is therefore not empowered.

Integrative medicine: combining conventional medicine with alternative care to benefit the patient.

Identity: how we define ourselves i.e. religion, culture, ancestry, status, achievement, participation etc.

Resilience: the ability to cope with stressful situations or crises, to adapt well in the face of tragedy, change and increased responsibilities.

Salutogenesis: the opposite of the pathogenic approach to health which deals with problems, salutogenesis focuses on maintaining and improving health.

Life skills: activities needed to function like reading, writing, ability to deal with all the forms that we have to fill in to function these days, self-care, care of others, looking after one's home, tackling the job market, i.e. any skill needed to function in the modern worlds.

Ecotherapy: healing and development via working with the outdoors, usually taken to mean in a facilitated environment.

Payment by results: a scheme set up to repay an organisation based on the savings it makes, in this instance for the government.

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The labyrinth: Reclaiming an ancient spiritual tool for a modern healthcare setting

Revd Lizzie Hopthrow

Since I stumbled by accident upon a labyrinth in the late nineties, I have been inspired to offer the labyrinth to the community. Working with the labyrinth in the holistic environment of a hospice showed me that though we may not be terminally ill, we are all, to some extent, dying of some grief, hurt or block within and that the labyrinth holds the potential to touch our deepest selves in a healing and transformative way. Now I offer workshops and retreats at The Quiet View where I live.

A labyrinth is an ancient spiritual tool that is being reclaimed in the modern world as a tool for contemplation. Particularly useful in any healthcare setting, Pilgrims Hospices in east Kent have used different forms of labyrinths with patients and carers as they have been found to be calming or enlightening. The Department of Health has funded a labyrinth as part of a therapeutic labyrinth garden. This article reports on Pilgrims Hospices' experience as an encouragement for other hospices and hospitals to provide a labyrinth as a part of the spiritual care offered to not only patients and carers but also staff and volunteers.

Defining a labyrinth

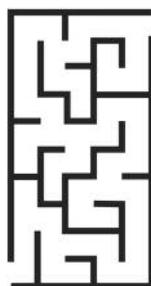
A labyrinth is a single path that winds to a central point and out again, unlike a maze which has dead ends and false starts and so can induce anxiety because it is difficult to find your way. A labyrinth, however, frequently induces spiritual or emotional calm and can help in decision-making. It is a timeless mystical and spiritual tool that is poignantly relevant to people approaching death and their loved ones coping with bereavement. Many people find their burdens are lifted and they are able to begin, at least, to let go of their grief. Although our

experience has been mostly within a hospice environment we have used the labyrinth in a variety of situations and have discovered that it serves as a potential benefit for anyone with any kind of problem or inner pain.

An ancient phenomenon that can be found across many cultures and faiths, a labyrinth also appeals to people of no faith at all. Based on the ancient ideas of pattern and spiral, the winding nature of a labyrinth draws us not only into the centre of the labyrinth itself but also into the centre of our selves. There we may face our deepest fears, hopes or longings and there is the place of inner healing or enlightenment. For the religious, we encounter the light of Divine love that shines in our darkness and for the non-religious a spiritual experience that may also be of profundity is not unusual.

Currently there is a worldwide resurgence in labyrinth building and usage and Jeff Saward in his research has found that the use of labyrinths is reborn every 200 or 300 years, usually at a time of some kind of break down in society (Saward 2003). Working with hospice patients we have discovered deep spiritual needs that are not often met by organised religion but are sometimes met in the mysterious path of the labyrinth. This seems to coincide with a spiritual hunger in society.

Walking a labyrinth may bring mind, body and spirit into balance and for those who are open to its possibilities, may be the way to a new sense of self, direction or inner peace. It may also be the path to reconciliation with others, or the world we live in or our life situation.



Maze



Classical labyrinth

Labyrinths are divine imprints. They are universal patterns most likely created in the realm of the collective unconscious, birthed through the human psyche and passed down through the ages. Labyrinths are mysterious because we do not know the origin of their design, or exactly how they provide space that allows clarity.

Lauren Artress (2006a)

Historical context

Labyrinths date back at least 4,000 years. The classical design has been found on ancient pottery, parchments, clay tablets, coins, and rocks. In South America, Egypt, Syria, Spain, Greece, Iceland, Scandinavia, Sardinia, China and India there is evidence of this mysterious phenomenon appearing across diverse cultures of the world. The history of labyrinths is very long, complex and wide-ranging and the books and website of Jeff Saward are recommended.

The origin of the design is unknown, but in reclaiming the labyrinth for the modern world we are tapping into a mystery that was birthed in prehistoric times. In Nordic countries there are many labyrinths laid out with stones. These were probably walked by seamen in the Dark Ages before taking to the sea as a blessing on their voyage. Many have been restored in modern times.

In the Middle Ages however, a significant development took place in the history of labyrinths. During the Crusades, when Christians were unable to pilgrimage to Jerusalem, a more complex design was built into the floor of the naves of some of the great European cathedrals, most noticeably in Chartres, France. Christians would thence make their pilgrimage, often journeying through the labyrinth in penance, on their knees. The Chartres medieval design is divided into four quadrants with a path of eleven concentric circles to the centre which takes the form of a rosette. There is much symbolism attached to the design and a full explanation will be found in the writings of Lauren Artress (2006b). The six petals at the centre, for example, may symbolise the six days of creation.

Many 17th century English turf labyrinths have been restored and are available to visit today. Today, both classical and Chartres design labyrinths are being built all over the world as organisations, both sacred and secular, are discovering their potential for inner healing and positive change. A labyrinth is added to the worldwide labyrinth locator every day!

