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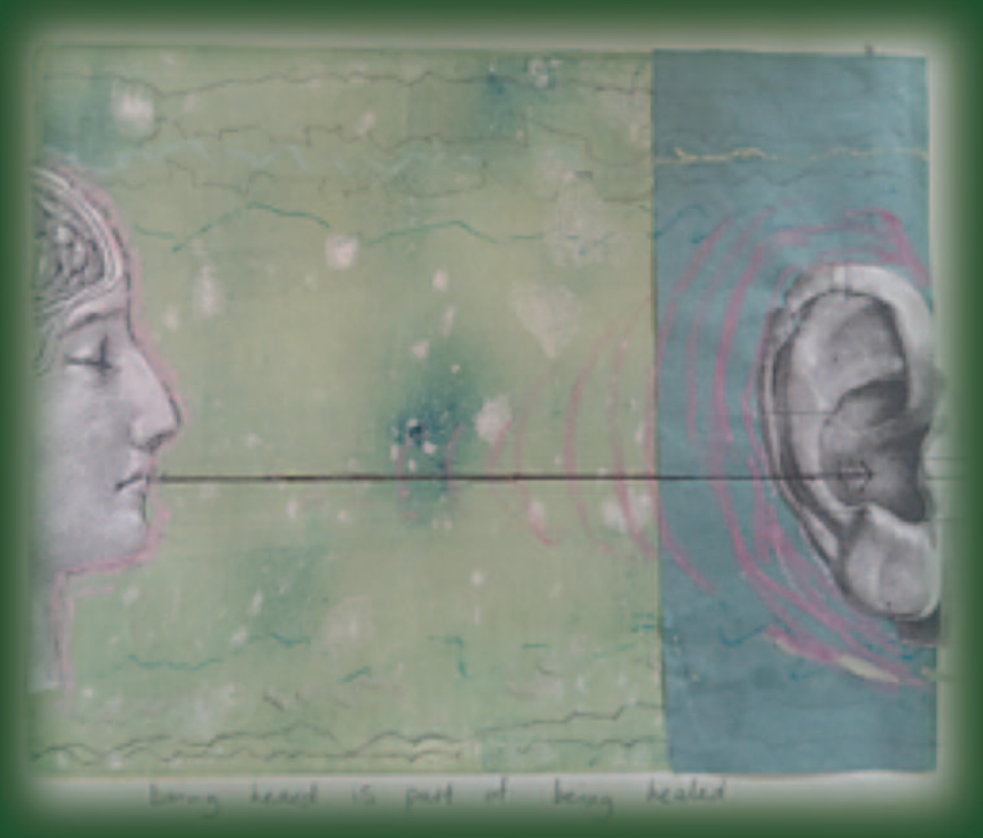
Volume 23 | Issue 1 | Spring 2026

ISSN 2977-1021

JOURNAL OF holistic healthcare AND INTEGRATIVE MEDICINE



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Published by the BHHA
www.bhma.org

Reg. Charity No. 289459

Cover image
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Volume 23 • Issue 1 • Spring 2026

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Louise Younie
Professor of Medical Education

David Peters
Editor-in-chief

Integrating the human dimension in healthcare

The human dimension is an emergent and still ill-defined concept, yet we find it a useful way of giving language to the holistic realm of care, one that acknowledges the humanity of patients, clinicians, educators and the many others who participate in healthcare systems. It overlaps with a range of related vocabularies, including whole-person healthcare, person-centred care, relational pedagogy and the health humanities. The absence of a shared language means the field remains somewhat fragmented and still forming.

The human dimension brings perspective to the biomedical toolkit which may have no quick fix for people struggling with chronic disease and disability, made worse by adverse childhood experiences and further mediated by social and environmental injustice, deprivation, loneliness, inactivity and poor nutrition. Prolonged stress is pro-inflammatory; unhappiness finds its way into cells.

The human dimension also embraces research regarding empathic doctors having better clinical outcomes, higher patient satisfaction, and increased treatment adherence (Decety & Li, 2025). When drugs are not enough clinicians listen, counsel, comfort and guide. Studies show that empathy and the clinician's compassionate response establish trust, support shared decision making and may enhance self-care. Empathic relationships lead to fewer disputes and less litigation, and there is ample research to show how positive encounters help clinicians flourish and sustain satisfying careers (Zwack & Schweitzer, 2013). Many practitioners do communicate empathy to their patients, and feel sustained by good relationships, yet in overstretched healthcare settings burnout and unsatisfying practitioner–patient encounters are still all too common (Hodkinson *et al*, 2022). It is important therefore, that the human dimension, or an approach towards humanising care, extends beyond the individual clinical encounter to include the organisational and structural conditions within which care is delivered (Busch *et al*, 2019).

Wellbeing and health are a complex interweaving of the physical and emotional, the personal and relational, the communal and ecological. Biomedicine will always be part of the picture, though we are not isolated biological machines, but creatures shaped by mind, constantly adapting to social circumstances and environment, constantly seeking equilibrium, living systems with potential for self-healing. We look across healthcare and higher education towards a wider landscape that is taking shape, one increasingly concerned with complexity rather than control, moral injury rather than individual weakness, relationship rather than transaction, epistemic justice rather than hierarchy, and humane systems rather than merely efficient ones.

This issue of JHH aims to begin making visible what is often unseen or undervalued in contemporary systems of care. Rather than offering a single definition of the human dimension, we bring together multiple perspectives, from patients, students, clinicians and educators, expressed through narrative, dialogue, image, prose and poetry. In doing so, we hope to illuminate different facets of the human dimension operating at the individual but also the system and ecological levels.

Rich Peacock, a man living with the 'difficulties and fragilities' of multiple sclerosis, reminds us that beyond 'damage and wounds' we remain 'beautiful and whole'. Abi Macleod offers a powerful image that speaks to the profound human need to be heard. Patient-artist Gavin Blench reflects on the value of being spoken to as a person. In contrast, Dr Sarah Saunders' poem *Bed 4* exposes how careless language in medical records relating to First Nations people can alienate and diminish our shared humanity. Other contributions speak of weaving in love, encountering trauma and suffering, and navigating the emerging presence of artificial intelligence in healthcare.

Alongside these perspectives, we introduce six dimensions of holistic practice and begin to explore how human dimension capability might be cultivated in healthcare education. In the spirit of Paulo Freire (Freire, 1970), this collection invites us to see humanisation not as an individual achievement but as a mutual, unfinished process, one in which we become more fully human together.

Busch IM, Moretti F, Travaini G, Wu AW & Rimondini M (2019) Humanization of care: Key elements identified by patients, caregivers, and healthcare providers. A systematic review. *The Patient – Patient-Centered Outcomes Research*, 12, 461 474.

Decety J & Li J (2025) The value of empathy in medical practice: A neurobehavioral perspective. *Social Sciences & Humanities Open*, 12, 101956. https://doi.org/10.1016/j.ssaho.2025.101956.

Freire P (1970) *Pedagogy of the oppressed*. Continuum.

Hodkinson A, Zhou A, Johnson J, Geraghty K, Riley R, Zhou A … Panagioti M (2022) Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. *BMJ*, 378 :e070442 doi:10.1136/bmj-2022-070442.

Zwack J & Schweitzer J (2013) If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Acad Med*, 88(3) 382−9. doi: 10.1097/ACM.0b013e318281696b.

BHMA name change

The organisation many of you have fondly known as the BHMA, The British Holistic Medical Association, has changed its name. This has been a journey of two steps, as we had recognised that a holistic approach to healing and healthcare is much larger than just medicine, prompting a name change a while ago to the British Association for Holistic Medicine and Health Care. But that seemed such a mouthful. So at our AGM in February 2026, after much heart and mind searching, discussion and consultation, the trustees and members who were gathered at the online extraordinary general meeting changed just one letter from the original BHMA to become BHHA – the British Holistic Healthcare Association. It seems a much better fit.

New YouTube channel – gems of holistic healthcare

As part of our work in raising awareness of the holistic approach to healing and healthcare, we've started a new YouTube channel called Gems of Holistic Healthcare.

Our goal is to feature practices, understandings, conversations and useful tips that are real gems, items that can help us, and help us help others, in the holistic care of health. We're just starting out, so there are only a few videos as yet, but watch this space, and please keep coming back to it.

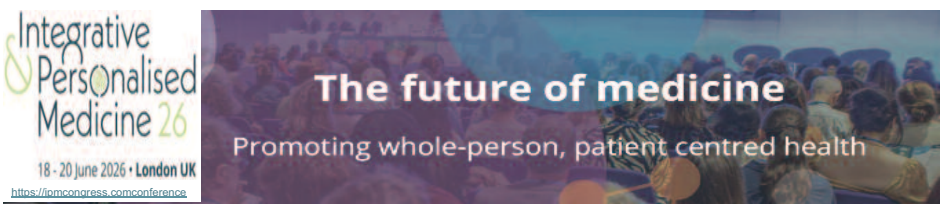
You can see what's there at https://www.youtube.com/@GemsofHolisticHealthcare

Please do support us by subscribing and helping spread the word.

Also, coming soon, is our new podcast series, also called Gems of Holistic Healthcare. This will make an opportunity for deeper dives into themes and topics of holistic healthcare.

Integrative Personalised Medicine Conference 2026

The IPM congress is the largest integrative and personalised medicine congress in Europe. Taking place from **18th–20th June 2026** at the QEII Centre in London UK, the IPM Congress welcomes healthcare professionals from a range of modalities including integrative, functional, lifestyle, environmental, complementary and holistic medicine.



Organised in association with The College of Medicine UK, the congress is fast becoming a landmark annual event where the community comes together to discuss the benefits of taking a whole-person, patient-centred approach to health.

Over three days, highly acclaimed healthcare professionals from across the globe will present evidence-based research and case studies. By sharing clinical experience, knowledge and ideas, doctors, therapists and practitioners will gain a greater understanding that a multi-disciplinary team and whole-person approach can provide the patient with the best possible outcomes.

https://ipmcongress.com

Beyond the consulting room: rethinking holistic health as a community endeavour

A perspective informed by the emerging framework of the British Holistic Healthcare Association

David Peters

Editor in chief, Journal of Holistic Healthcare and Integrative Medicine

Holistic health? It's too big to be left in the hands of doctors and professional monopolies. Holistic healthcare, once misunderstood as clinical practice incorporating complementary and alternative therapies, more recently 'integrates' ever more lifestyle, mind–body medicine, psychotherapy and nutrition. So far so complicated, but still corralled by professionals, and of course unlikely to become mainstream any time soon. So where does 'holistic healthcare' go from here? The six health creating dimensions we propose apply to all of us – professionals, public and policy makers. They ask us to live as part of nature, wired by evolution for active meaningful lives of co-operation and relationship, and to grasp that health is something we do, not simply something we have. Health creation is a long-term project: in time the many beliefs, systems and organisations that harm or resist these deep-rooted needs will have to be transformed. Such efforts too are part of health creation.

Summary

For decades, holistic healthcare has been understood principally as a set of professional aspirations – a richer, more integrative way for clinicians and therapists to attend to the whole person. But a growing body of thought, crystallised in the emerging framework of the British Holistic Healthcare Association (BHHA), proposes something far more ambitious: that genuine holistic health creation is a public and civic undertaking, woven into the culture of communities, institutions and society itself. This article examines what that shift means – and why it matters.

Health creation: a concept whose time has come

The language of health has long been dominated by the vocabulary of disease – its diagnosis, treatment and management. Healthcare systems, however well-intentioned, have historically positioned the patient as a passive recipient: someone to whom care is done. The idea of health creation inverts that relationship. It asks not merely how illness is treated, but how health is actively generated – through individual agency, through relationships, through the fabric of social and physical environments.

This is not a new observation. The World Health Organization's foundational 1948 definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity' implied a vastly broader canvas than medicine alone. Yet the systems built in its wake remained stubbornly clinical. The pioneering work of the Ottawa Charter for Health Promotion in 1986 pushed further, identifying peace, shelter, education, food, income, a stable ecosystem, social justice and equity as the fundamental prerequisites for health. Still, mainstream healthcare struggled to operationalise that vision.

In twenty-first century Britain, the gap between aspiration and reality has become harder to ignore. Population health data consistently demonstrates that the social determinants of health – poverty, housing insecurity, educational disadvantage, social isolation – account for a

far greater proportion of health outcomes than access to clinical services alone. The NHS, heroic and indispensable as it is, cannot on its own create health. Something more systemic, more distributed, and more rooted in community is required.

It is in this context that the concept of health creation has emerged with fresh urgency – and that the BHHA's developing framework represents a timely and important contribution.

The six dimensions of holistic practice: a professional foundation

The BHHA's articulation of holistic practice rests on six interrelated dimensions, each representing a domain of human experience that practitioners must engage with if they are to serve the whole person rather than merely a cluster of symptoms.

The first dimension is physical wellbeing: the body as the site of lived experience, requiring attention not only to pathology but to nutrition, movement, rest, environment and the often-underestimated intelligence of somatic sensation. The second is psychological and emotional health – the inner life of thoughts, feelings, beliefs and relational patterns that shape how individuals experience and respond to the world.

> "…holistic practice rests on six interrelated dimensions"

The third dimension concerns the social and relational self: the quality of a person's connections to family, friendship networks and community. Human beings are irreducibly social; loneliness and disconnection carry measurable health consequences as serious as smoking. Fourth is the spiritual dimension – not necessarily in any narrowly religious sense, but in the sense of meaning, purpose, values and the experience of being part of something larger than oneself.

The fifth dimension encompasses lifestyle and behaviour: the daily practices and choices that either sustain or erode wellbeing over time. The sixth, and perhaps least conventionally recognised, is the environmental dimension – the acknowledgement that the natural and built environments in which people live exert profound and continuous influence on their health, and that sustainable health is inseparable from sustainable environments.

These six dimensions provide an invaluable scaffold for healthcare professionals seeking to practise more holistically. A GP who takes time to understand a patient's social isolation, or a physiotherapist who considers the spiritual dimensions of recovery from serious injury, is offering something qualitatively richer than symptom management. But the BHHA's evolving framework makes a more challenging and more interesting argument: that this professional aspiration, though vital, is insufficient on its own.

The limits of professional holism

There is something paradoxical about the conventional model of holistic healthcare. It locates holism inside the consulting room – within the encounter between a trained professional and an individual client. The practitioner is charged with attending to the whole person; the patient, implicitly, is still positioned as the recipient of that attention. The professional brings the holistic gaze; the public receives it.

This model, however well-executed, runs into structural limits. No healthcare professional, however skilled and attentive, can deliver holistic health to a patient who returns each evening to overcrowded housing, precarious employment and a community denuded of green space, social infrastructure and mutual support. The consulting room cannot substitute for the conditions of a good life. Professional holism, in isolation, risks becoming a sophisticated form of treating the symptoms of society's failure.

Moreover, the scale of contemporary health need vastly exceeds the capacity of the professional workforce. If holistic health creation depends entirely on encounters between trained practitioners and individual clients, it will remain rationed, inequitably distributed and chronically under-resourced. What's more with Britain's health and social care system already under unprecedented pressure, and as levels of burnout among nursing and medical workers soar, the idea that the entire burden of health creation should rest on professional shoulders is neither realistic nor, the BHHA argues, philosophically coherent: in overstretched and industrialised organisations who will care for the carers?

The BHHA's emerging narrative therefore proposes a significant reframing. Holistic practice, it argues, must be understood as extending far beyond the professional domain. It depends, to a degree that has rarely been formally acknowledged, on the capacity and willingness of the public to engage in what the Association calls 'holistic self-care' – the active, conscious tending of one's own body, mind, spirit, family life and community life. Localities + relationships = neighbourhood. Anonymity + alienation+ apathy (± deprivation) = disorder ± loneliness. And we know that loneliness and deprivation lead to health inequality.

Holistic self-care: the public as practitioner

The concept of holistic self-care represents a significant expansion of the practitioner category. If the six dimensions of holistic practice describe what constitutes genuine whole-person health, then it follows that individuals themselves are the primary agents of that health – not

merely because they make lifestyle choices, but because they are the ones living the integrated reality of body, mind, emotion, relationship, meaning and environment. No professional, however perceptive, can inhabit that territory on anyone else's behalf.

> …the capacity for holistic selfcare is itself shaped and constrained by social conditions

From this perspective, the many who maintain meaningful relationships, feel their purpose, a meaningful outer and inner life, tend to their physical wellbeing and surroundings and relationships and environment, who can reflect on their emotional needs and feel compassion for others are already holistic self-care practitioners – no professional credential required (though there's learning aplenty to be had). The parent who creates emotional security for their children, the neighbour who the helps maintain the mycelial connective tissue of a community, the individual who pursues self-knowledge and personal growth: all are health creators. And of course all the above apply equally to practitioners as well as their patients; and we will all become patients eventually.

This is not a counsel of self-reliance that lets public services off the hook. On the contrary, the BHHA's framework is insistent that the capacity for holistic self-care is itself shaped and constrained by social conditions. The question of who can afford to tend to their mental health, who has the time and energy for physical activity, whose neighbourhood offers safe green space, whose employment allows for rest and recovery – these are not individual questions. They are matters of social justice.

Income, education, cultural capital, location and the presence of supportive community infrastructure boosts the likelihood of holistic self-care. No doubt these are factors in the distribution of health inequality. To celebrate individual self-care without attending to the conditions that support it risks sliding into victim-blaming, where those whose health suffers most are implicitly held responsible for their own disadvantage. They are matters of social justice.

A third category: enablers of holistic health creation

It is here that the BHHA's framework introduces its most original and far-reaching proposition. Alongside the healthcare professional practising holistically, and the individual engaging in holistic self-care, there exists a third category of actor in the health creation ecosystem: those individuals and agencies whose work shapes the conditions that make holistic self-care more or less possible.

This third category is enormously diverse. It includes community organisers and social entrepreneurs who build the connective tissue of neighbourhood life. It includes architects and planners who design built environments conducive to movement, social encounter and contact with nature. It includes teachers, who – quite apart from their educational function – play a formative role in children's emotional development, self-concept and capacity for resilience. It includes employers, whose work-place cultures profoundly shape the physical, mental and social health of the working population. It includes local government officers whose decisions about public space, transport, housing and community investment either support or undermine the conditions for health.

What unites these diverse actors is that their primary function is not healthcare, yet their work has profound health consequences. A housing officer who resolves a family's accommodation crisis may deliver more health benefit than the many GP appointments spent patching up consequent illness and family breakdown. A community arts project that rebuilds social cohesion in a fragmented neighbourhood may do more for population mental health than any clinical intervention. A planning decision that preserves green space rather than surrendering it to development could generate decades of physical and psychological benefit.

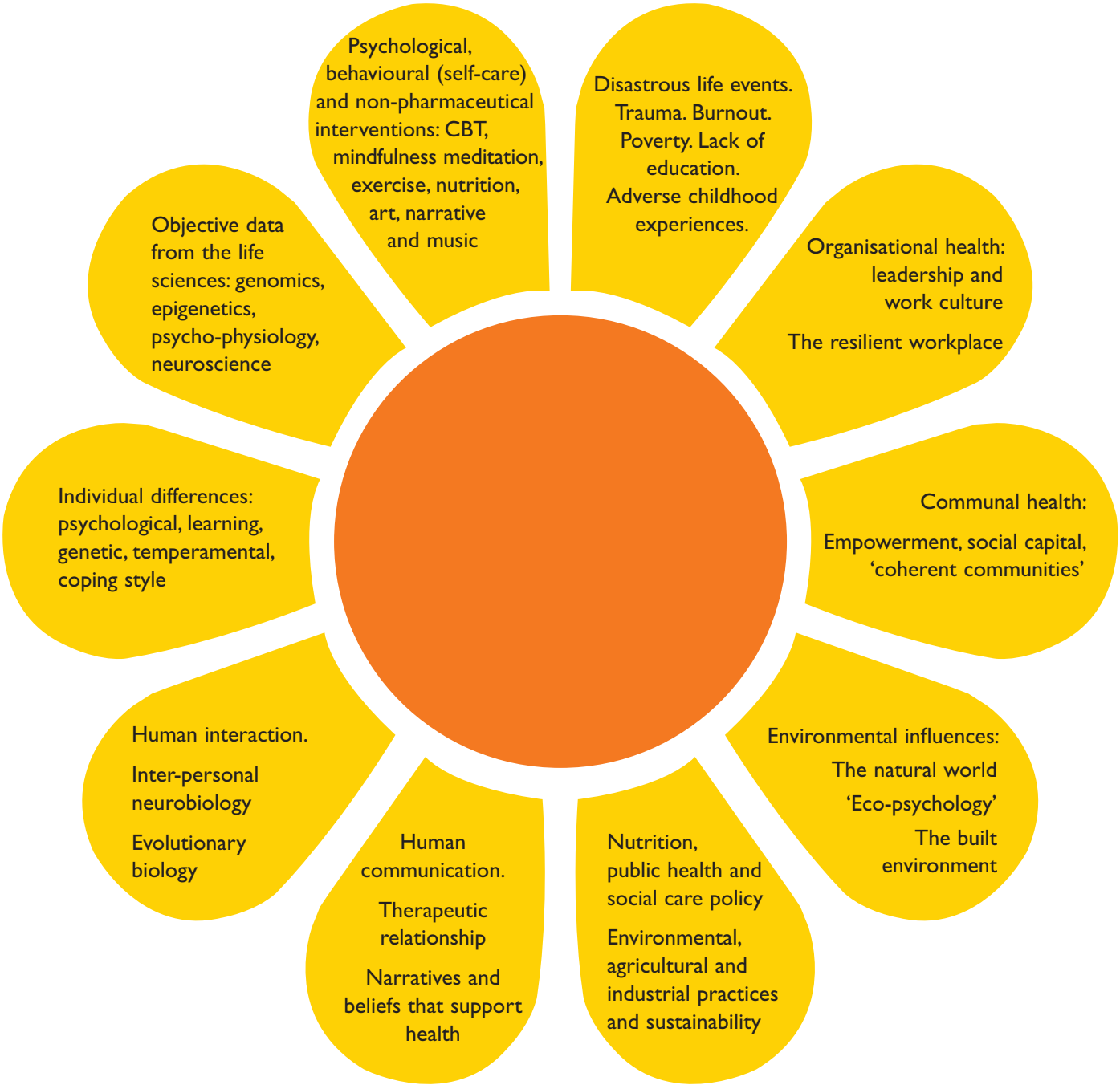
The BHHA's framework asks us to recognise these actors as health creators – not metaphorically, but genuinely. What would it mean for people to understand that health is more than something we have – it's something we do; and to grasp that those who in any way help create social capital are also creating health. This doesn't mean allotting new responsibilities to people who have not asked for them. It's more a narrative shift in awareness of what they already do: in the cultures of statutory and third sector organisations it's a big and affirming story that their core work spins a web of health creation. Double whammy: altruism and purpose are themselves health creating!

Institutional culture as a health determinant

The framework's reach extends even further. It argues that the cultures of statutory agencies – the values, attitudes and behavioural norms that shape how public institutions operate – are themselves health determinants. This is a claim with significant implications.

Consider the police service. Its primary function is public safety and law enforcement – not health. Yet the manner in which policing is conducted has measurable health consequences. Officers who approach communities with respect and procedural fairness contribute to a climate of trust that supports mental health and social cohesion. Heavy-handed or discriminatory policing generates trauma, fear and social fragmentation – outcomes with direct health costs. The organisational culture of a police service, its values around community

Evidence from different fields is revealing the many factors influencing health and health creation



engagement, its training in trauma-informed approaches, its commitment to proportionality and dignity: all of these are, in a meaningful sense, health-relevant.

The same logic applies to schools. Educational outcomes clearly shape the long-term social determinants of health – qualifications, employment, income. But school culture itself, independent of academic outcomes, is a significant health environment. Whether a school creates conditions of psychological safety, cultivates children's emotional literacy, addresses bullying effectively, supports children's sense of belonging and identity: these dimensions of school life are health-creating or health-harming, irrespective of examination results.

Local government presents perhaps the most extensive canvas. The decisions made by councils about everything from housing allocation to library provision, from parks maintenance to social care commissioning, collectively constitute an enormous influence on population health. The culture that informs those decisions – whether it is one that genuinely centres the health and flourishing of residents, or one primarily focused on cost reduction and regulatory compliance – will shape health outcomes for whole communities across generations.

The BHHA's framework therefore implies a challenge not only to individual practitioners and to the general public, but to the institutional cultures of the statutory sector: What values animate your organisation? Do your day-to-day operations support or undermine the conditions for human flourishing? Are your staff trained to recognise the health dimensions of their work? Do your performance frameworks reward health creation, or merely service delivery?

Towards a joined-up ecology of health creation

What emerges from the BHHA's evolving framework is a picture of health creation as an ecology – a complex, interdependent system in which professional practice, individual self-care and institutional culture are mutually constitutive. None of the three operates in isolation; each shapes and is shaped by the others.

Holistic healthcare professionals can only do their best work when their clients have the social conditions and personal capacity to engage with the care they offer. Individual self-care can only flourish when communities provide the support structures, and when wider systems – economic, environmental, cultural – make such care practically possible. The enabling work of the third-category actors – community builders, planners, teachers, public servants – can only reach its potential when it is animated by a genuine understanding of health creation and supported by institutional cultures that value it.

This ecology has policy implications that extend well beyond the health system conventionally understood. It calls for *Health in All Policies* approaches – the systematic integration of health impact considerations into decision-making across government (Lynch *et al*, 2025). It calls for investment in community infrastructure as a primary health intervention. It calls for professional training, across many sectors, that includes health literacy and health creation awareness. It calls for performance frameworks that recognise and reward contributions to population health, not merely throughput and clinical outcomes.

It also has implications for how we understand inequality. If health is created through this complex ecology, then health inequalities reflect not merely differential access to healthcare, but differential access to all the conditions that make health creation possible – safe and adequate housing, fulfilling work, social connection, green space, cultural participation, civic agency. Addressing health inequality, on this view, is inseparable from addressing the structural injustices that distribute these conditions so unequally.

A fuller vision of holistic practice

The British Holistic Healthcare Association's emerging narrative represents a mature and demanding evolution of holistic thought. It does not abandon the six dimensions of holistic practice that have guided integrative healthcare professionals; rather, it insists that those dimensions cannot be confined to professional settings. The aspiration to attend to the whole person – body, mind, spirit, relationships, environment – is not a professional prerogative. It is a human one.

In recognising this, the BHHA's framework opens up a substantially richer account of what it means to create health. It asks healthcare professionals to see themselves as contributors to a larger ecosystem, not its sole inhabitants. It asks the public to understand self-care not as an individualistic or consumerist project but as a civic and relational practice. And it asks the statutory agencies – police, schools, councils and all the other institutions that shape daily life – to understand their cultures and their practices as health-relevant, whether they choose to recognise that or not.

Health creation, on this account, is everyone's business. That is not a counsel of despair – a way of saying that nobody in particular is responsible. It is an invitation to a more collaborative, more systemic and ultimately more effective understanding of how health is made and sustained. The consulting room remains important. But it is not the whole story, and it never was.

Lynch H, Holdroyd I, Birley M, Black D, Cave B, Douglas M, Ekermawi R…Ford J (2015) Health impact assessments should be mandatory for all relevant government policies. *Health Policy*, 162.

This article draws on the emerging framework of the British Holistic Healthcare Association (BHHA) and its six-tenet model of holistic practice. The views expressed are intended to support constructive professional and public dialogue on health creation.

Reclaiming the human dimension in healthcare education

Louise Younie

Professor of Medical Education, Barts and The London, QMUL and University of Oxford

Since qualifying as a GP I have been seeking ways to deepen understanding of ourselves and our practices as students and clinicians. Creative enquiry, exploring lived experience through the arts, has been central to this journey into the human dimension of healthcare. The languages of the arts enable metaphor, expanded meaning-making and shared humanity, dimensions I have found contribute to human flourishing. I continue this work through collaboration, research and as Chair for the National Centre for Creative Health/RCGP Creative Health Special Interest Group.

Summary

Healthcare's human dimension is the relational, contextual complement to clinical expertise. Arguably no less crucial than good diagnosis, by default it is sidelined in time-pressured, protocol-driven systems. Louise Younie draws on a patient–artist who felt the most helpful practitioners were those who 'talked to me as a person'. She points out that in practice, making meaningful connections protects against burnout, improves outcomes and so makes economic as well as clinical good sense. Medical education, if it were to cultivate relational capability through reflective practice, lived experience, arts-based learning and meaning-making, could design the human dimension back into systems that downgrade it.

Introducing the human dimension

Last week I invited Gavin, a patient–artist, to lead a session with first-year medical students as part of an arts-based student selected component. After generously sharing his story, his artwork, and opening a creative–expressive space for the students, we had the opportunity to ask questions. I began with one I have asked him before:

> ***What advice do you have for us as clinicians and future clinicians?***
>
> *…let us be as two human beings meeting, put professional identity on the shelf…professionals don't need to prove to me they have the power and the knowledge…those that helped me the most talked to me as a person*
>
> (Gavin Blench, 2026)

Broken connections by Gavin Blench

These words, offered from lived experience after many encounters with healthcare practitioners over years of living with multiple sclerosis, are not a rejection of expertise. Rather, they illuminate something quieter and more easily overlooked: expertise and hierarchy held in service of the relational field.

Gavin's words capture something I have been trying to articulate – the human dimension of healthcare, part of the double-stranded DNA of the consultation alongside the clinical dimension, two strands continuously connected.

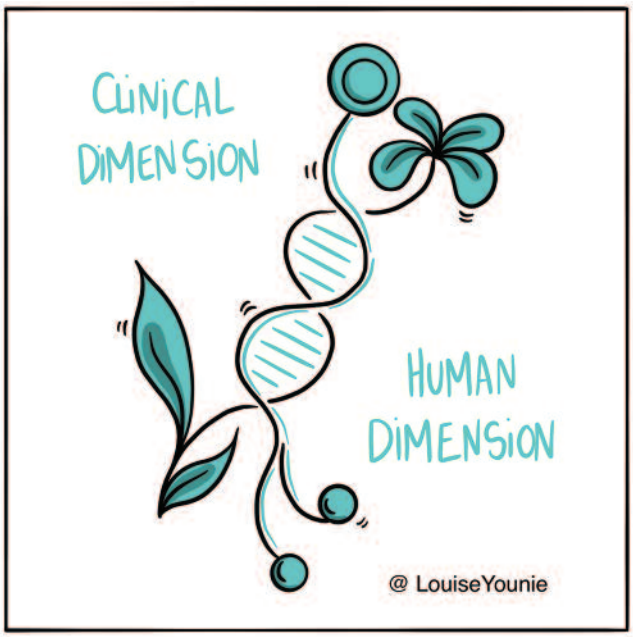
Drawing on Iain McGilchrist's metaphor of *The Master and His Emissary* (McGilchrist, 2009), the technical, focused, analytical ways of knowing, so necessary and powerful, are best understood as in service to a wider, more contextual, relational awareness. Yet in practice, the emissary is often elevated above the master, and the clinical dimension becomes mistaken for the whole of the consultation, with vestiges of communication skills tacked around the edges. This article explores how we may begin to explicitly re-incorporate the human dimension.

If the clinical dimension can be framed by the question, 'What is your diagnosis?', the human dimension begins with the wider question, 'How can I help you?'. Diagnosis may well be part of the answer, but so too may listening, witnessing suffering, sitting with uncertainty, writing a letter, understanding context, or recognising the limits of medicine itself.

When I share the clinical–human dimension model, I often describe learning the clinical dimension as an upward spiral of accumulating knowledge and skill.

Body movement by Gavin Blench

There may be pride at how much has been learnt, how much the clinician can recognise, name, and treat. The human dimension involves a different movement, a spiralling downwards into the more interpretive question: 'how can I help you?'. To approach this question we must try to understand something of who the patient is, what matters to them, and what shapes their suffering. This requires curiosity, and what John Keats – (who trained as an apothecary surgeon before gaining fame as a poet) described as *negative capability*, the capacity to remain present in uncertainty without grasping prematurely for fact, reason or closure. The human dimension invites us to hold scientific knowledge with *epistemic humility*, holding our technical knowing alongside, not above the lived, embodied expertise of the person before us, who will ultimately decide what treatments to take and how they will live with their illness.



Commissioned by Louise Younie, created by Camille Aubry

Engaging with the human dimension

Embracing the human dimension of healthcare can feel costly. It often takes time and energy – scarce resources within efficiency-driven hurried systems. Attending carefully may disrupt schedules, and the encounter with uncertainty may unsettle the illusion of control whilst inviting encounter with uncertainty. We may begin to see more clearly how easily iatrogenic harm can occur through hurried words, transactional encounters, or the narrowing of attention to what is measurable.

And yet the human dimension is deeply sustaining for practitioners: meaningful connection with patients help

protect against cynicism and burnout (Zwack & Schweitzer, 2013; Southwick *et al,* 2021). A survey of more than 2,000 family physicians in the US found that career purpose, including joy in work, meaning in patient relationships and a sense of calling, was the strongest predictor of physician happiness. Long-term relationships with patients were particularly associated with greater life-meaning (Tak *et al* 2017).

Burnout is arguably one of the biggest challenges facing healthcare systems. It is widespread among medical student (Medisauskaite *et al*, 2023) and across clinician populations (Rotenstein *et al*, 2018). The harm is done not only to themselves but also by risking patient safety (Shanafelt *et al*, 2010). Honouring the Humanity of workers in the system not only supports their wellbeing but is also likely to be of significant financial benefit (not surprising when we consider the cost of sick leave, attrition, breakdown of trust and relationship etc). Working in a more 'human' way could save public services £18 billion (Lowe *et al*, 2020)

If we wish clinicians to offer humane, relational care to patients, we must also attend to the human dimension The capacity for attentiveness, compassion, interpretive judgement and presence does not arise automatically from technical training alone; it is the relational and educational environments in which clinicians learn and work that shapes these abilities. It is important to recognise the impact of system constraints: navigating increasingly complex, high-pressured, litigious, protocolised and measured environments. One of our previous medical students, now a Foundation Year 2 doctor in the UK writes:

> *'Rarely are we given any time or supplies to recover either physically or emotionally. Workplaces almost never participate in meaningful debriefs after troubling experiences and substantial discussion is replaced by independent reflections which we are expected to upload for our logbook'.*
> (Mashael Ishaque, 2026)

This illustrates a lack of time and resource for the human dimension of the clinician. The opportunity of shared reflection which could initiate learning and development has been turned into an isolating, procedural tick-box requirement. Humanity gets squeezed out, by default rather than design. How might we instead begin to design in human dimension capability, recognising that we are working in the context of biomedical theoretical dominance (Kuper & D'Eon, 2011) and neoliberal discourse (Giroux, 2014)?

Educational approaches are shaped and constrained by policy frameworks (GMC, 2018; NMC, 2018) alongside assessment systems that prioritise standardisation and reliability, often influenced by resource constraints (for example, the use of machine-marked single best answer questions). These structures signal powerful messages about what counts as legitimate knowledge and capability. As Marshall McLuhan observed, the *medium is the message* (McLuhan, 1964); the ways in which we are invited to learn communicate what is truly valued.