Within Pilgrims Hospices we work with the classical design of labyrinth because it transcends all religious and cultural boundaries but is also inclusive of any religious tradition. It is also less complicated to walk which suits the context of working with people with decreasing physical ability.

Therapeutic benefits of walking a labyrinth

A labyrinth has been described in many ways, including a meditative walk, a spiritual journey, a path of prayer, a way of contemplating or a metaphor for our lives. Each person finds their own way round the labyrinth and there is no right or wrong way to walk. When a labyrinth is walked, the analytical left-hand side of the brain gives way to the more intuitive right-hand side and we are led by the path away from stressful thoughts into stillness. The labyrinth leads us into the spiritual part of our being and gives us the potential for inner transformation.



Being pushed in my wheelchair round the labyrinth by my husband, together we found that it was the most spiritual and magical thing we have ever experienced. I have Motor Neurone Disease ... and the feeling of inner calm and love made us both feel complete. It was thought-provoking and awe-inspiring, also something we could share together.

Patient

Over a period of more than five years, we have witnessed in Pilgrims Hospices many changes experienced by those who have walked the labyrinth and it has been our privilege to share in some very emotional encounters. Most people have spoken of the calm they have felt; many have been taken into the deepest part of their grief and have spoken of the cathartic nature of that experience. Some have wept and have said that they don't know why. Others have discovered an answer to a problem or received a creative idea. Burdens of guilt have been lifted and the pain of bereavement has been eased. Joy and hope have also been felt and all of these experiences have clearly been real and at the same time mysterious.

It takes me from the horrors of this world to a place where it is peaceful and calm. It's peace in a different way to watching the telly – peace in a way you can't describe or find anywhere else.

Patient

A labyrinth walk may be divided into three parts – the walk to the centre, arriving at the centre and the walk out again.

Lauren Artress has helpfully incorporated teaching from the Hebrew scriptures into a way of walking the



labyrinth that relates closely to its three parts. She offers us the four Rs based on the *Via Positiva* (Blessing), *Via Negativa* (Emptying), *Via Creativa* (receiving the creative spirit) and *Via Transformativa* (the transformed person returns to the world to transform it). At Pilgrims we call the three parts Releasing, Receiving and Returning (or Resolving) as Lauren Artress suggests. (Because of the end of life context in which we work and also time constraints, we usually leave out the first R – Remembering – remembering our blessings before we begin the journey into the labyrinth).

As we walk towards the centre we may become released from stresses and strains, hurts or concerns that cause us tension or emotional or spiritual pain. We let go of anxious thoughts or situations and may enter into prayer. At the centre we pause to receive – a blessing, peace of heart, a moment of relief or enlightenment, a deep sense of calm, a creative idea or a resolution. On the way out again we return to the world taking with us our experience of the labyrinth.

The labyrinth is an archetype of transformation. Its transcendent nature knows no boundaries, crossing time and cultures with ease. The labyrinth serves as a bridge from the mundane to the divine. It serves us well.

Kimberley Saward, Former President of The Labyrinth Society

Christianity and the labyrinth

In 2001, 72% of the population of Britain told the census that they were Christian and yet 66% of the population have no contact with organised religion or church (Crabtree 2007). This is born out in my work as a hospice chaplain as, over several years, countless patients have said, 'I don't go to church but I believe in God, or 'I don't go to church but I say my prayers every night'. In the western world where, in modern times, material values have often taken precedence over spiritual values, spirituality has become a popular concept.

The inclusive nature of the labyrinth welcomes all and there are many ways in which the labyrinth may be used as a tool to help to reconcile humankind's spiritual hunger especially for those experiencing illness or uncertainty. Reclaiming the labyrinth as a means to meditation, contemplation or prayer is a gift to the modern world and its resurgence provides a path on which the unconditional love of God for every human being may be experienced

not only in the head but in the heart, where perhaps the greatest potential for transformation exists.

For Christians, the labyrinth serves as a heart-opener to the tender, healing love of God, shown through Jesus Christ, for all his people on earth. It breaks through the thin veil that separates heaven from earth and brings the beautiful spiritual gifts of peace and joy to those who seek them.

I entered the labyrinth – fully expecting to be in tears by the time I entered the middle circle. But instead, I felt joy and peace about a situation that I had been thinking about and was on my mind. I feel settled about the things that were troubling me – and feel God's peace.

Visitor

Development of project within Pilgrims Hospice

Making clay finger labyrinths in the day hospice inspired patients to request that we make our own indoor fabric labyrinth that they could walk, albeit often with mobility aids. So many reported therapeutic benefits, especially experiences of calm and peace that it became clear we needed a permanent labyrinth that could be accessed at all times by anyone.

With funding from the Department of Health, a therapeutic labyrinth garden was built and is now used by groups of day patients, carers, bereaved loved ones including children, staff, volunteers and, of course, patients and their families from the ward. The labyrinth itself has a path wide enough for wheelchairs. Finger labyrinths are also available for patients in their beds. An added benefit is that individuals and groups from the wider community are able to use the labyrinth and this is building valuable links between the hospice and the people in the surrounding area, thus helping to break down barriers around the concepts of death and dying.

Pilgrims have created the first permanent labyrinth in a UK hospice and we are keen to share our knowledge and experience with other healthcare professionals. Labyrinth facilitator training is available through our education department and these courses are led by the chaplain and supported by trained volunteers.

Potential for use of labyrinths in healthcare settings

Other hospices are now exploring the possibilities of having a permanent labyrinth made and it would be worth any healthcare provider submitting proposals to commissioners and boards of trustees. Fabric labyrinths are naturally considerably less expensive and can be made to accommodate the size of a specific space out of a variety of materials and in many different ways. Laying out a fabric labyrinth in a chapel in which religious artefacts had been removed is a way of welcoming people into the mystery of the labyrinth. Any other sizeable space would of course work too but it helps to beautify the space with

flowers and candles for example. The labyrinth is a sacred space and is helped by being 'set aside' as such if only temporarily.