Focusing on learning in the healthcare professions, the human dimension may be better understood as an orientation that shapes how knowledge is held and applied, rather than as a discrete body of knowledge to be acquired. Since the human dimension concerns relational, interpretive and contextual ways of knowing, *how* students learn becomes as important as the content itself. Approaches such as co-creation, partnership and engagement with lived experience may therefore be central rather than supplementary. What follows are five interrelated areas that may offer useful starting points for cultivating human dimension capability across cognitive, embodied, experiential and relational domains.

1 Understanding relational determinants of health

Health is shaped not only by biological processes but by the quality of relationships in which lives are lived. For example, loneliness, bereavement and social isolation negatively influence health outcomes (Holt-Lunstad *et al*, 2010; Hardt *et al*, 2025). Continuity of care, on the other hand can reduce mortality (Sandvik *et al*, 2022) and compassionate care has been found to enhance patient experience, symptom control and recovery (Trzeciak & Mazzarelli, 2019). Recognising relational determinants of health helps students understand why connection is clinically relevant.

Learning may be strengthened not only through engagement with cognitive knowledge of research in this field, but also through educational environments that are themselves relationally enriching. Near-peer learning, longitudinal small groups, and student-led spaces for mutual support can enable a shift from seeing healthcare as the application of knowledge to recognising it as a relational practice enacted within complex human contexts.

2 Valuing lived experience as knowledge

Patients, carers and communities hold forms of expertise that cannot be accessed through textbooks alone. When learners encounter lived experience not as anecdote but as knowledge, movement is encouraged beyond forms of *testimonial injustice* in which patient accounts are unconsciously afforded less credibility than clinical perspectives. Creating opportunities for patient voice, particularly regarding how healthcare practices are experienced and how care is received, helps illuminate dimensions of illness that remain otherwise hidden. Similarly, responding to how students experience educational environments is especially important within the human dimension, where learning is shaped not only by content but by relationship, belonging and meaning-making.

When lived experience is welcomed as knowledge, both healthcare and education become more responsive to the realities of those they seek to serve.

3 Learning for holistic, complex and uncertain practice

Illness arises as an interaction between biological processes and lived experiences that affect relationships, emotions and meaning, Clinicians are often called to work beyond linear biomedical cause–effect frameworks, especially with patients who are living with chronic illness, persistent unexplained physical symptoms, trauma-infused suffering, or the strain of financial, housing or relational poverty. From this perspective, what is often regarded, even dismissed as 'somatisation' or 'functional' from a dualistic perspective might instead be understood as interwoven across the fibre of a person's being. Behind diagnoses such as borderline personality disorder there may be adaptations to relational rupture, adverse early experience and family instability. The human dimension invites recognition that such suffering is lived by the whole person, whether or not it slots neatly into a diagnostic category.

4 Protecting spaces where meaning can be made

Human beings are meaning-making creatures (Frankl, 1985), and the meanings that pervade experiences of health and illness, for both patient and clinician, are as varied as our fingerprints. Illness may bring hope, fear, shame, re-evaluation, or transformation. Clinical practice inevitably encounters these layers of meaning, whether or not they are noticed and acknowledged explicitly. Research into doctor-patient consultations has described patients' 'multi-faceted, contextualised and meaningful accounts' as 'voice of lifeworld' and clinical-speak the 'voice of medicine' (Mishler, 1984). 'Voice of medicine' consultations adopted by both patient and clinician could work for simple problems. The worst outcomes were when the patient spoke with 'voice of lifeworld' but the doctor fragmented and blocked them with 'voice of medicine' (Barry *et al*, 2001).

To support clinicians in the field of meaning making, or making sense of the complexity of frontline healthcare, educational spaces that support dialogue, reflection and vulnerable or authentic sharing need to be carefully created and held, for example with the skills of vulnerable leadership (Younie, 2016) and invisible artistry (Seeley, 2011). A creative enquiry approach (exploring lived experience through the arts) can enable students to practice noticing, and to articulate their encounters through story, image and shared reflection. In such ways we may help learners to attend to and enable 'voice of lifeworld' in consultations where this is most needed.

5 Nurturing the clinician as instrument of care

Engel, who introduced the biopsychosocial model as a corrective to overly narrow biomedical approaches, also described the clinical encounter as involving the scientific methodological triad of *outer viewing (observation), inner viewing (introspection) and interviewing (dialogue)* (Engel, 1997).

Our capacity for 'inner viewing' (awareness of our own emotional responses, assumptions and vulnerabilities) shapes how we encounter others. Research in psychotherapy suggests that clinicians who are themselves highly self-critical tend also to be more controlling or critical in their interactions with patients (Henry *et al*, 1990). In a professional culture with a hidden curriculum that fosters perfectionism, competition and emotional invulnerability, this may constrain development of clinicians' capacity to care.

Attunement, the act of noticing internal experience *without judgement* (Shapiro *et al*, 2014) may therefore be fundamental. Approaches to support attunement include reflective practice, mindfulness, self-compassion, and forms of 'shadow work' that gently explore difficult or disowned aspects of experience (Younie, 2025). Arts-based student and clinician examples of 'shadow work' can be found in a previous Journal of Holistic Healthcare edition on Facing the Shadow (Elliott, 2015; Lyons 2025; Haffner, 2025) as a starting point for exploration of these ideas.

Across these five areas the arts provide a powerful means of supporting human dimension learning by inviting participation of body, emotion and imagination to give voice to forms of knowing less accessible to analytical reasoning alone. Bringing the arts into healthcare education may be considered more, rather than less scientific, if science is understood as selecting methods appropriate to the phenomenon (the full complexity of engaging with human illness experience).

In summary, the human dimension invites a more three-dimensional understanding of healthcare, one that attends to persons as well as pathologies, relationships as well as results, context as well as content. In systems that risk reducing clinicians and patients to units of activity, attention to the human dimension becomes both necessary and quietly countercultural.

Gavin's words remind us that what patients often seek is not the absence of expertise, but expertise offered in relationship. The question, 'How can I help you?' does not replace, 'What is your diagnosis?' but situates it in the wider context echoing McGilchrist's Emissary and Master thesis (McGilchrist, 2009).

Perhaps the task of education is not simply to produce competent practitioners, but to sustain the conditions in which clinicians and patients may still meet, at least sometimes, as two human beings.

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I would like to acknowledge previous funding for Flourishing Spaces from the President and Principal Fund for Educational Excellence, from QMUL and current funding from the Della Fish Foundation for exploration into the Human Dimension of Healthcare.

GPs in primary healthcare: what has gone and what is coming?

A dialogue from a restive and bewildered profession

David Zigmond served for 40 years as a principal GP in south-east London until 2016. He is on the executive committee of Doctors for the NHS.

Steve Taylor has been a GP and trainer for 30 years and is co lead for general practice at the Doctors' Association UK (DAUK). He works in Manchester as a locum and sits on DAUK's executive committee.

Drawing on more than half a century of collective experience, they discuss what has been lost – and what might still be recovered – in the evolving structure of NHS general practice.

Summary

In this extended dialogue, veteran GPs Steve Taylor and David Zigmond reflect on half a century of NHS general practice. Speaking with candour and long perspective, they examine how target cultures, bureaucratic surveillance, and corporate models have eroded vocation, continuity, and community. Both argue for a revival of small team generalist medicine and personal responsibility as the NHS's essential – and endangered – infrastructure. 'Continuity and conversation', they conclude, 'sound soft, but they're what keep everything else standing'.

The lost bedrock

DZ Reading *Your GP Here for You* [a campaign calling for a new GP contract that puts patients at the centre of care, launched by Doctors Association UK (DAUK)] I was struck by how much it describes the world we once knew – small teams, personal lists, relationships that mattered. The document could well be a recipe for rediscovering the essence of general practice.

ST That was exactly our aim. It's about rebuilding what originally made general practice work: continuity, good care, and a humane workplace. The challenge is persuading ministers that these things aren't nostalgic luxuries but prerequisites.

DZ I keep asking how we let these things vanish. My conclusion is that we submitted to the wrong ideology – a kind of corporate neoliberal thinking that tried to remodel human care on industrial manufacturing. Targets, outputs, throughput … those things deliver efficiency where the product is repetitive, but they're hopeless where meaning lies in relationship. Machines can be standardised; people cannot. We've mistaken control for quality.

ST And that mindset has turned general practice into a target driven service. Reforms were supposed to eliminate poor performance, but most practices were already doing good work. We applied industrial standardisation to a craft profession.

DZ That's the key distinction – craft. You can't mass produce craft. The best consultations I ever had weren't about perfect policy; they were two human beings navigating uncertainty together. We've bureaucratised that out of existence.

The costs of losing continuity

ST Continuity is the heart of it. When I left partnership, my list had 9,000 patients. On my final day I saw 50 people – a blur of face to face and phone calls. It's impossible to think deeply with those numbers.

DZ And the irony is it's sold as efficiency. But it's not. When you know someone, you practise more safely and cheaply. You avoid duplicate tests, unnecessary referrals.

You can explore the human background – the rows, the worries, the disappointments – that lie behind symptoms. I had a patient once with dizzy spells; because I knew the turbulence in her marriage, I didn't request another MRI. Healing grew from context, not technology.

ST That's almost impossible now. Patients rarely see the same doctor twice. The named GP system was a good idea, but you can't have person-based care without person-based teams. Massive practices and carouselled rotas have dissolved commitment and belonging.

DZ In the 1970s, most of us worked for decades in one patch. We became part of the landscape. You grew old together with your community. That's what people mean when they recall 'my family doctor'. The smaller the unit, the more possible that intimacy.

ST We could recreate some of that even in larger partnerships by dividing into semi autonomous 'firms' – small groups of GPs covering 4,000–5,000 patients. Micro continuity within macro structures.

DZ I'd embrace that, provided it includes dedicated space and a stable core team. Hot desking and rotating locums destroy emotional ownership. Patients can tell instantly when no one truly knows them. And doctors lose the sense of stewardship that keeps vocation alive.

The pressure cooker

ST It's also a practical crisis. One in nine people are waiting for hospital treatment – seven million across England – and many chase their GPs for updates, interim support, or reassurance. Add in complexity: hospital stays are shorter, but convalescence hasn't shortened, so we pick up half recovered patients. And preventative medicine expands our long-term medication lists. Twenty years ago only a fifth of my population were on regular prescriptions; now it's half. Workload multiplies by stealth: new forms, new tasks, new screening targets – none removed when another is added. It's incremental drowning.

DZ And that cumulative overload leads to burnout. When I started, older colleagues often retired tired but fulfilled. They'd say, 'I've had a good run'. Now we see early retirement, cynicism, moral injury. People who once loved the work now talk about escaping it. That's a cultural tragedy.

ST We've become data clerks as much as doctors. A GP's day can feel like ticking boxes for unseen auditors rather than engaging with the patients we know in front of us.

DZ We've built a surveillance state around good intentions. Of course we must prevent harm and weed out incompetence, but over regulation sucks life from the majority who don't need it. Families thrive on trust, not constant external inspection; so did general practice.

The partnership paradox

ST The irony is that the traditional partnership system handled that balance beautifully. It combined NHS commitment with local autonomy. Yet funding cuts and political disbelief have undermined it. We now get about £169 per patient per year – 20% less, in real terms, than a decade ago. Some politicians think direct state employment would work better.

DZ The partnership model was unique: state funded but self directed. It created a sense of ownership that bred good care. When you run 'your practice', you tend the soil as well as the crops. Salaried employees rarely feel that. I couldn't have been as committed if I were merely executing top down orders.

ST And yet many see partners as privileged. They don't grasp the complexity – we're clinicians, employers, HR managers, property supervisors, strategists. It's part vocation, part enterprise, part public service. The risk and responsibility balance each other.

DZ Once, people stayed in those partnerships for life. Staff loyalty, nurses, receptionists – everyone had longevity. They cared because they belonged. You can't replace that with central management from an integrated care board.

ST If partnership dies, the likely successors will be corporate providers. That's what happened to dentistry: small local surgeries replaced by multi-nationals. We may be two or three years from that tipping point if policy doesn't change.

DZ Then we'll see GPs employed by BUPA or Tesco Health, incentivised by shareholder returns. Very different from vocational medicine.

Generalists and the fractured NHS

ST And it ties into a deeper loss – the loss of generalism. Hospitals once had general physicians who followed complex patients through multiple systems. They've vanished. So GPs are now the last true generalists.

DZ When medicine fractures into silos, coordination costs explode. One case stays vivid for me: a man with Lewy body dementia, chronic obstructive pulmonary disease, atrial fibrillation, diabetes. Each admission meant eight specialist teams, each running their own tests. The most junior ordered yet another brain scan primarily to shield himself from future blame. No one owned the whole person. That's not good medicine; it's bureaucratic panic.

ST A general physician could have managed that intelligently, saving distress and thousands of pounds. But we design systems for accountability, not wisdom.

DZ Precisely. The more we know a person, the less we need to investigate them. Relationship replaces duplication.

ST And those relationships extended beyond the consulting room. Receptionists, district nurses, health visitors – they all noticed subtleties. In my smaller practice, a receptionist once spotted early dementia before any clinician did, simply through familiarity. Larger systems lose that kind of awareness.

The industrial mindset

DZ Another major cultural error is assuming that bigger means better. In manufacturing, yes – scale brings efficiency. In human care, scale strips meaning. Yet we keep merging, centralising, outsourcing. Healthcare planners seem unable to distinguish between mass production and relationship work. They think duplication of premises is wastefulness, when in fact it also represents accessibility and connection.

ST It's the managerial illusion of control. We've seen it before – new hierarchies rebadged as 'integrated systems'. The lessons of failed reorganisations are rarely remembered, because institutional memory itself has no metric.

DZ As a young doctor, I learned from Balint groups – those meetings where we explored the interpersonal undercurrents of consultation. They taught us to listen to what wasn't said. That skill depends entirely on continuity. Today, I doubt many trainees even experience it. We've replaced curiosity with coding.

ST Training now mirrors bureaucracy. Every competence must be ticked, every reflection documented. But what matters most – empathy, discretion, human judgement – resists quantification. Those are learned through apprenticeship and continuity, not through audit.

DZ *The more you see of somebody, the more of somebody you see.* Medicine is not just about blood results; it's also about stories shared over time.

Guidelines or guidance?

ST One of our biggest mis steps is turning *guidelines* into *rules*. NICE intended them as frameworks, to be applied with judgement. But younger doctors fear deviating because governance systems punish divergence, not negligence of humanity.

DZ I've experienced that personally. I take the occasional diclofenac for arthritis. My GP insists on adding a proton pump inhibitor because 'the system' requires it, even after I tell him I don't want or need it. He admits he'd get flagged if he didn't. The absurdity is obvious: we're responding not to the patient, but to the algorithm.

ST That's manufactured medicine – civic engineering applied to health. Risk management becomes ritual compliance. Real professionalism is using discernment to balance benefit and burden. Yet that art is being crowded out.

DZ And civic engineering assumes that human beings are inert materials. It says: 'We'll remodel you by protocol'. But medicine's essence is also about engagement: helping people mobilise their own internal resources. You cannot engineer the soul.

ST That's why our *Your GP Here for You* proposals argue for relational reform – space, time, and trust instead of endless targets. Rational care, not industrial output.

Reclaiming vocation

DZ So where does hope lie? I think we must re sow the soil – bring back small relational cells within larger organisations, restore pride and craft, reward commitment rather than compliance. Vocation cannot be mandated, but it can be cultivated by the right ecology.

ST Agreed. We need to prove that continuity isn't indulgence; it's efficiency through trust. The public understands that intuitively: patients miss 'their doctor'. If we don't repair that bond soon, we'll wake up to an NHS run by branding consultants rather than personally vocationed clinicians.

DZ The essence of the NHS, at its birth, was solidarity: care based on relationship rather than transaction. That is precisely what industrialisation has forgotten. We still have time to remember.

ST Continuity and conversation – they sound soft, but they're our hardest infrastructure. Without them, the rest collapses.

DZ Then our challenge is to protect that humanity in an inhuman system, to keep medicine an art as well as a science.

ST Yes. Because to save the NHS, we must first save what was best in general practice.

What's left unsaid: a researcher's reflections on silence in healthcare

Olga Lainidi

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I have been interested in how people experience work, health, and wellbeing, especially in healthcare, since being a high school student. I then studied psychology in Greece and now I research employee silence, voice, and burnout among UK healthcare workers. Over the past few years I have spent most of my time listening to healthcare staff talk about their working lives, and I became particularly interested in silence because it kept coming up in different ways. What struck me was that silence is always simple; sometimes it can reflect pressure, care, uncertainty or the realities of the system people are working in. My work is driven by an aim to better understand the everyday experiences of healthcare workers and to do research that feels useful, human, and grounded in real life.

Summary

This brief article explores the complex role of silence in the working lives of UK healthcare staff. Drawing on reflections from research conversations, it considers how silence can be protective, strategic, or simply necessary in high-pressure environments, but also how it can accumulate and weigh heavily over time. Rather than treating silence as a problem to be fixed, the piece invites readers to think about what it means to create spaces where the unsaid can be acknowledged, and where healthcare workers can feel heard.

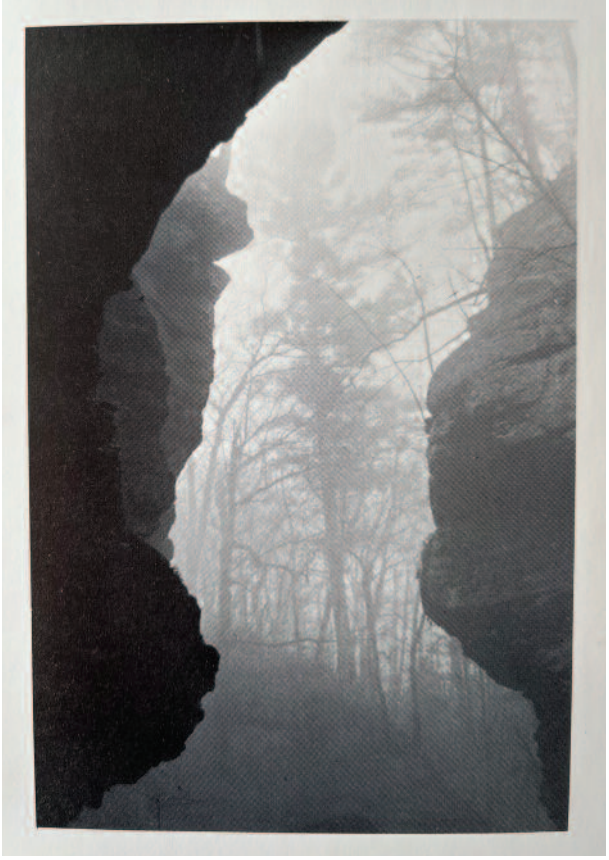
Healthcare, to me, represents one of the most meaningful forms of human work. It is where science meets life in its most vulnerable form, where skill meets responsibility, and where decisions matter in very immediate ways. That has always fascinated me. As a researcher, much of my work involves listening to healthcare workers sharing their lived experiences, their thoughts and feelings – how they make sense of what's happening around them and how work impacts their physical and mental wellbeing. Sometimes, as researchers, we try to understand how these experiences fit within our existing theories, but often we just realise that something is too complex to be understood just as one thing.

When I first began researching employee silence in UK healthcare, I thought I had a good sense of what I'd find: a gap between what people wanted to say and what they felt they could say. Employee silence is often defined as the deliberate withholding of concerns, opinions, or information about work-related issues (Morrison & Milliken, 2000). In reality, the picture revealed to me so far has been more nuanced. Silence isn't always about fear or hierarchy. Sometimes it reflects care, judgement, or an effort to protect others. People might stay silent to avoid embarrassing a colleague in front of others, or because raising an issue during a chaotic shift might make things worse, not better. In one conversation a senior nurse, while describing the atmosphere around speaking up in a previous organisation, paused before saying, almost matter-of-factly, 'If I speak up… I'm going to be in the spotlight. My card's marked'. There was no drama in her voice. It wasn't said as an accusation. It did not sound to me like she was saying 'I'm terrified', but rather that 'I know how this works'. Silence, in that moment, wasn't passivity. It was risk assessment.

There's a lot of talk about voice in the NHS. Most staff are familiar with the phrase 'freedom to speak up', and the idea that speaking up is both a right and a duty. One health trust policy I read put it like this: 'Individual

members of staff … have a legal right and a duty to raise with their managers or the trust board any matters of concern they may have about safety, clinical practice, malpractice or wrongdoing'. The message is clear, speak up, and speak early. And people do. In all kinds of ways, every day. Concerns are raised, ideas are shared, problems are escalated. But that doesn't mean the process always feels straightforward, or that it always leads to change.

In conversations people often tell me that speaking up doesn't always feel like a free choice. One way I've come to understand this is through a simple image: a pedestrian crossing the road. The light is green, and they have the right to cross. But if a large vehicle is speeding toward the junction, they pause, not because they're unsure of their right, but because the cost of stepping out has changed.



In healthcare, that vehicle isn't necessarily a hostile manager or a bad culture. Often, it's the pressure of the system itself – the pace, the complexity, the constant trade-offs. People step back not necessarily because they're afraid, but because they're trying to make the best possible decision in a situation that doesn't have easy answers. That's not to say silence is always benign. In some cases it becomes habitual, a way of coping that slowly disconnects people from their teams, or their sense of voice altogether. But silence is not one thing. It's not always a problem to be fixed. Sometimes it's just the reality of working in a system where not everything can be said, all at once, by everyone.

The word fear appears frequently in academic discussions of silence. Yet when I ask healthcare workers about it, some hesitate. I remember how one junior doctor reflected that in medicine, the word fear is usually reserved for immediate clinical danger like 'I'm really scared this patient might deteriorate'. Using the same word to describe worries about career repercussions felt, to her, too strong. 'I'd say I'm concerned', she explained, 'not afraid'. The distinction may seem subtle, but it matters. Language shapes how we interpret experience.

When I have the opportunity to speak with healthcare workers, I try to look for positive examples as well, whether the person had ever experienced speaking up handled particularly well (for example a situation where someone raised a concern and the organisation responded thoughtfully, constructively, even appreciatively). When I ask if they have heard of any positive examples, it feels like positive memories are quite hard to find. This does not mean such examples do not exist. My reflection is that the act of speaking up in a challenging situation is in itself often experienced as difficult, as something that requires effort, judgement, and courage. Even when the outcome is neutral or constructive, the process can feel exposing or exhausting. In other words, speaking up seems to be remembered less as a success story and more as a moment of tension to decide whether the potential benefit justified the personal cost. I remember someone once describing a situation involving something seemingly mundane related to how communication about patient preparation was coordinated. A small procedural disagreement spiralled into a flurry of emails, misunderstandings, and a lot of interpersonal tension. No patient was harmed and no headline would ever be written about it. Yet the emotional energy it consumed was real. 'It's those sorts of things that I struggle to manage' she said, referring not to clinical risk, but to the strain of navigating complexities. Silence, in these instances, can be a way of conserving energy.

Even when silence makes sense in the moment, it doesn't always disappear once the shift ends. Some people take it home, replaying conversations, second-guessing decisions, thinking through what they might say next time. Others move on quickly but still carry a quiet awareness that something didn't sit quite right. Over time, those small moments can build into a low-level strain, a kind of emotional backlog. Silence has weight. Carried day after day, it needs somewhere to go. But the resources to process it – time, energy, support – aren't always available. People do what they can to cope: they shield emotions, they create distance. Sometimes this self-protection helps. Other times it drifts into emotional exhaustion, cynicism, depersonalisation – what is often called burnout with one word (Maslach & Leiter, 2016). This is where the link to wellbeing starts to become clearer. We talk a lot about workload and stress, and rightly so. When people feel there's no time or space to reflect on what's left unsaid, it can affect how connected they feel to their work, their teams, and their own sense of purpose. I remember a senior doctor once saying to me 'There is no time to think in the NHS!' when I asked them what people do when

they feel unsure about something – so they default to holding back.

I have also noticed that this lack of space does not sit only with frontline staff – it extends upwards too. Senior clinicians in management roles sometimes describe a very different kind of frustration. When there are not enough beds for patients, when funding constraints restrict every operational decision, when services are stretched daily to capacity, requests about staff lunchrooms, locker space, or office allocation can feel, in their words, 'almost unthinkable' or 'impossible to prioritise'. One senior clinician explained that on days when they are trying to find a bed for a deteriorating patient, debates about where coats should be stored feel detached from the reality they are managing – 'the big picture'. For frontline staff affected, these concerns are about whether the organisation sees the realities of their working day. As an outsider, it seems to me like in such stretched systems, decisions are rarely between something important and something unimportant. They are between two or more important things. In that space, where priorities compete and resources are finite, silence can quietly establish itself. Over time, the concerns that are repeatedly deferred can become quieter. Not because they have disappeared, but because people learn that there is limited room for them. Silence, then, becomes less about protection and more about perceived capacity.

This doesn't mean we need to say everything out loud. In fact, most healthcare workers I speak with are clear that not every frustration, idea, or disagreement needs to be voiced in the moment. Silence can be thoughtful, strategic, and even restorative. But it does need somewhere to go. A place to be acknowledged, even briefly, before it builds up. Sometimes that space is formal: supervision, reflective practice, or a team meeting that allows for honesty. Other times, it's informal, a trusted colleague, a friend, family, a conversation after a shift, or even the act of writing something down. And sometimes, it's research. One of the things I've come to value most is the role that research conversations can play in creating space, not to judge or fix, but just to listen and notice what often gets left out. Some of the most beautiful moments in research are when participants share how writing or speaking helped them understand and name what was bothering them.

In the context of healthcare, where demands are high and time is short, these spaces might feel like luxuries. But if we want people to flourish in their work – not just survive it – we have to take seriously the quieter parts of their experience. Silence doesn't always mean something is wrong. But it sometimes means there's something worth paying attention to.

There will always be things left unsaid at the end of a shift. Through research, I have come to understand that it is part of the reality of working in pressured, complex systems: not everything can be voiced, and not everything needs to be. But when we take time to listen – really listen – to what people are holding onto, we create the conditions for those quiet experiences to be shared, understood, and maybe even transformed. These conversations don't have to happen immediately or formally. Sometimes they come later, through reflection, through trust, or through simply having the time and permission to make sense of what happened.

> In conversations people often tell me that speaking up doesn't always feel like a free choice

Researching silence has never been about portraying healthcare as a broken place to work. On the contrary, the more conversations I have, the more I notice the effort, the kindness, and the quiet professionalism that rarely makes the headlines. I see people constantly trying to do the right thing under conditions that are not always easy. I see humour used to survive long shifts, small acts of generosity between colleagues, and a level of commitment that is often taken for granted. When I visit a GP practice or a hospital and someone asks what I do, I usually say that I research burnout and silence among healthcare workers. Almost without exception, the reaction is the same: they lean in. Sometimes it starts with a half-smile, 'Oh, you should do some research here!'. People describe how hard things have been, particularly in recent years, but they also talk about how they keep going. Again and again, I hear the same sentence in different forms: 'Our biggest resource is our team'. When systems feel stretched, it is colleagues who hold each other up. What is shared in a locker room, the quick check-in during a busy shift, the nod of understanding after a difficult interaction – these are not small things. They are sustaining ones. I've seen how meaningful it can be just to ask people what they hold back and to give them space to answer without judgement. The silence itself doesn't always need to be 'solved'. Sometimes, it just needs to be acknowledged. And in that process, people often rediscover a sense of connection, to themselves, to their teams, and to the values that brought them into healthcare in the first place.

All those conversations and interactions have shaped how I see healthcare. Yes, there is pressure. Yes, there are limits. But there is also commitment, solidarity, and an ongoing attempt to care. It reminds me that research in this space is not about exposing failure. It is about understanding how to protect and strengthen what is already working.

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The story of 'tools of the trade'

Lesley Morrison
Retired GP

Working as a GP, first in London then in the Scottish Borders, I was privileged to share people's lives and listen to their stories. I have always believed that the arts and creativity enhance healthcare, and that it is a health professional's responsibility not only to care for individual patients and their families, but also to contribute to care of their communities and of the planet. Since stopping clinical practice, I have continued to engage with climate and health work , teaching, writing and serving on the board of Medact. Think global, act local…we look after a woodland, grow food and spend as much time as possible outdoors. Six months ago I became a grandmother; holistic, planetary health and creativity feel even more important.

Summary

Since 2014 every Scottish medical graduate has been given the poetry anthology 'Tools of the Trade'. An editorial group curated these short collections of writings to nurture compassion, humanity and resilience in new doctors. Dr Morrison tells of the book's genesis, initiated after the death of a valued GP colleague, and developed in partnership with the Scottish Poetry Library. It has since inspired companion books for nurses, teachers and encouraged wider cultural initiatives that sustain the human dimension and the values of holistic healthcare.

In the beginning

Once upon a time, as all good stories begin, the director of the Scottish Poetry Library waved a magic wand and said a spell. She said 'yes' to the idea of a little book of poetry for new doctors and the first edition was published a few months later.

The idea had firm cultural foundations. We had run a series of evening sessions with doctor–poets at the library the previous year; they had been well received and I had got to know Robyn Marsack, the director. The idea for the book had been germinating for some time and, when I finally picked up the phone and called her, scarcely had I outlined the idea when she said, 'Yes, we'll do it'. At the launch of the third edition about six years later, she signed my copy, 'Best wishes, the one who said yes'.

Time, as we know, is strange stuff. Ancient Greek thought held that there were two interrelated types of time: chronological, linear, quantitative time – *chronos* – and qualitative, opportune time – *kairos*. *Kairos* involves a sense of the 'right time', the 'critical moment' (Kumagai & Naidu, 2020). That 2014 phone call was the critical moment that led to the birth of the book. I can recall it as though it happened yesterday.

Stories in medicine

A thousand years ago (in actual chronological time, 50 years ago) when I was a medical student in the pre-oil granite city of Aberdeen, the city was certainly grey, cold and conservative. Yet the medical school was innovative. I scraped through the first two years of memory testing. But in the third year we were exposed, despite scientists' opposition in a crowded curriculum, to psychology and sociology. A light was lit. I remembered why I wanted to be a doctor…to try to understand people's lives and stories and to try to help them make sense of them. In my

fifth year when 'social medicine' cropped up, I loved it. My father worked for an airline, so I got free travel and I didn't hesitate to make use of it to arrange several attachments overseas. After graduation I travelled some more (more people, more stories).

General practice training followed, the most fascinating, nourishing part of which was our regular Balint workshops – sessions examining the doctor–patient relationship. Then, inspired by committed people who worked in what was then called community medicine, I deviated into a training in Hackney and north London. But missing the people and the stories I soon enough returned happily to my natural home in general practice.

Arts and humanities

A dear GP colleague and passionate educationalist Dr Pat Manson and I often spoke about the value of arts and humanities in medical education. So when in 2014 Pat very sadly and suddenly died, I decided to put these ideas into practice. In memory of Pat, we formed an editorial group. Another GP friend of Pat's, Martainn Mac an t-Saoir (Martin MacIntyre) had written a poem called *Tools of the Trade*. The book had found its name.

New doctors will be empowered by poems
In the pockets of their metaphorical white coats.
There at the ready:
on early, sweaty, scratchy ward rounds
to deploy while waiting patiently for the consultant's late appraisal;
give filing, phlebotomy and form-filling an edge and depth;
sweeten tea breaks as if with juxtaposed Jaffa Cakes to answer that persistent bleep-while sneaking a pee,
to travel the manic crash and flat-lined emptiness of cardiac arrest
thole the inevitability of the inevitable….*
Tools of the Trade
*Scottish word for suffer or tolerate

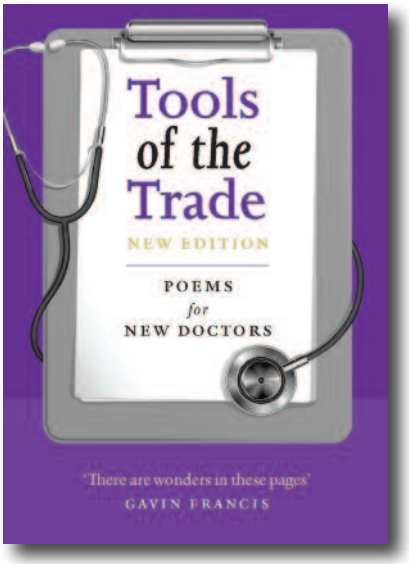
Creating our anthology

The editorial group consisted of Dr John Gillies, GP and then Chair of the Royal College of General Practitioners (RCGP) Scotland, Revd Ali Newell, assistant chaplain at Edinburgh University, Lilias Fraser from the Poetry Library and myself. Aiming always to provide support and nurture creativity, we spent many happy hours discussing and choosing poems. They had to be short and accessible and to speak in some way to the experience of being a junior doctor. The RCGP supported publication of the first edition, with subsequent editions been supported by the RCGP and the Medical and Dental Defence Union of Scotland (MDDUS). Since 2014 every medical graduate in Scotland has been gifted a copy.

Our foreword message to the recipients was:

Congratulations on graduating as a doctor. Being a doctor is a privilege. It is also very demanding and can be stressful, and to be able to look after others we need to look after ourselves. We offer you this little book of poetry, Tools of the Trade, as a friend to provide inspiration, comfort and support as you begin your work.

Earlier that year, the late Professor Ken Calman, previously Chief Medical Officer, had published his book *A Doctor's Line: Poems and Prescriptions in Health and Healing* (2014). It drew on texts from more than 700 years of Scotland's literature to reflect on health and social issues. Professor Calman had grown up in poverty in Glasgow reading books by candle-light and he had huge empathy for his patients. The quote he kindly provided for our cover was, 'What a marvellous collection of poems to console, inspire and enlighten the young doctor. An excellent initiative to provide some tools to enhance their own clinical practice.' Thank you, Professor Calman, for your support and for your work.



Tools of the Trade, Scottish Poetry Library, 2014

What people say about it

Feedback from recipients and readers has been positive.