Providing finger labyrinths for use on wards is another possibility. Wooden ones are expensive and may not pass infection controls but finger labyrinths made from perspex are now coming onto the market. Drawing labyrinths onto paper or card can be both therapeutic for the creator and also the one who 'walks' it.

The labyrinth also provides a helpful way for health-care staff to let go of stress and chaplains who have responsibility for the spiritual care of staff could find the availability of a labyrinth beneficial. Group walks for staff would be advantageous not only as a means of relaxing, praying or seeking guidance, but also as team-building exercises. I know of a surgeon who regularly walks the labyrinth as a preparation for his day's operating list.

The labyrinth revival reflects the need for a more holistic paradigm... Having seen what I have seen and knowing what I know, it is hard for me to imagine that any thoughtful and progressive architect or planner would conceive of a new church, retreat centre, spa or healthcare facility, without including a labyrinth.

Robert Ferré, labyrinth designer and builder, 2003

Conclusion

When our permanent labyrinth was built, a member of staff said, 'I wonder how that will change the spiritual life of the hospice'. We have yet to realise its full potential, but undoubtedly countless patients and their loved ones have already been helped through a painful part of their life's journey. More staff are walking it or becoming aware of it and the therapeutic labyrinth garden is drawing people into this new sacred space that mysteriously calms and strengthens many of them. The labyrinth is a spiritual tool that is always old and always new.

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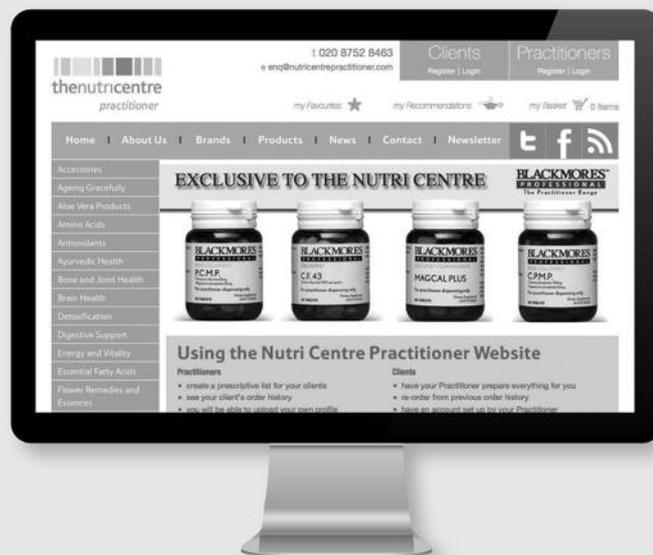
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This is an edited version of an article that first appeared in *The Journal of Health Care Chaplaincy*, vol 10, no1, 2010.



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Compassion in healthcare

Report from the multidisciplinary conference hosted by the open section of the RSM and The Human Values in Healthcare Forum

Clio Kennedy Hutchison

Medical Student, King's College London

Paquita de Zulueta

*Honorary Senior Clinical Lecturer, Imperial College London;
Chair, Human Values in Healthcare Forum*

William Osler said 'the good physician treats the disease, whilst the great physician treats the patient who has the disease'. Osler understood the true therapeutic encounter to be a meeting of unique individuals. And I think we can also infer from this famous quote that he is also invoking the idea of compassion: compassion as a ... 'deep awareness of the suffering of another coupled with the wish to relieve it'. (Chochinov, 2007). In this profoundly systemic and humane view of medicine, compassion is integral to the holistic treatment of patients as unique individuals, and the doctor's ability to support them and their family members and friends. Consequently, compassion should be a crucial element in healthcare education and practice. But, as many a headline has demonstrated of late, this is clearly not the case. Could it be that our current climate of 'healthcare delivery' ruled by the QOF, quotas, targets, cuts, assessment-gear learning and ever more biomedically oriented medical training, makes it more difficult to work compassionately?

The conference, in addressing the tensions between medicine's timeless ethical and imperatives and the unfolding challenges of 21st century industrialised healthcare, brought together a diverse group of speakers. Together they explored compassion from philosophical, neurobiological, psychological, clinical and pedagogical perspectives. That so many viewpoints can now be brought to bear is perhaps a unique phenomenon of our time – and one which implies that inter-professional approaches will be needed for restoring compassionate

care to the health service.

Two divergent perspectives

The convenor, Dr Paquita de Zulueta, compared two divergent perspectives of healthcare organisations – one as a machine or business whose priorities are efficiency and commodification, and the other as a living human system with relationships and caregiving at the foreground. She proposed that the former system is in danger of dehumanising individuals and eschews compassion. Professor Paul Gilbert gave an evolutionary neurobiological perspective to compassion and explained how the three basic systems of emotional regulation in the brain need to be in balance. The threat system – the most powerful – can inhibit the affiliative system – essential for compassion – and can also restrict resourcefulness and creativity (the incentive system). He described two models for delivering healthcare: The first involves a top-down model, using targets as the driving force and threats to ensure an efficient service. The second incorporates a more holistic, patient-centred model, involving trust between patients and practitioners and between practitioners. He outlined evidence that the latter model enables compassionate care, benefits patients and improves health outcomes. Dr Alys Cole King showed us a film of different patients giving their stories of depression and attempted overdose and interviews with their family members. The film revealed how each person's experience is unique and requires individualised treatment. Film can also be used as a tool to raise awareness, break down barriers, develop empathy, and stimulate a sharing of perspectives – all-important aspects for developing compassionate care.