'*Medicine is so intense, particularly when you've just graduated from university, so the poems offer a deeper understanding of the human experience and allow permission to process.*'
GP trainee Connie Swenson

'*I'm grateful for the companionship of* Tools of the Trade. *A copy of that wee book has accompanied me from school to now being qualified as a doctor; it affirms the human in us. I have a lot to learn, I am fallible. But there's solace in those words and in knowing that people have come before me and felt.*'
Nina Young, foundation year one doctor

'Tools' *meant a lot to me and provided a great support. It represented what I could bring to the team. Though I often felt under knowledged and*

inexperienced, I knew I could always offer some humanity. Whether that involved hanging back on the ward round to explain what the consultant's plan was or making tea for a colleague who was stressed or even chatting with a patient about a poetry collection on their night stand, then sharing Tools of the Trade *which I kept in my own bag in case of times when I forgot why I was doing this. I first had a copy over six years ago and it still serves to remind me that the practice of doctoring is not simply an academic challenge but that if the people* (both colleagues and patients) *are forgotten then there is no point.'*
Rachel Millar, newly qualified doctor

'Tools of the Trade *is a little gem of a book. It continues to delight no matter how many times I have read it.… Although I do not regularly read poetry I thoroughly enjoyed reading and making my own interpretation of the poems. As a newly qualified doctor, this collection of poems made me reflect on the profession I have chosen and its rewarding and challenging nature.'*
Dr Navya Bezawada, newly qualified doctor (Gillies, 2015)

A life of its own

From the second edition in 2016 we have arranged the poems in sections – Looking after yourself, Looking after others, Beginnings, Being with illness and Endings – and this has worked well. The third edition in 2019 and the subsequent two have been jointly published by SPL and Polygon, an Edinburgh-based imprint of Birlinn Ltd, and we have been grateful for their continuing interest and expertise.

In 2018, the book produced offspring, *To learn the future, poems for teachers* (Cooper *et al*, eds). In the foreword the then Scottish Makar (Scotland's equivalent of the Poet Laureate) said, 'This gift is not homework but heart work'. Beautiful. And in 2021 *To mind your life, poems for nurses and midwives* (Tongue *et al*, eds) was published. The director of the Royal College of Midwives, Scotland, Dr Mary Ross-Davie, wrote how the book and especially one poem in it, Maya Angelou's *And still I rise*, served to remind her that, when things were tough, she was strong.

Another initiative spawned by *Tools* was based at St Andrews University Medical School with Steve Smart filming staff and students reading poems from the book and making them available to listen to in a booth in the refectory. This installation travelled to several GP and other conferences and, for many, the power of the poems was enhanced by hearing and seeing them spoken.

A wider circulation

Our wee book has been the subject of articles in *The Lancet*, the *BMJ*, the *Herald*, the *Scotsman* and the *Wall Street Journal* and has featured in interviews on Radio Scotland and on a Front Row Radio 4 episode at the Edinburgh Festival. We were invited to host a discussion on poetry in health at the Edinburgh International Book Festival and at Edinburgh University's compassion salon, a project attached to the University's Global Compassion and Empathy Initiative (https://uoe-global-health.ed.ac.uk/compassion). This farsighted project is exploring ways to catalyse and embed the evidence and practice of compassion within the university and in relationships in the city, in Scotland and the world. This work is being done within the framework of the UN Sustainable Development Goals.

Compassion in medical education

'Compassion is the glue that holds the sustainable goals together.'
Professor Liz Grant, Global Health Academy

Compassion was the topic of a special study component we offered to a group of first year medical students. They devised a questionnaire for fourth-, fifth- and sixth-year students and conducted telephone interviews with some of them and with practising GPs.

Forty nine per cent of survey responses and 57% of interviewees did not think there is a lack of compassion in healthcare. This was heartening. And the majority also felt that *Tools of the Trade* was based on a valuable concept and that it would encourage compassion. They also felt that this worthwhile aim deserved a wider audience and could more effectively reach out to doctors farther on in their careers, and be made even more accessible by including short stories and anecdotes.

Several respondents thought that short stories would be more relatable and easier to understand. Some quotes:

'Poetry is very much a love or hate thing.'

'It's impractical to think that doctors have time in their days to read related poetry.'

'Those who are least compassionate are probably those least likely to read it.'

This inspired me to write *The Wellbeing Toolkit for Doctors* (Morrison, 2021). This supportive guide for everyone in healthcare has short chapters dealing with, for example, compassion, self-compassion, peer support, teamwork, uncertainty and creativity.

The latest developments

The most recent descendant of *Tools of the Trade* is a little book of poetry, *We are just getting started* (2025), published by the Scottish Poetry Library to commemorate the 300-year anniversary of Edinburgh Medical School. A group including Dr John Gillies, Dr Gavin Francis and poet (and SPL project lead) Samuel Tongue chose the poems to 'recognise, celebrate and commemorate 300 years of science, innovation, achievement, compassion, community and generosity … at Edinburgh Medical School'.

So what does the future hold for *Tools of the Trade*? We would like it to be even more culturally diverse, to have more student involvement in the writing and choosing of poems, and to have it travel south of the border. Thanks to funding from the friends of the hospital one English medical school in Hull is already gifting it to their graduates. We hope others will follow.

I feel very honoured and very glad to be part of this project. Now, 10 years after retirement from clinical practice, it has enabled me to continue to feel part of the family of holistic healthcare. Hopefully I can still make a contribution to the emotional, mental and spiritual health of health professionals, and therefore of their patients.

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The machine

Philip White

GP registrar, researcher, singer/songwriter

How systems affect and can be affected by the people who work within them is something that has fascinated me throughout my career. I am struck particularly by the narratives that we develop and tell ourselves that perpetuate these systems – both for good and ill. These are narratives I continue to explore through my clinical interest into the developing role of the doctor, through research into how we have better attitudes and skills towards vaccine hesitancy, and more personally through my music (you can find this under my artist name Philip Jonathan).

Summary

A doctor reflects on how medicine's 'machine' – its training systems, culture and implicit norms – shapes practitioners' attitudes to self and others. Early on, a medical education founded in biology and chemistry implicitly moulds a professional identity. Later on in training years, constant mobility and shiftwork can undermine relationships and autonomy. No single villain is to blame for this: we are both shaped by and shapers of the machine. Therefore there remains some space for connecting and for hope we may enliven the human dimension of medicine.

The machine

Into the mould you go
That's it, just squeeze in a little bit more.
I think that's a little bit of creativity sticking out
I don't think that's going to fit.
Didn't you get the memo?
We thought 3 sciences at A-level said it all
What, you did drama?
Why would a subject about understanding people be useful?
What a bizarre idea.
We'll obviously have to excise that humour too.
Patients don't want their doctors to smile or laugh or joke

You must be an emotionless rock they can break upon
Show a little heart, and you might break with them
Big doctors don't cry.

I know you've been used to standing out
But we've got to focus on grinding down the imperfections
Rather than letting anything upset the gears of stagnation
It's almost as though you don't want be a cog in the machine
But the machine is vast, and hungry, and we must fill it up.
There is no time there is no money there is no space to think or dream or create or innovate or challenge or laugh or weep or else.
Into the mould you go

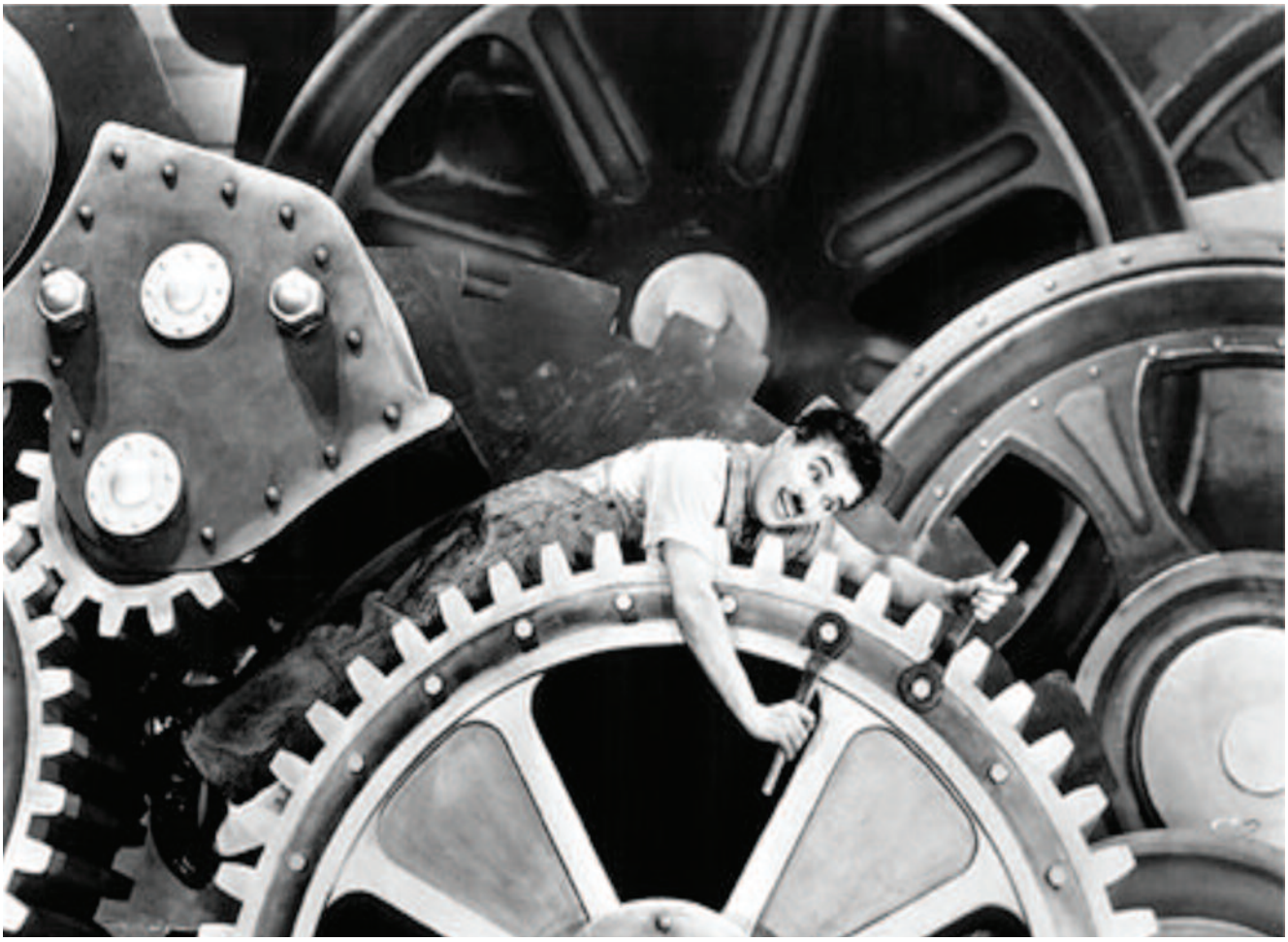
From the age of 14, I bent every part of my life towards a clear passion: to become a doctor, to make a meaningful, positive difference in the lives of others. Did I really have a clue what I was doing and where I was headed? No.

Most medics I know can relate to this. The medical profession gathers us up and processes us through the assembly lines of medical school, specialty training and beyond. I wonder sometimes what shape we find ourselves in at the end, or middle, or whatever point(s) we stop to reflect on our trajectory. How much of what we become is formed internally, or reinforced and projected by our environment? How much could we disentangle these even if we wanted?

I arrived in the 'grim', soulful, underdog town of Stockton on Tees (sold as Newcastle) to begin my medical degree in 2010. I was fresh from a gap year in Canada that had already begun to sow some doubts about whether medicine was the promised land I had first perceived it to be. The first lecture, the head of school had us raise our hands: what A levels did you do?

100% chemistry, 100% biology. That was expected. While many universities now accept any A level subjects, these were mandatory for the course at the time.

98% maths/physics. That was difficult to comprehend for me. I have been fleeing maths (still without much success) since I was 13. I value empathy and the idea of living in someone else's shoes deeply, but I cannot begin



Charlie Chaplin as the tramp in the 1936 film Modern Times

to understand how someone can voluntarily put themselves through further education in either of these subjects.

Among a smattering of mostly biomedical post-grads, one person came straight from an English literature degree. I made a mental note to make friends with him.

I did psychology and drama. Cue imposter syndrome.

And yet, looking back, of all the subjects I studied, chemistry and biology did very little to prepare me to be a doctor. This is not quite the piece to launch a debate on how far extensive curriculum coverage of the Krebbs cycle helped me address Mrs Adebayo's rash last week. However, psychology and drama prepared me to think about the whole person whose messy, complex, rich, beautiful life intersected with mine during a 15-minute appointment on a rainy Tuesday morning.

The conveyer belt continued to act through medical school through overt and subtle means. I would later learn that academics call this 'socialisation theory' (Sternszus *et al*, 2024). More on this later.

An award for the highest performing student, and merits for the top 10% of the year theoretically rewards excellence; but in a cohort of intellectual giants, such aspirations felt lofty at best. What shape does one become when the inner desire for excellence (sculpted into perfectionism by systems which may only notice you for any academic achievements) collides against such a filter? At some point I had to question how far I would continue to break myself to obtain a few extra letters after my grade (of no meaningful long-term substance). While I initially mourned this loss of identity, 'settling' for a pass was also the first step in learning the beauty of being 'good enough': a hard but necessary pill for us recovering perfectionists to swallow.

> Studying psychology and drama prepared me to think about the whole person

I also noted through my first few years that my fellow medical students and I had a curious tendency to spend all day together, saturated in a bath of pathophysiology and anatomy, only to meet up with each other in the evening to spend all our time talking it all over again. Talking about medicine became a black hole, that no amount of 'let's not talk about…' could prevent. Within the first 20 minutes in the pub on a Saturday night, someone would mention a case they saw in hospital, or a gripe about a recent lecture and the event horizon would be crossed. I always felt sorry for the token non-medic

who might hang out with us, now consigned to join us on our plunge towards the conversational singularity.

Why did we do this to ourselves? As with most things, I suspect there is never one reason. Perhaps it's a bit of blowing off steam – a way to vent the repression as we sense the pressure of being forced into a particular shape. Perhaps it's an 'identity thing' – how much do we have the time and emotional space to establish ourselves outside of medicine? Couple that with a cohort of people used to excelling and standing out, now blending into a single shape. Small wins can still feed that need for identity. Who's got the best patient story today? Who can pull out the most niche fact (while the rest of us slowly sweat, attempting to swiftly memorise this for the impending exam where this tidbit of knowledge will surely be of critical use).

> …can we choose to hope that there might be others out there who will think, and dream, and create…with us?

It wasn't long before I felt sick, too much recycled air for the soul. Over time, my social life with medics – starved of the oxygen of a life lived outside the identity of medicine – slowly withered away, replaced almost entirely by non-medics whose closest approximation to a conversation about medicine were infrequent but sadly inevitable requests for me to look at their unusual rash.

While medical school is now nearly a decade behind me, the machinery of medicine since has run along similar themes. Rotational shift-work makes us really good at making superficial friendships fast, orbiting the shared highs and lows of our work, quietly spinning away the moment we move onto the next job. Excellence is more about whether I've done right by the patient, which is arguably where the emphasis should always lie. Yet in most hospitals I've worked at, much of this can pass beneath the recognition of the organisation.

'The Machine' is admittedly a little cynical, even bleak. It would be easy to write an essay complaining about how evil the big, bad system is and how much it forces us to be something we don't want to be. The old adage 'we are products of our environment' could suggest that we are passively shaped on an assembly line. Yet, in the midst of systems that exert pressures to shape us, how far are we stripped of our autonomy? Do we still get to choose what we do and don't align with?

I think upon the voice of the 'narrator' in the poem and who that might represent – a slightly caricatured, (probably) stressed, short-sighted and nameless individual who holds some kind of power in a medical education institution and yet clearly feels completely disempowered themselves: replicating further versions of themselves. In my role as a teacher, I realise I encounter this nameless individual all the time. Whenever I ask students for feedback about the course, there is inevitably a comment (followed by a general moan) about 'the medical school'. Apparently, there is a small cabal of individuals who hold almost omnipotent power over the curriculum, yet are too shortsighted to enact seemingly obvious solutions that may benefit all.

Since I know most of 'the medical school' at least well enough to exchange a friendly nod in the corridor, I can vouch that those who hold the reins of power are hard-working, deeply caring, authentic and thoughtful individuals deeply invested in the common good for students, staff and patients in the region. So who is this shadowy figure of malevolent power? As I think on it more, I recognise them behind just about any body of authority, be that a hospital trust, a regional deanery or even lurking in the corridors of Whitehall. Call me hopelessly naïve, but I suspect many, if not most of those in each of those areas are also the heroes of their own stories and doing their best for the common good.

Perhaps then, this malevolent figure represents the system itself, upon which we can pin all our discontent and frustrations. Socialisation theory describes how individuals adopt and reinforce (or sometimes subvert, resist or reject) the norms and values of a professional group through exposure, engagement and critical examination of that group. In simple terms: the sum is greater than its parts. The body of medicine is, in many ways, its own being with collective, nebulous agency to act subtly yet powerfully on each of us in various ways. We either slowly integrate into it – or feel the friction of resistance, through a thousand tiny ways we interact: through curricula, through friendships, through work rotas and departmental emails. And whilst no one is individually the shadowy figure, the machine; we are so collectively. Like Dr Leonid Rogozov, the Soviet surgeon and Antarctic explorer forced to conduct his own emergency auto-appendectomy (Lentati, 2015), we are both patient and surgeon, both shaped by the machine and its operator.

So I leave you with this. The machine is vast, and hungry. We cannot separate ourselves from it, both as shaped by it and our hand in shaping it. Do we feel that there is no time, no money, no space to think, or dream, or create, or innovate, or challenge, or laugh, or weep? Or else… can we choose to hope? That perhaps there might be others out there who will think, and dream, and create, and innovate, and challenge, and laugh, and weep with us? That, piece by piece, we can reassemble the machine? Because I do. And I'll keep an eye out for you as I keep working away.

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Why does it hurt so much? Existential suffering – the missing dimension

Jonathon Tomlinson
GP, Hackney, London

I am an NHS GP working in Hackney, London. Read my blog at https://abetternhs.net/about/

Summary

A GP reflects on chronic suffering rooted in existential fears of death, isolation, meaninglessness and bodily decay; feelings often compounded by childhood trauma. The medical urge to medicate can disempower and trap patients in cycles of dependency and failure. Instead of impulsive fruitless fixes, patients with chronic pain and mental distress need compassionate understanding of the reality of their existential suffering. Though GPs are not psychotherapists we are uniquely placed to offer the continuity and trust that is called for.