Compassion in education

Professor Jenny Firth-Cozens discussed compassion within the education of doctors, and Dr Ann Gallagher talked

about compassion in the education of nurses. Professor Firth-Cozens challenged the educational dogma of ‘professional distance’ and proposed that this leads to the idea that compassion is to be avoided and to students frightened into believing that to be ‘professional’ one must always remain emotionally detached. She suggested setting up Balint-style groups, with physicians coming together to discuss interactions with their patients and reflect on their responses. Such reflective groups would also enable students to process their emotional responses to patients before they start working as doctors.

Dr Gallagher took this a step further by suggesting that healthcare incorporates aspects of the Slow Movement, an ethos for life that values quality over quantity and encourages followers of the movement to take time over things of value. This would allow for more compassion towards patients, but also for practitioners to take care of themselves in the process. Feeling pressure to be constantly emotionally available and compassionate could lead to burn out amongst practitioners, particularly if they feel they are not fulfilling their duties in all areas. In order to prevent this from occurring, structures and systems need to be available to support nurses and doctors.. On the whole, however, evidence suggests that compassionate care benefits those who carry it out as well as those who receive it. Professor Ranaan Gillon gave examples of successful strategies to enable and achieve compassion. Dr Jocelyn Cornwell of The King’s Fund informed us about the Point of Care Programme, including the introduction of Schwartz rounds in the UK – multi-disciplinary Balint-style group discussions within hospitals. After this, delegates worked in small, facilitated groups, using an appreciative inquiry model, to generate key ideas as to how to achieve more compassionate care. One member from each team presented these at the plenary.

Emerging themes

Various themes emerged. These included:

- Making time to listen and reflect. Mindful communication. Presence.
- Improved training and resilience building.
- Responding empathetically to patients’ authentic needs and rights.
- Reduced wasteful bureaucracy.
- Constructive criticism, and learning from past mistakes.
- Using multidisciplinary Appreciative Inquiry conversations to develop creative strategies.
- The importance of teamwork, focusing on individuals’ complementary strengths.
- Using other resources available within the healthcare setting, such as the chaplaincy service.
- Respecting patients’ autonomy and dignity, and finding out from them what they need. Working with patients and their representatives to improve care.
- The importance of self-care, such that health professionals can maintain the resilience and motivation necessary to deliver optimal compassionate care.
- Leadership is key, and courageous, authentic ‘resonant’ leadership is required at all levels to achieve compassionate healthcare,
- A systemic approach is required for wholesale organisational change. This means engaging with leaders at the top level as well as fostering bottom-up grassroots’ initiatives. Individual and organisational changes need to occur concurrently, with the elimination of threats and a fear-based culture. Proposals to achieve this included consultations at all levels, interdisciplinary training, the cultivation of a no-blame culture and remembering to show compassion toward colleagues as well as patients.
- Compassion needs to be encouraged not just within healthcare settings, but also within the wider community, as this is central to human flourishing.

These were positive and useful ideas to leave with, all of which could be implemented in a variety of healthcare settings.

Most students are drawn to healthcare wanting to be the great physicians that Osler described. They see the role of the healthcare professional as treating and caring for patients, restoring health where possible and enabling quality of life. Unfortunately, there are many constraints and barriers to providing compassionate patient-centred rather than disease-orientated care, and this often leads to apathetic practitioners who forget why they were drawn to medicine in their youth. Conferences like these re-inspire that passion, as well as create the scope for forums of practitioners who share the same values and aspirations to work together in pursuing the goal of cultivating greater compassion and humanity in clinical medicine.

The content of this conference resonates with the words of Kleinman (2012):

‘The great failure of contemporary medicine to promote caregiving as an existential practice and moral vision that resists reduction to the market model or the clarion call of efficiency has diminished professionals, patients and family caregivers alike. Leaving out caregiving demeans the profession and leaves something hollowed of its humanity and moral values.’
We seek to remedy this failure.

Chochinov H (2007). Dignity and the essence of medicine: The A, B, C, and D of dignity conserving care. *BMJ*, 335: (7612).

Kleinman A (2012) Caregiving as moral experience. *The Lancet*, 380 (9853).

Sealed with a prayer

Is the NHS up for sale?

William House

Retired GP

Many people in England believe we have been taken for a ride. But this isn't an April Fool, it's for real. The Health and Social Care Act came into force on 1 April 2013 though many of the changes ushered in by the Act – such as the abolition of primary care trusts (PCTs) and of the strategic health authorities (SHAs) – were effectively implemented long before then. It is an extremely complex piece of legislation which claims to reduce bureaucracy, give more power to the people and end top-down political meddling in healthcare. However, there is already a proliferation of new institutions replacing those that were abolished, and employing many of the same staff. There have also been high-profile examples of local communities and the newly formed clinical commissioning groups (CCGs) being overridden: the fight over Lewisham Hospital A&E, Hackney out-of-hours service and the launch of 111 telephone system.

But the most intensely argued issue is whether this Act is really about 'privatisation'. Strangely, the media, including the BBC, have been very quiet. Except for *The Guardian*, the press and broadcasters seem to have taken government press releases with ministerial reassurances at face value. Argument among a relatively small section of the population has focused on whether CCGs will really be able to commission health services according to local need and in what they believe to be the best interests of patients. If large commercial healthcare corporations have open access to bid for providing services under EU rules they will have a big advantage. Then

the likelihood of small local providers, charities, consortia of complementary practitioners having anything other than a niche role in unprofitable areas is remote. From the Swedish experience of privatisation, public funds will be insufficient to provide anything close to the access we now have. Preventive care is always an early casualty when money is short, except where a new and lucrative early intervention market is found – usually long-term medications. Profit-driven providers have absolutely no incentive to promote self-care – why would they? In terms of holistic healthcare, profit and compassion sit very uneasily together, and large corporations lack the local connections that promote caring. We know from the USA that, once entrenched, largely privatised healthcare is not only the most expensive, it has poor outcomes and the corporations are almost impossible to dislodge. This is a one-way street.

Whereas the Act became law on 27 March 2012, the enabling regulations, which finally made clear the rules for competition, were not placed before parliament until 13 February 2013, shortly before the Act was due to come into force. These crucial regulations were introduced through what is sometimes called the 'back door' of parliament. Such secondary legislation is normally subject to relatively brief examination by the parliamentary scrutiny committee. However, after an unprecedented public outcry in February the regulations were withdrawn and hastily redrafted. The new version was again refused by the scrutiny committee and referred for



debate in open parliament – a most unusual step for secondary legislation. Thousands of letters were sent to peers asking them to attend the debate and annul this statutory instrument.

The order paper read as follows:

National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Motion to Annul.

Otherwise known as a '*prayer to annul*', this debate took place on 24 April 2013 in a well-filled chamber. The motion was moved by Lord Hunt of Kings Heath and the debate opened at 8.11pm. The strangely formal and archaic Hansard transcript makes fascinating reading. After the winding-up speech by the Parliamentary Under-Secretary of State for Health, Earl Howe, the Lords divided at 10.25pm and the motion was defeated by 254 votes to 146. The regulations will therefore become law and the fate of the NHS, for good or ill, was sealed with a prayer.

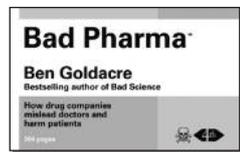
Has this been a cleverly constructed story about localism, decisions nearer to the people and a new culture of social enterprise, all disguising the real plan for a gradual hollowing out of the NHS until it is little more than a brand and a logo in US-style pursuit of profit? Or will the new NHS be slimmer, fitter, more dynamic, more patient-focused yet keeping the collaborative ethos, the commitment to shared responsibility, social solidarity and the common good? Any bets?

Reviews

Bad pharma: How drugs companies mislead doctors and harm patients

Ben Goldacre

Fourth Estate, 2012



Pharma is big. I mean really big. According to The King's Fund, in 2009 in the UK, 886 million items were prescribed at a cost of £8,529 million. In *Bad Pharma* this huge austerity-proof enterprise gets a good going-over from the energetic and uncompromising keyboard of Dr Ben Goldacre. For Ben, Pharma ain't just big, it's *bad*. Ben is not against drugs *per se*. In fact he is a brilliant spokesperson for *pharmaceuticals*, even if he has some serious truck with the pharmaceutical *industry* and its regulators. If only drugs were developed, regulated and marketed according to the rules of evidence-based medicine, we would be on the road to a decent healthcare system. We don't have such a system because of one salient fact – the pharmaceutical industry is an *industry*. In other words, from their emergence from the chemical giants of late 19th century Germany, these companies have aggressively sought to develop products, markets and *profits*.

So, what is so *bad* about Pharma? Let's start with the problem of missing data. Imagine you are designing a radical new type of gearbox for BMW. You get something that looks good on paper, and even in the workshop, but when you fit it to the rest of the car it keeps getting stuck in reverse. So you don't tell many people about this, fire a couple of engineers and move on to a new prototype. But in healthcare the disappearance of such information has a very adverse effect on our ability to judge the safety and effectiveness of new medicines. Ben quotes the example of lorainide. On paper this drug should be a boon for people who have had a heart attack because it stops the fatal arrhythmias that can occur after a myocardial infarction (MI – heart attack). So in the 1980s we started giving it to *all* patients with MI (whether or not they had abnormal heart rhythms). It is estimated that 100,000 people died unnecessarily before it was realised that this drug was in fact very dangerous when used in this way. It turns out that a very early study by a pharmaceutical company had convincingly demonstrated this danger but the study had never been published for commercial reasons. This is *bad*.

You can lose the books and you can cook them. As well as missing data, there is data that is heavily biased in favour of commercially desirable outcomes. Ben shares a raft of studies that confirm the universality of such bias. For example industry funded trials of statins are 20 times more likely to give positive results than those that are not commercially funded. There is a host of tricks for ensuring this chicanery. For example Pharma may fund trials that compare their medicine against a rubbish alternative, or show effectiveness in a highly selected (and therefore unrepresentative) population, or, my favourite, use surrogate outcome measures. Surrogate outcome measures are measures that suggest a desired outcome without actually measuring it. For example, blood pressure is associated with death from stroke and heart attack. It makes good sense then to judge the

effectiveness of anti-hypertensive treatments by their ability to bring down blood pressure. However it doesn't make good science. When the anti-hypertensive Doxazosin was studied for its ability to prevent heart failure (a real outcome measure) the study was stopped early because patients taking Doxazosin were doing so much worse. This worries me because Doxazosin is still widely prescribed in primary care.