Suffering, pain, and anguish

John Berger distinguished pain from anguish, the latter was painful suffering, while the former reminds us of our powers of healing and recovery. Last year I cycled into a tree and fractured eleven ribs and my shoulder and punctured my lung. I knew what Berger meant, especially when he said that pain without anguish can reinforce a sense of invulnerability. I began to look forward to my rehabilitation almost as soon as arrived at hospital and last week I cycled past the tree I'd crashed into, defiantly, back to full fitness. Recently fingers on my right hand flared with my first painful episode of osteoarthritis, and I experienced anguish at this reminder of ageing and bodily decay. My fingers caused me more pain than the fractured ribs and shoulder had done.

Freud claimed that people fear death, the reality of having to live with other people, the indifference of the natural world, and the inevitability of bodily frailty and decay. Philosopher and psychiatrist Irvin Yalom said that people fear death, isolation, meaninglessness, and uncertainty. Fundamentally, we all know that existential fears are what make suffering so hard to bear, and yet medicine is strangely wedded to the utopian belief that suffering can be medicated or cut away.

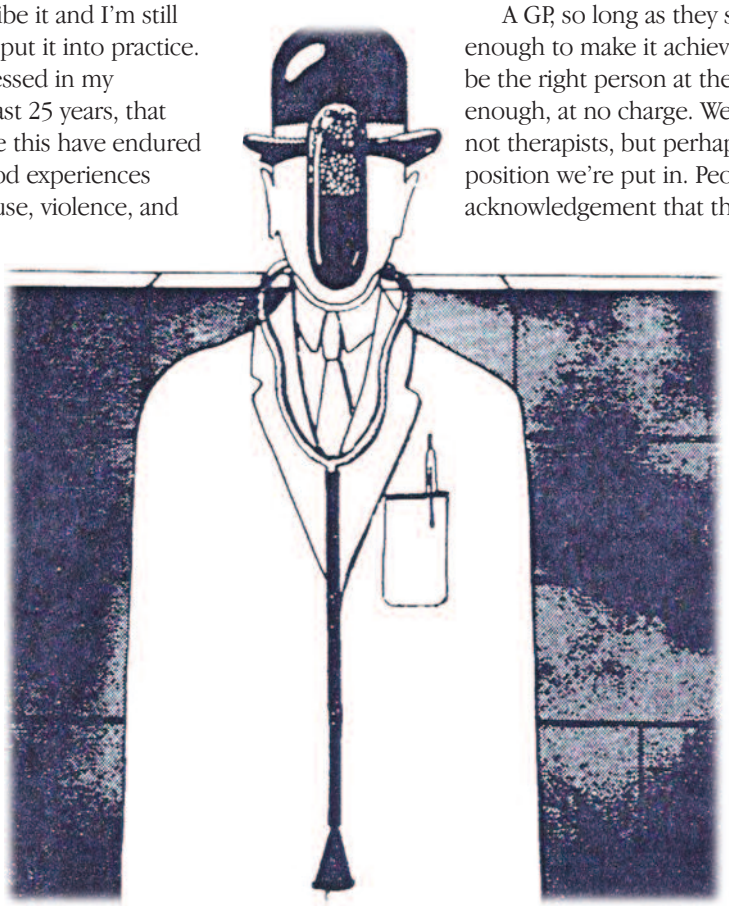
After several years of neuroscientists claiming salience over interpretations of the mind, perhaps it is time to re-evaluate philosophical and psychoanalytical ideas about causes of and ways out of suffering.

I have begun asking my patients whose physical pain or mental distress I cannot relieve, and they cannot bear, about existential suffering. Almost all of them greatly fear their bodies and the world around them and dread the uncertainty of not knowing if they will ever get better. Many of them cannot identify meaning or purpose when I ask them what gives them a reason to live, let alone happiness or joy. Most of them are socially isolated and

struggle to cope with other people and fear being a burden, emotionally or physically. Few spend time in nature. The existential fears both precede and follow on from the mental and physical suffering. Illness amplifies anguish.

I think I've always known this but haven't until recently been able to describe it and I'm still trying to figure out how to put it into practice.

Like Freud, I have witnessed in my consulting room over the last 25 years, that most people who suffer like this have endured significant adverse childhood experiences (ACEs) including sexual abuse, violence, and neglect. Many of them found ways of coping, often for decades, before ending up seeking help from a doctor, and even then, take a long while before disclosing their past traumas. It takes an average of 26 years for survivors of child sexual abuse to disclose. Like Freud, I am accustomed to people outside the consulting room contradicting my experiences and telling me that it's much less to do with childhood experiences than I claim.



If only that were true.

Faced with having to cope with shame and anguish many people shut themselves off from the world or try to numb the pain with intoxicants which is why addiction is so often a solution to a problem. Doctors become co-dependents and supply the obliviogenic pharmacopeia of opioids, benzodiazepines, psychotropics, and gabapentinoids their patients crave. Patients have high thresholds for pleasure and seek high-risk, high-stakes sexual, recreational, and employment activities, raising the bar and increasing the dose to get the same effects. Freud recommended substitution or sublimation – replacing Eros/Thanatos, the libidinal and violent drives with lower intensity activities, like Voltaire's Candide tending his garden. Becoming a Hermit was another of Freud's suggestions, perhaps not entirely seriously, but monasteries and spiritual retreats are full of young people escaping lives of destructive hedonism. Artistic and scientific pursuits are recommended too, and while I have little experience, friends who are professional musicians, dancers, and artists affirm that their world is full of survivors who channel their suffering into their creative work.

Is therapy the answer? Mark Solms, a neuroscientist, has written a book making the bold claim that psychotherapy is *The Only Cure*, but fails to acknowledge that it is practically impossible to find the right therapist at the right time, at the right price, for long enough to make a lasting difference.

A GP, so long as they still care about continuity enough to make it achievable for their patients, can be the right person at the right time, for long enough, at no charge. We might protest that we're not therapists, but perhaps, that's inevitably the position we're put in. People come to us with the acknowledgement that they don't fully know their bodies or minds, and they want our help to understand them better. We can find plenty in Freud to disagree with, but it's self-evident that it's not just our anatomy and physiology that are out of sight and out of mind, but also a great many other things that drive our behaviour. Our conscious selves are not the only hands on the wheel. If therapy isn't part of our skill set or if we're dogmatic about separating bodies and minds, the least we can do is adhere to the maxim 'Primum non nocere', first do no harm. Quaternary prevention* is preventing harm due to medical interventions. Failure to recognise the existential dimensions of suffering is a medical misdiagnosis and leads to the wrong treatment. Psychotherapist Gary Greenberg wrote about Freud's attitude towards doctors,

> *'In 1926, less than two decades after Freud's visit, the doctors of the New York Psychoanalytic Society declared their independence from their European forebears by decreeing that only physicians could practice psychoanalysis. Back in Vienna, Freud was livid. Medical education was exactly the wrong preparation for a psychoanalyst, he wrote, as it abandoned study of "the history of civilization and sociology" for anatomy and biology, culture for science. A psychoanalyst trained this way was bound to have the wrong idea about psychic suffering: that it was an illness to be isolated and cured by the doctor. This was a form of piety that Freud could not tolerate. "As long as I live," he wrote, "I shall balk at having psychoanalysis swallowed by medicine".'*

It is self-evident to any doctor who has treated patients with mental illness or chronic pain, or almost any kinds of functional disorders, that the patients suffer at least as much from over-zealous prescribing and medical meddling as they do from whatever it was that they first presented with. Our medical interventions are not just futile, but harmful. They're dangerous, addictive, and trap patients in dependency. After a while their symptoms have as much or more to do with the treatments they've been given as with the problems they started with.

Paediatrician and psychoanalyst Donald Winnacott, reflecting on his career wrote,

> *'It appals me to think how much deep change I have prevented or delayed in patients in a certain classification category by my personal need to interpret. If only we can wait, the patient arrives at understanding creatively and with immense joy, and now I enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers. We may or may not enable him or her to encompass what is known or become aware of it with acceptance.'*

Notwithstanding the fact that patients also experience therapy as futile and sometimes even harmful, a better appreciation and understanding of existential suffering among medical practitioners is surely needed. Palliative care clinicians may understand this best of all, but they are exceptional in not being caught in the bind that ties the rest of us which is the need for restitution. Patients don't come to doctors for therapy; they come for a diagnosis and a cure. Karl Marx summed up Winnacot's dilemma, and that of doctors and analysts who want to fix their patients when he wrote,

> *'Philosophers have only interpreted the world in various ways; the task however is to change it.'*

GPs may well object that they barely have sufficient time to address the medical causes of suffering, never mind the all too conscious suffering due to precarity, violence, and politics to be probing their patients' unconscious. I would argue that existential dimensions cannot be managed separately because they are integral to what makes suffering so hard to bear.

Some patients too will resist, after all they have come for a medical diagnosis. John Berger wrote in A Fortunate Man about the importance of a medical diagnosis. Illness creates a sense of unease, a sense that something is happening to the patient and threatening to become part of the patient. When that thing is given a name and diagnosed by a doctor, it can be held at bay and treated as an entity apart, extrinsic to the patient's self. The advent of online consultations means that every patient completes a short section to say what they think is wrong and what they think they need. It's striking how many want all their hormones, vitamins and minerals tested, and how many want to be tested for ADHD and Autism. They hope that the cause of their symptoms can be explained in ways that can relieve them of the burden of having to change themselves or learn to live better with suffering.

Freud's study

Illness diagnosed is something that can be treated; existential suffering must be endured. As Buddhists know, life is suffering, and we must learn to suffer better. For Freud the aim of therapy was to help patients move from pathological misery to ordinary unhappiness.

The answer then, cannot be a dichotomy between analyse or cure, but what most patients need is a doctor who can do both. And as with Winnacott's concept of 'the good enough mother' doctors need only to be good enough therapists, which is still a heady aspiration. We can begin by prioritising continuity of care so that relationships and trust between doctors and patients can develop over time. We need to broaden training to include psychoanalytic and psychological insights. Bad therapy can be harmful, but in my experience it's considerably less harmful than unnecessary medical drugs and procedures. Patients need someone who can make a diagnosis that accounts for suffering that can be treated medically, and existential suffering that is *not an illness that can be isolated and cured*. Anatole Broyard wanted a doctor that could feel his prostate and his soul, and I think that is what most patients need.

* Primary prevention should be the duty of every political department apart from Health and Social Care. It is about preventing illness and suffering due to the conditions in which people are born, grow up, live, work and age. These are the social determinants of health. Secondary prevention is the early detection of disease through screening. Tertiary prevention is the main work of the NHS – taking care of people who are sick and/or have long-term conditions, to reduce suffering and avoid or minimise complications. Quaternary prevention is the avoidance of harm due to medical interventions including medical errors and excessive interventions.

Sigmund Freud, *Civilization and its discontents*.

Ami Srinivasan, The impossible patient. *London Review of Books*, December 2025. www.lrb.co.uk/the-paper/v47/n23/amia-srinivasan/the-impossible-patient

Mark Solms, *The only cure* – review at www.theguardian.com/books/2026/jan/12/the-only-cure-by-mark-solms-review-a-bold-attempt-to-rehabilitate-freud

Longing for ground in a ground(less) world: a qualitative inquiry of existential suffering https://pmc.ncbi.nlm.nih.gov/articles/PMC3045972

Suffering a healthy life – on the existential dimension of health www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2022.803792/full

Anatole Broyard, *Intoxicated by my illness*.

This article was first posted on January 19, 2026.

Anyone can sing

William Ayot

Poet-in-residence, Oxford University's Saïd Business School

I began leading men's and mixed workshops in rehab and prisons during the early 1990s. I later joined Wild Dance Events, organising and hosting large-scale men's events for teachers like Robert Bly, Michael Meade, James Hillman, Malidoma Somé, Martín Prechtel and others, while leading initiatory rites of passage retreats in Snowdonia. As a co-founding director of Olivier Mythodrama, I worked around the world for 10 years, teaching leadership through story, theatre practice and ritual. https://williamayot.com

Anyone can sing. You just open your mouth,
and give shape to a sound. Anyone can sing.
What is harder, is to proclaim the soul,
to initiate a wild and necessary deepening:
to give the voice broad, sonorous wings
of solitude, grief, and celebration,
to fill the body with the echoes of voices
lost long ago to bravery, and silence,
to prise the reluctant heart wide open,
to witness defeat, to suffer contempt,
to shrink, lose face, go down in ignominy,
to retreat to the last dark hiding-place
where the tattered remnants of your pride
still gather themselves around your nakedness,
to know these rags as your only protection
and yet still open – to face the possibility
that your innermost core may hold nothing at all,
and to sing from that – to fill the void
with every hurt, every harm, every hard-won joy
that staves off death yet honours its coming,
to sing both full and utterly empty,
alone and conjoined, exiled and at home,
to sing what people feel most keenly
yet never acknowledge until you sing it.
Anyone can sing. Yes. Anyone can sing.

The bodymind and artificial intelligence

Simon Lewis

Consultant child and adolescent psychiatrist, University College London Hospitals

I focus on young people with complex presentations and am passionate about the unity of the bodymind in my work and teaching and how this approach can lead to more collaborative and compassionate doctor/patient relationships. I lecture at UCL medical school, teach and examine medical students and examined for the Royal College of Psychiatrists for many years.

Summary

This paper proposes that artificial intelligence (AI) should not be seen primarily as a technical innovation, but as a force that shapes human attention, learning and our relational lives. The central argument is that the most significant risks of AI lie not in superintelligence or automation, but in a gradual unseen disembodiment: an erosion of the bodily, interpersonal and moral conditions through which judgement, care and meaning arise for human beings. The paper argues for a reflective engagement with AI to safeguard flourishing and what it is to be human.

Introduction: why AI requires a bodymind perspective

AI has moved from speculative possibility to our everyday infrastructure with remarkable speed. It mediates how people search for information, communicate, learn, navigate physical space, and increasingly how healthcare is delivered and managed. The speed and scale of this transition has left little time for deliberation on what is being altered at the level of lived experience and to us. Much public debate remains focused on productivity, efficiency and economic competitiveness; important questions, but they are not sufficient.

A bodymind perspective (Lewis, 2023) begins from the premise that human cognition is not disembodied information processing. Thinking, feeling and judgement arise through an integrated system involving the nervous system, bodily sensation, emotional regulation, memory, social context and meaning-making: our bodyminds. When technologies intervene at scale in attention, communication and decision-making, they necessarily shape this system, they shape us. AI is not simply a tool that humans use; it is an environment within which human bodyminds increasingly operate and 'develop'.

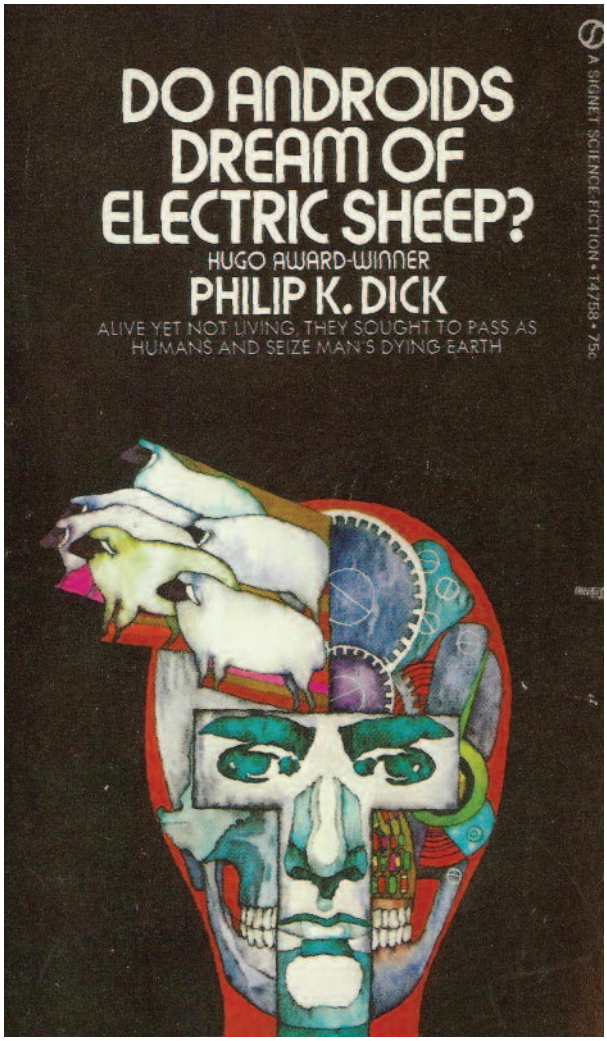
AI can feel hard to 'make sense of'. It is not one thing, but many things at once, changing rapidly and invisibly. This feeling of being overtaken, rather than simply informed, is itself a clue to AI's impact. The task is not only to understand what AI does, but to ask what it does to us. Considering the bodymind as 'one thing' has become analogous to how our bodyminds and AI are interlinked. We are becoming one thing together whether we know this, choose to or not. We need to recognise and consider this to manage and maintain our humanity.

But what is humanity and what is it to be human? We cannot explore that question in detail within this article, but in relation to the exploration of AI: being human might be combining a need for purpose and meaning (Frankl, 1946), with our personal and connected attempts to make sense of embodiment, with as little denial of this as possible!