I thought I already knew the gist of Ben's complaints about the drug industry. What was new to me was his expose of the *regulators*, the bodies charged with protecting us from the excesses of Pharma's commercial zeal. The key problem is that these commercial interests have penetrated to the heart of the regulatory process. Personnel flow readily between the two camps, such as Thomas Lonngren who stepped down as director of the European Medicines Agency in December 2010 and started work as a private consultant to the pharmaceutical industry in January 2011. Patient representatives and academic advisors also often have industry ties (Ben documents this in the case of the shamed drug Vioxx). The granting of patents for drugs is of unimaginable commercial significance – a 10-year monopoly on production. But because creating a new drug is commercially risky, companies tend to focus on developing drugs that are very similar to existing products – the so-called 'me too' drugs. The regulatory process does nothing to disincentivise this tendency, even though it means the industry's resources are devoted to drugs that do little to improve human health. I found Ben's coverage of the story of esomeprazole very enlightening. AstraZeneca's patent on Omeprazole was about to run out and the company was about to lose a third of its revenue. So in 2001 it patented a new drug called esomeprazole. Unlike omeprazole, which is a mix, esomeprazole contains only the left-handed enantiomer (mirror opposite). This is exactly the same molecule with no proven clinical benefits over the original mixed version. But the new form has been a huge, \$5 billion a year, commercial success. The success is due largely to how the drug is marketed – and it is to marketing that Ben next turns his attention.

A quarter of the revenue generated by Pharma is reinvested in marketing. In the US that amounts to \$60 billion each year. And they invest in marketing because marketing works. Even in the UK where doctors (like me) think we are immune to influence (we aren't) it is marketing that accounts for the fact that £1 billion of our £9 billion drug budget is spent (wasted) on patented drugs for which there are generic equivalents of equal effectiveness. Although this can be construed as normal (not bad) capitalism in action, Ben points out a lot of things that a lot of us probably don't know about how this business is conducted. For example patient pressure groups typically receive funding from industry though those links are often not obvious. When NICE advised against expensive arthritis drugs, the Arthritis and Musculoskeletal Alliance organised a letter criticising NICE which was published in *The Times* and signed by 10 rheumatology professors. Half of the charity's income is from drug companies. Ghost writing is another deceit. Pharma keeps pet academics who will give their name and credentials to publications written by staffers as part of choreographed

marketing campaigns. This is hard to prove but was exposed when Lilly appeared in court charged with overselling the benefits of the anti-psychotic Zyprexa (Olanzapine). A favourable review published in *Progress in Neurology and Psychiatry* by Dr Peter Haddad, was, it turns out, written by the Lilly marketing team.

Bad Pharma is an important and courageous book. The author is a medical academic. He knows the research process from the inside and is enthusiastic about the place of medicines in healthcare. This should make us listen more carefully than we would to a sensationalising journalist or conspiracy theorist with an axe to grind. Are there chinks in Dr Goldacre's intellectual armour? If you have ever seen Ben lecture you will know the guy is verging on the manic. With evident pressure of speech, he yearns to express all the material bursting the seams of his overactive brain. This same trait means the book is a bit over-long and at times a bit chaotic, though skipping the occasional section bit won't impair your grasp of the overall message. Should we trust the opinion of one man, even one as brainy as Ben Goldacre? Being smart is no insurance against being wrong. I am a fan of the American polemicist Michael Moore. However when I read his analysis of the Northern Ireland situation, in which I grew up, I was disappointed to discover that his coverage was hopelessly biased. Most readers would have taken Moore's opinions on trust. Maybe if I was an industrialist I might see this book in a similar light, or see it for the perspectives it lacks.

For me Pharma is bad in another sense altogether. Pharma is bad because it has found its way to the centre of pretty much all we do in medicine. Though all the individual prescriptions I sign each day have a rationale, together the enterprise feels out of balance. We have medicines for things that some people and cultures don't even consider disease (eg HRT), we have medicines for the side-effects of other medicines, we have medicines interacting in ways that are impossible to predict, we have people feeling worse just because they are taking medicines and we have medicines that people take even though they are not working but which we are nervous to discontinue (such as SSRIs in folk with dementia). Then there is the problem that there are many problems for which there is no medicine. So while I have enthusiasm for the stuff that does work, I am less sanguine than Ben about the overall benefits that Pharma offers for human health. I fear that even the best system of evidence-based pharmacology will tend to ever more prescriptions. You feel that for Ben, drugs are really what medicine is about, if only we could get the best evidence to support their use. But there are other aspects of medicine such as self-help, nutrition, exercise and strategies for emotional resilience that don't need Pharma at all. In medical practice and education these aspects are very much second fiddle. Maybe this neglect could be the theme for Ben's next book *Bad Preventative Medicine*? More people should know, for instance, that two out of three members of the steering committee of the Department of Health's Food Network have strong industry links. Meantime I would recommend *Bad Pharma* to anyone who wants to get the bonnet up on the forces that shape modern medical prescribing.

Trevor Thompson, GP

Working with the labyrinth

Ruth Sewell, Jan Sellers and Di Williams
Wild Goose, 2012

This book tells me of a growing number of people who are working with the labyrinth, and that in our time this ancient form is renewing finding a role again.

Apparently the authors met in 2008 at a training programme in Chartres and left with a passion to develop labyrinth work in the UK. They wanted to collect the practical experience of people already working with labyrinths and bring together their ideas and inspirations.

So this is first and foremost a practical book which offers ideas and examples of labyrinths in use in the arts, community and social settings; in schools, colleges and universities; in a hospice and a secure hospital; in counselling, psychotherapy and wellbeing; even in churches, retreats and interfaith contexts. But also, intentionally I hope, it leads you lightly on the journey the authors have taken to realise its publication. Most intriguingly, I feel a great curiosity about why this book should be here at all and about what its being here is telling us. Because for me it doesn't go far enough in exploring the experiences and challenges that have brought it into being; the fact that there is so much genuine interest in creating and exploring labyrinths. Surely this cries out to tell the human stories that generated their emergence once again into the religious and sacred dialogue. So this for me is the heart of the matter: why should it be in the 21st century that we are consciously returning to these beautiful old pathways, and be attracted to other forms of ancient ceremony and worship? I believe it clearly indicates the spiritual poverty of our time, and the inability or unwillingness of established religions in the West to connect with important – even vital – emerging new religious paradigms. But all the same I am grateful that the book is here and for its innate gentleness, with its call to recognise the individual journey of every soul and to take that journey to heart.

Peter Owen Jones, Author, Presenter and Parish Priest

The milliner and the phrenologist

Kay Syrad

Cinnamon Press, Blaenau Ffestiniog, 2009

So we do not talk of love, but only of that which is explicable with recourse to method. (p149)

This is a story of unrequited love beautifully told. It has the power of all tragedies to make us yearn that somehow it could be otherwise. But this story left me, not with sorrow, but with hope.

The novel is set in Victorian London. Dr John Motton, phrenologist, practises his learned profession among well-heeled women, giving them a 'scientific' understanding of their character through precise measurements of their skulls. His mother, with whom he lives, engages Miss Alice Heapy, a young milliner with a growing local reputation. She also measures the heads of her well-coiffed clients, and uses her understanding of their character in the design and construction of her eccentric hats. Yet Dr Motton and Alice are not only separated by social class, but by the eyes through which they comprehend the world. Not knowing how to express or even understand their feelings for the other; Motton attempts to possess Alice as his patient, while Alice's hat designs become ever more wild. They each find secret intimacy elsewhere: two tragic characters trapped in the cage of moral constraints and Victorian English social hierarchy.

If only she were not a little in love with a phrenologist, a man she didn't even like, a man who had no respect for hard working artisans. (p94)

...if only she would allow him to examine her, he would be able to trace, decipher every contour of her sensuality... (p118)

continued on p48...

Research Summaries



The research page is compiled with the help of Greenfiles (www.greenfilesjournal.com) and James Hawkins.

Wheat intolerance is real

Belief in non-celiac wheat sensitivity (WS) has led a growing number of people to avoid gluten ingestion. Yet the existence of WS remains controversial and specific markers are lacking. This study of 276 patients with WS, diagnosed by double-blind placebo-controlled challenge, confirmed the existence of non-coeliac WS and identified two distinct groups, one more similar to Crohn's disease and the other more akin to food allergy.

Carroccio A, Mansueto P, et al. (2012). Non-celiac wheat sensitivity diagnosed by double-blind placebo-controlled challenge: Exploring a new clinical entity. *Am J Gastroenterol* 107(12) pp 898–1906.

Mid-life exercise helps prevent dementia

How can dementia be prevented? In this study 19,458 community-dwelling, non-elderly adults had a baseline fitness examination between 1971 and 2009. All incidents of dementia in the group from 1999 to 2009 were analysed. Higher fitness levels were associated with lower hazard of all-cause dementia with or without previous stroke. Findings suggested that higher fitness levels earlier in life may lower risk for dementia later in life, independent of cerebrovascular disease.

DeFina LF, Willis BL, et al. (2013). The association between midlife cardiorespiratory fitness levels and later-life dementia: A cohort study. *Annals of Internal Medicine* 158(3) pp 162–168.

Mediterranean diet reduces cardiovascular risk

This randomised trial in Spain of using the Mediterranean diet for the primary prevention of cardiovascular events involved people at high cardiovascular risk, but who had as yet no signs of cardiovascular disease. One group ate a Mediterranean diet supplemented with extra-virgin olive oil, another a Mediterranean diet supplemented with mixed nuts, and a third a control diet (advised to reduce dietary fat). The results showed that the incidence of major cardiovascular events in people at risk was significantly reduced by a Mediterranean diet supplemented with extra-virgin olive oil or nuts.

Estruch R, Ros E, et al. (2013). Primary prevention of cardiovascular disease with a Mediterranean diet. *N Engl J Med*, 368 pp 1279–1290.

Multivitamins may improve mood and stress tolerance

Biochemical processes in the brain affect mood, so minor dietary inadequacies could cumulatively influence mood states. This meta-analysis of RCTs (eight studies met the inclusion criteria) evaluating the impact of multivitamin/mineral supplementation on mood in non-clinical populations showed that micro-nutrient supplementation has a beneficial effect on

perceived stress, mild psychiatric symptoms, and aspects of everyday mood in apparently healthy individuals. It appears too that supplements containing high doses of B vitamins may be more effective in improving mood states.

Long SJ, Benton D (2013). Effects of vitamin and mineral supplementation on stress, mild psychiatric symptoms, and mood in nonclinical samples: A meta-analysis. *Psychosomatic Medicine* 75 (2) pp 144–153.

Does work-related stress raise the risk of cancer?

This meta-analysis pooled data from 12 European cohort studies: a total of 116,056 cancer-free men and women aged 17–70 who were followed up for a median of 12 years. Overall, high job strain was not associated with overall risk of cancer and there was no clear evidence for an association between the categories of job strain and the risk of cancer.

Heikkilä K, Nyberg ST, et al. (2013). Work stress and risk of cancer: Meta-analysis of 5700 incident cancer events in 116,000 European men and women. *BMJ* 346 f165.

Multivitamin-multimineral supplements are safe

Recent epidemiologic findings have suggested that multivitamin use increases the risk of mortality. This meta-analysis of randomised controlled trials selected 21 high quality articles – a pooled sample of 91,074 people and 8,794 deaths. Across all studies no effect of multivitamin-multimineral treatment on all-cause mortality was found.

Macpherson H, Pipingas A, et al. (2013). Multivitamin-multimineral supplementation and mortality: A meta-analysis of randomized controlled trials. *Am J Clin Nutr* 97(2) pp 437–444.

Five a day helps prevent depression?