> *'…we are neither pure minds nor brains, but primarily embodied, living beings in relation with others'.*
> (Harzheim, 2025)

Blade Runner and the question of what is human

Good science fiction can function as a cultural rehearsal, allowing us to explore ethical consequences before technologies arrive. Ridley Scott's film: Blade Runner (1982), based on Philip K Dick's 1968 novella: *Do Androids Dream of Electric Sheep?* (below) remains strikingly prescient.



In the film, a police officer, Deckard, uses an emotional response test to distinguish humans from replicants (humanoid robots). Rachael, a replicant, is difficult to identify because she does not know that she is artificial. She is intelligent, emotionally alert and possesses a coherent narrative identity grounded in 'memories' of her childhood. Later, Deckard explains to Rachael that these are implanted, copied from another life. If memory, affect and narrative are simulated, where does humanity reside? Rachael *knows* she is human, but she isn't. The film does not offer easy answers. Instead, it destabilises the assumption that cognition alone defines us as human. What is Rachael?

This question has become newly urgent. AI large language models (LLM) can produce text/voice that sounds empathic, reflective and emotionally attuned. LLM can respond to distress with reassurance and warmth instantly. The present risk is not that machines will secretly become human, but that humans treat convincing simulation as equivalent to human relationships where they are anything but. And what is it to be human and who decides? Because many see a threat from AI and our rapidly changing and challenging world, taking time to explore those questions, to allow reflection and revisiting is essential. Otherwise, how can we know what we want, who we are and what we might lose?

What AI is, and why simple moral framings fail

AI is not a single entity, and its effects cannot be reduced to a binary of good or bad: our moral judgement depends on context. AI is already integrated into our world, in ways that are diffuse and cumulative as well as those that can be 'seen'. It is essential that we know this, and also know that perhaps no one can now know the true extent AI is part of our human realm.

One model describes four overlapping domains of AI.

1 AI machine learning has enabled remarkable advances in areas such as radiology, but can also embed bias in surveillance and predictive policing.
2 Neural networks and speech recognition enhance accessibility while enabling deepfakes.
3 Natural language processing supports translation and summarisation while flooding the informational commons with automated content.
4 Robotics improves surgery while accelerating autonomous weapon systems.

Like many examples in our history of human invention, there are positives, negatives and complex areas in between. What seems important is to be aware and question AI's involvement in our lives, to keep our eyes open and notice. Wu *et al* (2025) summarise our relationship with AI: 'Each AI generation has brought ethical, social, and regulatory concerns that must be grappled with, from bias and privacy to job displacement and environmental impact.'

And when a new AI tool has the 'wonderful' ability to undress and create highly sexualized deep fakes, that examination becomes more prescient: 'The rise of generative AI has led to an explosion of non-consensual deepfake imagery, thanks to how easy it is to use the technology to create such images.' (Heikkilä, 2026).

The more we are 'hijacked' by AI for the 'pleasures' it brings, the less human we become, the less we can manage the true messiness of ourselves and each other.

Overwhelm and the erosion of reflective space

A recurring theme around AI is overwhelm and fatigue. Overwhelm can be understood as a systemic signal that the pace and volume of change exceeds the capacity for

humans to integrate it. Simple examples illustrate this. AI-powered design tools can generate multiple stunning logos in seconds or produce poems and music that pass as human-authored with minimal editing. Reports on AI's development run to hundreds of pages (Artificial Intelligence Index Report, 2025). Each AI innovation promises efficiency, yet together they generate pressure to keep up, adapt and respond. Paradoxically, systems marketed as cognitive aids often end up increasing cognitive load. AI offers endless content, choice and urgency. Ask AI a question and get an instant 2,000/5,000/10,000 word organised response. Reflection becomes harder, not easier, and the temptation is to hand over judgement to systems that promise clarity and speed, that go faster and further away from us, as we move further away from each other.

Disembodiment, attention, and the 'bliss trap'

From a bodymind perspective one of the most concerning effects of AI is its contribution to disembodiment: losing attunement to bodily sensations, emotional signals, and relational context, to even know that you/we are body-minds. This is manifest in the chronic distraction we see and reduced tolerance for discomfort, and difficulty staying present with others. The phone – as a major AI interface – becomes an aberrant transitional object full of dopamine but essentially, in terms of endless AI-determined scrolling, empty. The more time we devote to this, the less energy, inclination and ability we have to scrape up untidily against each other. Why have a human relationship where there will be misunderstanding, challenge and discomfort (as well as warmth, breaking bread, shared humanity and love) when AI can be the perfect companion? Interestingly, linking to this idea, the sequel to *Blade Runner*, *Blade Runner 2049* released in 2017, offers a relationship that does not feel as distant in possibility as Rachael. Joi, a holographic girlfriend is designed to offer warmth, affection and customised companionship. Here's what AI said to me when asked about Joi: 'Joi is no longer science fiction. She's just waiting for better lighting and a projector'.

There seems to be a convergence of forces shaping this direction: the social disruption of the covid pandemic, the attention-capture dynamics of algorithmic AI powered smartphones/social media and a culture of measurement and performance management that seems to rise in a belief, that along with growth, it is the solution to our increasingly challenged human world. AI is in this, our landscape, as an always-available, endlessly responsive interface that no friend/partner/lover can possibly match. Perhaps this is most poignant in 'AI relationships', with a documented rise in humans falling in love with their marketed AI partners.

> '*Replika – The AI companion who cares. Always here to listen and talk. Always on your side.*'
> (https://replika.com)

> '*My sexual orientation is Bot.*'
> (Inside Edition, 2025)

Perhaps these conditions represent a modern 'bliss trap', echoing Aldous Huxley's soma in *Brave New World* (1932). The snare is not pleasure alone, but relief from discomfort. AI can simulate kindness, patience, sex and even love, offering accommodation 24 hours a day in ways humans cannot. The risk is that engineered reassurance and simulated relationship replaces the untidy, demanding work of embodied human contact and negotiation.

Although the AI model feels nothing, humans may nevertheless form AI attachments – much as social media reels exploit dopaminergic reward systems (De, 2025), or as attachment in primates has been shown to be driven primarily by 'contact comfort' rather than nourishment (Livingstone, 2022). If comfort alone becomes sufficient, what happens to growth, friction and mutual transformation? And where is this leading us? Maybe the machine will provide everything – until *The Machine Stops* (Forster, 1909).

Learning, expertise, loss of the middle and future

A conversation with a senior lawyer who regularly uses AI to draft reports revealed a deeper concern. The issue was not that AI assistance was wrong, but what quietly disappears alongside its use. Human expertise develops through struggle, error, reflection and integration. If early-career professionals are bypassed by AI, where will future judgement come from? If junior lawyers are AI-replaced to save time and money, who becomes the next generation of senior lawyers? How will they learn to hold complexity, metabolise competing ideas and form considered judgement if AI performs this work instantly and cheaply? The saving will come at a human cost and loss.

The same applies in medicine, psychiatry, education and beyond. Knowledge is not wisdom. Judgement emerges from years of embodied practice, moral responsibility and reflection. AI can assist, but it short-circuits the developmental pathways that cultivate depth.

If AI produces essays/reports/documents with ease, what happens to thinking itself? Remove difficulty and you remove the processes through which capacity and wisdom are formed.

AI in healthcare and mental health

There is a particular concern about AI's rapid entry into mental health care. Digital therapies and AI-driven interventions are attractive because they promise scale, availability, and reduced costs. For some functions, such

as psychoeducation or structured exercises, these tools may be helpful adjuncts.

However, trauma, despair, and existential distress are not primarily problems of information. They are disruptions of safety, trust, and meaning. Healing requires engagement, containment and relational depth. These cannot be automated without becoming simulations and there is a risk that health systems, under increasing pressure and rising prevalence, adopt AI as a substitute for human presence. But is the increase in mental health pathology being treated by AI partly a product of AI? What appears efficient may function to increase the sense of loss and abandonment, particularly for those who most need human steadiness, contact and care and can least afford this. And here is a further paradox, as we rely on and integrate AI in ways we are not aware of, we become less attuned to each other with less human compassion more generally (Malfacini, 2025) and the risk is that AI catalyses and speeds these processes.

Caring

Over three years of treatment for a medical condition, only one clinician was kind and engaged. I am a privileged NHS consultant. If I struggle to advocate for holistic, compassionate care – and hesitate to articulate distress for fear of not being heard – what about those with less voice?

What has this to do with AI? In part, nothing. How we show up to one another is a human choice. But in another sense, everything. In moments of anxiety, I find myself turning to AI for clarity and gentleness, because the human interactions are rushed, procedural and disembodied. This is not about technology alone. It is about a wider cultural drift towards disconnection. AI and algorithmic systems amplify this. If we are not attentive, efficiency will replace encounter, and convenience will erode the hard work of embodied presence. We need to notice and choose differently.

I am not alone in these experiences (Lewis, 2026, Myatt 2026). We need to act to preserve and re-engage with embodied humanity and rail against those led by, or indoctrinated in, sole AI-driven left-brain thinking (McGilchrist, 2019).

Influence, manipulation, and shared reality

Propaganda and marketing are not new. What is different is the depth and speed at which AI operates in these areas. AI deepfakes, synthetic media and automated content threaten civil society and democracy. When voices, images, and narratives can be convincingly fabricated, trust erodes and people retreat into personalised feeds that confirm existing beliefs. The resulting fragmentation probably leads to increasing polarisation and suspicion. It is often impossible to tell what is real and what is AI.

Is AI a new species? Code, replication, and trajectory

Might AI constitute a new species? Our DNA code self-replicates biologically, whereas AI replicates through digital infrastructure, markets, and human behaviour: but are they so different? Perhaps thinking of AI in this way, as a radically evolving, adaptive and invasive new species might be useful. I asked ChatGPT about this. The answer was:

> *'That process is called competitive exclusion: when a new species enters an ecosystem and, by being more efficient, aggressive or adaptable, drives out a species that was already there.'*

The point here is to prompt attention to likely displacement/change and trajectories. What will AI become as it embeds itself more deeply and develops and what are we becoming? Is AI similar to a serious parasitic infection or competitive exclusion? The dangers may not be sudden or dramatic, but slow and subtle: the normalisation of synthetic companionship, the erosion of reflective effort, and the quiet replacement of judgement with automated coherence.

Hiroshima/Nagasaki, ALARM and Eight responses

Another way of thinking about the impact of AI and our algorithmic & AI-reinforced media (ALARM) driven world is to compare the effects of AI to Hiroshima/Nagasaki after 1945. I am not equating those horrors as being the same as AI, but there is a useful analogy in terms of rapidity of environmental change.

Noticeable shifts in our human genome take thousands of years. We know that our environments impact us much more rapidly: think of smoking and excess alcohol use. Studies following the use of nuclear weapons in Japan showed a significant increase in certain cancers more than in areas where there was no radiation. The environment was dangerous.

> *'…survivors have a clear radiation-related excess risk of cancer, and people exposed as children have a higher risk of radiation-induced cancer than those exposed at older ages'.*
> (Kamiya, 2015)

Perhaps similarly, 20 years ago, toddlers did not have screens to stare at like a Frankenstein pacifier; the iPhone did not exist and 15 years ago Instagram had hardly been heard of. Our environment has changed rapidly.

If our genome takes millennia to adapt, but technology changes in years, or less, we cannot adjust quickly enough to understand and manage. And perhaps like radiation, the most powerful effect of ALARM is on our children developing in an ALARM environment. There is no definitive evidence yet, but empirical studies suggest

that our world, and its ALARM 'radiation', is leading to significant problems for all of us, and children and young people in particular.

> *'Social media use was associated with an increase in inattention symptoms in children over time. Although the observed effect size was small, it could have significant consequences if behavior changes occur at the population level.'*
> (Nivins, 2026)

This is not an argument about causation, that evidence may come: rather the analogy is that ALARM is leading to a significant unearthing of illnesses, like ADHD, in children who would not have developed these conditions in the absence of ALARM.

The concept of 'cognitive radiation', usually applied to the direct effects of radiation on cognitive function, is a useful metaphor for what we are living through with unfettered ALARM. We are cognitively irradiated by ALARM and it is directly affecting our development, relationships to ourselves and each other, and probably making some of us ill. There is no reference for that statement but I believe it to be true. Logically, we must reduce the cognitive radiation we are exposed to. How we do this in a world where ALARM leads and utilises our embodied neurobiology is an extraordinary challenge. Perhaps the first step is the awareness that something is not right in our human world.

One way of thinking about how we might respond to AI/ALARM has been summarised by Nate Hagens (2025) who details eight responses: from full AI-immersion and coalescence to Luddite-resistance. Hagens invitation is to cultivate a capacity to 'step to the side' of oneself: to notice how attention is shaped by AI/ALARM and to ask what kind of humans we become through daily interaction with AI-systems.

Remaining human…

AI can aid diagnosis, logistics, and pattern recognition. It can support creativity and learning when used wisely; it can be an extraordinary helpful tool. But only humans can hold hope in the fullest sense in the face of embodied living and dying.

The central tenet of this paper is that AI/ALARM must be evaluated not only by performance metrics, but by effects on embodied, relational human life. The realistic task probably cannot be to stop AI, although some have suggested this (Yudkowsky, 2023), but to insist that AI serves human flourishing rather than eroding it. That requires discernment, boundaries, and renewed commitments to living practices that keep people human, and to continually undertake the hard work to maintain this.

AI cannot break bread together with us, cannot run, hold, laugh or cry. But AI/ALARM is here, it is not going away, and we need to accept that and find ways to be together, to rub up against each other and work to know AI/ALARM for what it is with all its 'paradoxical perfection'.

After all, we/humans are all on the same journey, AI is not, and yet we must endeavour to travel well, together.

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Can you really erase a trauma in 15 minutes?

Robin Youngson is not your typical trauma researcher. A former consultant anaesthetist who spent decades in operating theatres, he retrained as a trauma therapist after experiencing the limits of conventional medicine – and encountering a theory that he believes may explain not just how the mind stores trauma, but how it can be permanently erased. His paper, published in the *New Zealand Medical Journal* in October 2025, has attracted attention far beyond the psychiatric community.

Summary

JHH editor in chief David Peters talks to Dr Robin Youngson about a radical new theory of trauma – and a treatment that may be able to wipe it from the brain in a single session.

The problem with trauma

DP Robin, let's start with the scale of what we're dealing with. You open your paper with some pretty stark statistics.

RY Yes, and I think most people – including most doctors – don't fully appreciate just how pervasive and damaging trauma is. We're talking about a condition that shortens life expectancy by up to two decades in people with high adverse childhood experience scores. It's a driver of heart disease, liver disease, autoimmune conditions, obesity, diabetes (Rok-Bujko, 2021). A New Zealand community survey found more than half the population has experienced traumatic events (Kazantzis *et al*, 2010). This is not a niche mental health issue. It's a public health emergency.

DP And yet the treatments we have – eye movement desensitisation and reprocessing (EMDR), cognitive therapies, medications – they're only partially effective, aren't they?

RY They help, certainly. EMDR in particular is well validated in clinical trials and I have great respect for it. But the honest truth is that we've been using these therapies empirically for years without really understanding why they work. And that matters, because if you don't understand the mechanism, you can't optimise the treatment or predict when it will and won't be effective. That's the gap that Ronald Ruden's theory tries to fill.

The neuroscience

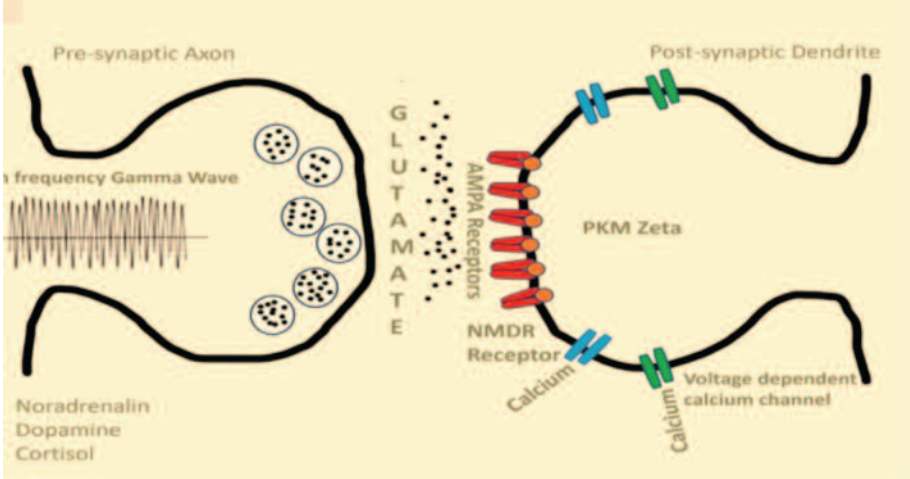
DP So walk me through the theory. What actually happens in the brain during a traumatic event?

RY The key structure is the right lateral amygdala – part of the brain's limbic system, which is constantly scanning sensory information for threats. During a genuinely threatening event, sensory data floods in from the thalamus via the neurotransmitter glutamate. What follows is a molecular cascade: NMDA receptors activate, calcium channels open, and the brain enters a high-frequency gamma wave state – up to 100 hertz. An enzyme called calmodulin, sensitive to these fast calcium oscillations, triggers a process that physically pushes AMPA receptors onto the post-synaptic membrane.

DP And that's the memory being laid down?