Can diet contribute to your mental health? In Canada between 2000 and 2009 this repeated (five times) cross-sectional study asked 296,121 people (aged 12 years and upward) whether they had experienced a major depressive episode over the previous 12 months. Stats were adjusted to rule out effects of age, gender, household income, education, physical activity, chronic illness and smoking. Greater fruit and veg intake was significantly and consistently associated with lower odds of depression and distress. High fruit and veg intake was also associated with better perceived mental health status, lower incidence of previous mood or anxiety disorder.

McMartin SE, Jacka FN, et al. (2013). The association between fruit and vegetable consumption and mental health disorders: Evidence from five waves of a national survey of Canadians. *Prev Med* 56(3–4) pp 225–230.

Are CBT self-help books useful if you're depressed?

Despite the NHS' Improving Access to Psychological Therapies initiative demand for CBT for depression still outstrips supply. One solution may be guided self-help using a CBT book (GSH-CBT). This randomised controlled trial in Glasgow compared two groups of adults with a Becks (BDI-II) score of more than 14 (ie at least mildly depressed). One group of 141 was randomised to use 'Overcoming Depression: A Five Areas Approach' book plus 3–4 short face-to-face support appointments (up to two hours of guided support in total). The other group had treatment as usual with their general practitioner. At four months the GSH-CBT group's mean BDI score was by 5.3 points lower than the treatment as usual group's. At 4 and 12 months significantly higher numbers of participants had achieved a 50% reduction in BDI-II in the GSH-CBT group. And there was significantly less deterioration in mood in the GSH-CBT group. (2.0% compared with 9.8%). GSH-CBT seems substantially more effective than 'treatment as usual'.

Williams C, Wilson P, et al. (2013). Guided self-help cognitive behavioural therapy for depression in primary care: A randomised controlled trial. *PLoS One* 8(1) e52735.

Strictly depressed? Tango it away!

Ninety-seven people with self-declared depression were randomised into tango dance or mindfulness meditation classes, or to a control/waiting list. Classes (six-week programmes of 1½ hr/week of tango or meditation) were conducted in metropolitan Sydney, Australia. The outcome? Sixty-six participants completed the programme. Depression levels were significantly reduced in the tango and meditation groups relative to waiting list controls, but stress levels were significantly reduced only in the tango group. The authors conclude that mindfulness meditation and tango dance could be complementary adjuncts for treating depression and managing stress. The therapeutic mechanisms involved remain a mystery!

Pinniger R, Brown RF, et al. (2012). Argentine tango dance compared to mindfulness meditation and a waiting-list control: A randomised trial for treating depression. *Complementary Therapies in Medicine* 20(6) pp 377–384.

Making health professionals more resilient

Health professions face time pressures, high workload, multiple roles and emotional issues in clinical practice. Frequent work-place stress can harm their physical and mental wellbeing, cause burnout and even result in post-traumatic stress disorder (PTSD). These outcomes impact on their ability to practice effectively, so preventive approaches are imperative. This literature review explores and explains how to boost resilience in the health professions (nursing, social work, psychology, counselling and medicine) and the implications for clinical practice and further research.

McCann CM, et al. (2013). Resilience in the health professions: A review of recent literature. *International Journal of Wellbeing* 3(1) pp 60–81.

Taiji enhances self-compassion

The aim of this study was to examine the impact of Taiji practice on self-attribution of mindfulness and self-compassion, two potential components well known for their health-promoting effects. Seventy healthy participants (age range: 23–50 years) were randomly assigned either to the intervention group or to a wait list control group. The intervention group attended Taiji classes twice a week for three months. Before, shortly after and two months after the intervention, the degree of self-attributed mindfulness and self-compassion in all study participants was measured using self-report questionnaires. Compared to the control group, the intervention group showed significantly higher increase scores in self-attributed mindfulness after the intervention that persisted two months later. Increases in self-attributed self-compassion were also higher in Taiji practitioners, with significant group differences from pre-intervention to follow-up assessment. Findings suggest that Taiji practice can effectively enhance self-attribution of mindfulness and is likely to have beneficial effects on self-compassion in healthy participants. The role of mindfulness as a mechanism underlying the beneficial effects of Taiji practice warrants further research.

Nedeljkovic M, Wirtz P et al (2012). Effects of taiji practice on mindfulness and self-compassion in healthy participants – a randomized controlled trial. *Mindfulness* (NY).

REVIEWS

continued from p46...

The echoes for our modern times are powerful: in important ways we have not moved on. Social class tensions, now more fluid and less part of a rigid social structure, nevertheless thrive as 'inequality', still symbolised through possessions. The beautiful and sensitive work of the creative artisan such as Alice Heapy is still admired and still undervalued. However for me the most enticing and enduring aspect of this book is the allegory woven through it. Alice and John embody the archetypal struggles between sensuous and calculating, unique and generalised, fact and interpretation, spontaneity and control, passion and reason.

She used the methods of all artisans, taking what he might describe as an 'impressionist' view, without benefit of categories or principles or laws; and of course without any moral purpose. Her work was, therefore, frivolous. (p34)

...with every measurement, with every client, every pen mark. ...Delineate, demarcate, line, angle and number: this was not love, it was barely even mind. It was his elbow or his shinbone working, his long cold shinbone, where his mind should be. (p148–9)

This chasm is also, of course, the unhealed fracture within healthcare. This is the energy behind evidence-based medicine and the vitriol against homoeopathy. This is the root of the neglect of older patients in hospitals and care homes. This is the impediment to the marriage of heart and mind without which neither will thrive. This is the hopeful lesson from this wonderful book: that without that union, the heart withers away. Healing this fracture is our task.

William House, Chair BHMA