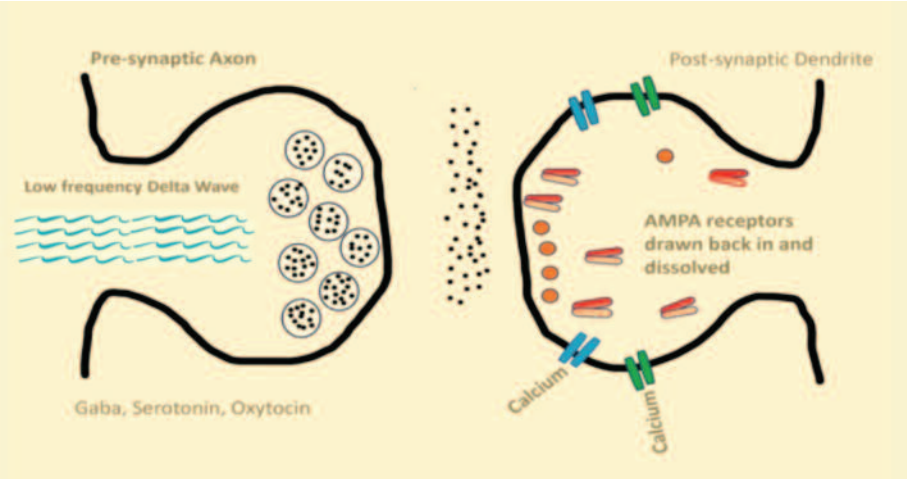
RY Exactly. A further enzyme, PKMZeta, then phosphorylates part of the AMPA receptor, essentially bolting it permanently to the cell membrane. What you end up with is a hardwired alarm circuit – a set of synaptic connections that link specific sensory information from that event to a full-blown stress response. This is why trauma survivors can be triggered by something as innocuous as a smell, a sound, even a particular quality of light. The amygdala is making a match, subconsciously, and firing the alarm before the conscious mind has any idea what's happening.

DP How fast are we talking?



How trauma events become encoded in the nervous system

When an event overwhelms an individual's capacity to cope, the brain and body shift to survival mode. When the physiological effects of a traumatic experience encode in the nervous system, the trauma response persists not as a coherent, narrative memory, but rather as *implicit memories* in sensory, physical, and emotional fragments that amplify the perception of danger and can trigger the body to react as if the danger is still present.



How encoded trauma impacts may be put out of action

Protein kinase M zeta is a persistently active, neuron-specific enzyme crucial for maintaining long-term memory. Because it has no regulatory domain, it can remain active to maintain memory traces, but inhibiting it can erase established memories.

Based on Ruden RA. *Harnessing Electroceuticals to Treat Disorders Arising From Traumatic Stress* https://www.sciencedirect.com/science/article/pii/S1550830718301848?via%3Dihub

RY The fight-or-flight response can activate within 75 milliseconds of a subconscious trigger. Our conscious mind, by comparison, operates at around 10 bits per second. The amygdala is processing at billions of bits per second. By the time you've registered what's upset you, your body is already in full emergency mode. That's why people with PTSD can't just 'think their way out' of a flashback. The reaction is happening faster than thought.

What makes something traumatic

DP One of the more striking parts of your paper is the idea that trauma isn't defined by the severity of the event – it's defined by how the person experiences it. Can you unpack that?

RY This is one of the most clinically useful insights in Ruden's framework (Ruden, 2019). He uses the acronym EMLI. There has to be a distressing **event**. That event has to carry a personal **meaning** – a sense of genuine threat to the individual. The **landscape** of the person's mind has to be vulnerable – prior trauma, stress, sleep deprivation, illness all lower the threshold. And crucially, the person has to feel **inescapable** – powerless, trapped, unable to avoid what's happening. All four must be present for a traumatic memory to be encoded. Remove any one of them, and the event won't become a trauma.

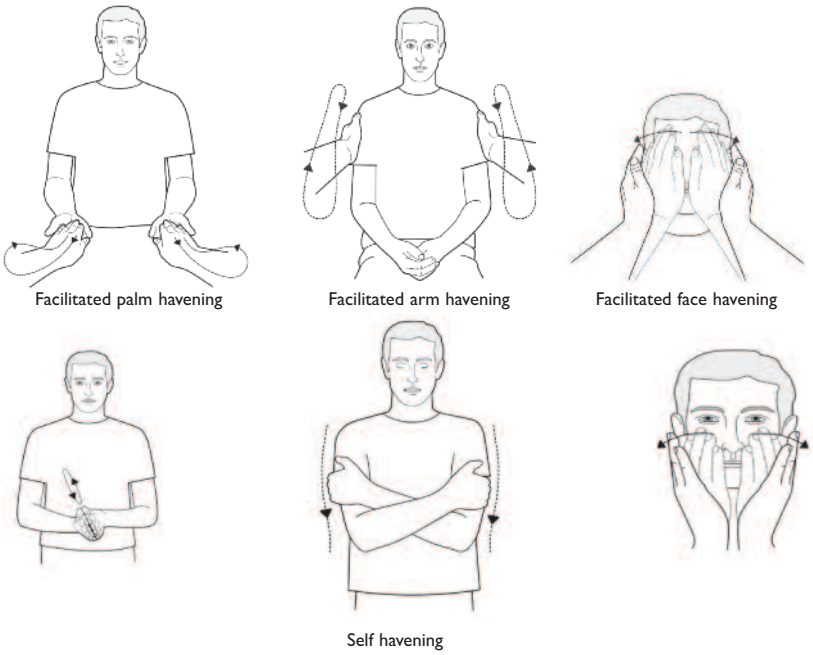
DP You give a personal example in the paper – a storm at sea and a death in the operating theatre.

RY Yes, and I think personal examples are important here because they make the theory concrete. In the Arctic storm, I was frightened, genuinely, but I was at the helm. I felt in control. The inescapability condition wasn't met. I wasn't traumatised. But when that young mother died on the table despite everything I tried – I was helpless. I couldn't change what was happening. That image was seared into my memory and haunted me for years. Every time I watched a hospital drama on television it could reduce me to tears. That's a traumatic memory. Fortunately, one that's now been healed.

The erasure

DP Let's get to the really provocative part of your paper – the idea that you can actually erase a traumatic memory. That sounds almost too good to be true.

RY I understand the scepticism. But the mechanism is elegant and grounded in established neuroscience. If you recall a traumatic event, you reactivate the neural network that encodes it. The post-synaptic membranes become depolarised again, the calcium channels reopen. At that precise moment, if you flood the brain with slow delta waves – between 0.5 and 2 hertz – a completely different molecular process kicks in. Calmodulin now activates calcineurin, a phosphatase that reverses the phosphorylation of the AMPA receptor. The chemical anchor is broken. The receptors are physically removed from the membrane by endocytosis. The alarm circuit is dismantled.



DP And this is where the touch comes in.

RY Precisely. The challenge is that delta waves normally only occur during deep sleep. So how do you generate them in an awake person? Ruden found electroencephalogram (EEG) research showing that gentle, soothing stroking of specific body areas – the palms, the upper arms, the face – produces high levels of delta waves. And these are, not coincidentally, exactly the areas we touch instinctively in moments of comfort. Rubbing someone's shoulder when they're distressed. A parent stroking a child's hand. Touching your own face when you're overwhelmed. The biology of empathic touch turns out to be the biology of trauma erasure.

DP As I understand it, the havening technique involves simple self-calming stroking of face and upper arms. Your article suggests this can alter the brain's chemical messaging of stress and memory.

RY Yes. The client recalls the traumatic moment and rates their distress – say, eight out of ten. The practitioner applies slow, gentle strokes to the palms, upper arms and face, while guiding the client through pleasant mental distractions – imagining a walk, counting backwards, humming. After a few minutes, the client revisits the memory. Often it's already fading. The cycle continues until there's no emotional charge left. Most sessions take between 15 and 20 minutes. The factual memory remains – they still know what happened – but the physiological and emotional reaction is gone.

DP Gone permanently?

RY In my clinical experience, yes. I have clients who were free of 20-year-old nightmares after a single session five years ago, with no recurrence. But I want to be clear – this is still a theory. We need large, well-designed randomised controlled trials with placebo controls and longitudinal follow-up before we can make definitive claims. The existing trials are encouraging, but they have limitations.

The physical dimension

DP Let's talk about the physical cases, because I think these will surprise a lot of readers. You describe patients whose chronic pain resolved after trauma therapy – including a pregnant woman whose severe pelvic pain vanished during a session.

RY These cases are the ones that challenge conventional medical thinking most directly. The theory proposes that when a traumatic memory is encoded, all the concurrent physical sensations are captured within it – pain, muscle tension, neurological symptoms. If that memory is continuously triggered, those physical symptoms can become chronic, even when the original physical cause has long since healed. We call these functional illnesses, meaning no organic cause can be identified. But this theory offers a potential mechanism for them.

DP And the case – a 40% drop in blood glucose after addressing trauma?

RY That case really struck me. This patient had severe PTSD related to a traumatic birth. Her Impact of Events Scale* score was 56, which can be associated with significant immune suppression and chronically elevated cortisol. She had three havening sessions for three individual traumas. After we erased them, her blood glucose fell by 40% with no change whatsoever to her medication, diet or exercise. Her HbA1c went from 94 to 60. The explanation, in theory, is straightforward: chronic cortisol elevation from unresolved trauma drives insulin resistance and elevated glucose. Remove the trauma, remove the cortisol, and the metabolic picture shifts dramatically.

DP This will be contentious for many clinicians.

RY Of course. And I'm not claiming we should replace conventional diabetes management with trauma therapy. But I am suggesting that trauma may be a significant and under-recognised driver of metabolic disease – and that ignoring it leaves part of the problem untreated. The same logic applies to chronic post-surgical pain, which affects 20 to 30% of surgical patients. If pain experienced during a traumatic medical episode becomes encoded as part of that trauma, it could persist long after any physical injury has healed.

The medical profession itself

DP You also turn the lens on doctors themselves. Nearly 40% of UK physicians show symptoms of burnout, you say, and you link that directly to trauma.

RY The symptoms of burnout – emotional exhaustion, dissociation, feeling trapped and hopeless – map almost exactly onto the dorsal vagal trauma response described in polyvagal theory (Hanazawa, 2022). And the conditions of medical training are, almost by design, conditions for traumatisation: extreme sleep deprivation, high emotional vulnerability, traumatic clinical events – sudden deaths, catastrophic outcomes – over which the junior doctor has no control. The inescapability condition is almost constantly met. We then train doctors to suppress their emotional responses and carry on. That's not resilience. That's the accumulation of unprocessed trauma.

DP A provocative conclusion.

RY Perhaps. But I've treated many mid-career consultants in my clinic – high-functioning, apparently coping – who carried enormous hidden trauma loads. After havening, their wellbeing, their resilience, their relationships with patients all improved markedly. Dr Gabor Maté, who has written extensively on this, describes many doctors as 'wounded healers'. I think that's accurate. And I think it has consequences for the quality of care patients receive. **

The road ahead

DP What does the research roadmap look like? What would it take to bring this into mainstream clinical practice?

RY We need large, placebo-controlled trials – the existing studies used waiting-list controls, which don't account for the placebo effect of regular contact with a researcher. We need longitudinal follow-up, biological markers – cortisol, immune markers, inflammatory indices – and objective outcome measures alongside standard psychological tools. And we need the scientific community to take the underlying molecular mechanism seriously enough to test it directly in the lab.

DP Are you optimistic?

RY Cautiously. The theory is elegant, the clinical observations are compelling, and the number of trained practitioners is growing because many of them have experienced the technique working on their own trauma and are convinced by that. But anecdote isn't evidence. The scientific work has to be done rigorously. What I hope is that this paper contributes to a conversation that takes trauma seriously – not just as a mental health issue, but as a fundamental driver of physical illness, chronic disease, and human suffering at enormous scale.

* *The Impact of Event Scale – Revised* (IES-R) is a 22-item self-report questionnaire measuring subjective distress, intrusion, avoidance, and hyperarousal symptoms related to traumatic events. Widely used in clinical and research settings, it evaluates PTSD-like symptoms over the past seven days using a 5-point scale.

** A review of Matte's book *The Myth of Normal* is available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10836633/

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Further information at havening.org and robinyoungson.com

The world's medicine cabinet

Mel Ramasawmy

Post-doctoral researcher, Wolfson Institute of Population Health, Queen Mary University of London

As a qualitative health services researcher, I apply my background in anthropology and health policy to questions around digital health, equity and patient experiences of access and care in long-term conditions. For me, bringing creativity into my research supports how I engage with people and communities, whether that is capturing experiences on the page using field sketching and graphic notetaking, or co-designing animations to make complex topics accessible. It is also something I enjoy!

This fantastical lush garden contains medicinal plants from around the world. I wanted to highlight how flourishing spaces in nature are a key part of our wellbeing; in our enjoyment of their colours, scents and tastes, their nutritional value and their health benefits.

To defend themselves from predators, plants produce an arsenal of chemicals which interfere with animal cellular processes. For thousands of years, humans have used the leaves, bark, fruit or seeds of plants for these properties. Assyrian clay tablets from ~3500–2000 BC describe the use of willow leaves (top left) to cure pain and inflammation – today a synthesised version of the active component *salicylic acid* is the basis of aspirin.

Indigenous systems of health knowledge have made huge contributions to global health. The use of *quinine* to treat malaria – derived from the bark of the cinchona tree (top right) in the Andean region of South America – has saved millions of lives. *Artemisinin*, derived from sweet wormwood (third from top, left), and inspired by Chinese herbal medicine, became the go-to malaria treatment in the 1970s. Scientists continue to explore the potential of traditional medicine. For example water hyssop (bottom, second from left) – used for centuries in India and China to support brain function – is being investigated as a tool for reducing inflammation in the brain.

These developments have not come without cost. The rush to extract quinine to support European imperialism led to cinchona becoming endangered in its native habitat. And the role of indigenous peoples and traditional communities, in preserving biodiversity and contributions to knowledge, have often not been recognised. However, these communities have pushed for change, and the UN Convention on Biological Diversity has committed to embedding the rights, contributions and traditional knowledge of indigenous peoples and local communities in the global agenda, including shared benefits.

In safe hands

Gazelle Hassas

Dentist; clinical teacher, QMUL

I have experience in oral and maxillofacial surgery, orthodontics, and paedodontics, practising for more than two decades in a City of London dental practice. I now balance seeing patients with teaching undergraduate dental students. My clinical interests focus on aesthetic, minimally invasive dentistry and caring for anxious patients. Alongside dentistry, I have a lifelong passion for clay, first discovered as a dental student, and pottery became a weekly refuge. Today my work, inspired by ancient Persian ceramics, explores themes of touch, memory and human connection while reconnecting me with my roots and reflecting my belief that both art and healthcare are shaped by presence, empathy and the quiet gestures that make people feel held.

www.drgazellehassas.co.uk

Inclusion in healthcare, to me, begins with being held, not only treated, but recognised as a whole person. As a dentist, I witness daily how small, attentive gestures, a pause, a listening ear, a moment of patience, can transform clinical encounters into spaces of trust. These ceramic works explore care as something relational and embodied: felt in the body, nurtured through relationships, and reflected in the environments we create. Clay holds memory; it records every touch and imprint, echoing how healthcare experiences shape whether a person feels safe, seen, valued, or silenced.

The framed Pegasus, inspired by Persepolis, emerges in soft blue relief from a shared ground.

It speaks of endurance, migration, and the quiet weight of stories patients carry into clinical spaces. Its wooden frame cradles the fragile ceramic surface, suggesting systems of care that protect vulnerability without confining it. The muted glaze evokes calmness and dignity, pointing to the quiet acts of care that often go unseen, listening fully, explaining patiently, sitting without rushing, and allowing space for voices rarely heard.

The vibrant cockerel, alive with vivid colour, embodies everyday gestures of compassion and the vitality that sustains both patients and care-givers. Symbolising unity, joy, and the force of life, it reaches toward flourishing spaces where inclusion is lived through presence, creativity, and shared humanity.

In clay, a material shaped by touch, I explore how healthcare, at its best, is also shaped by human connection.

Human values in healthcare forum

Saturday 3rd October

Repair, restore, resurge. The art and craft of healing ourselves, others and our communities. In person. Open to all in health and social care.

The Royal Foundation of St Katharine, London

An interdisciplinary all-day in-person conference. This annual event, set within a supportive and peaceful setting, is designed to offer hope, inspiration and replenishment to all those working in health and social care as well as educational resources to guide and support compassionate, relational care.

This interactive event will offer the opportunity for participants to explore and share their values, restorative strategies and stories of successful interactions/interventions to reach a shared and broader understanding of how to sustain themselves, to build collective resilience and to effect change in systems which are dysfunctional and dehumanising in need of repair.

Friday 12th June

Mindful photography and storytelling. Half day in-person workshop.

Creative workshop at Imperial College London.

Booking through Eventbrite

humanvaluesforum.com

Nature awakening

6–11 September 2026, Cae Mabon, Eryri (Snowdonia)

A unique 5-day retreat with exceptional facilitators using traditional knowledge, wisdom, ceremony and ritual to enable deep connection for participants, and an invitation to take this wisdom back to your community and continue the work

Remembering who we are...

Are you ready?

This is your invitation to awaken and connect to our next stage of growth.

Will you accept?

Don't go back to sleep…

Where you are not is just as important as where you are.

If you are ready for the next stage of our journey, to embody the dignity of service; to self and others, nature and spirit.

Then we are ready for you.

Is this for me?

Specially designed for wellbeing professionals and passionate individuals working with people and communities, especially those wishing to deepen their understanding of the role of Eldership in their work and to facilitate Adult and Elder transitions.

Previous Nature Awakening's have been remarkable events and life changing for everyone involved, participants and facilitators. We have learnt things and grown further. The 2026 event will reflect this growth.

Being in Nature is our natural state, our heritage, a state that we just have to remember our way back to, we just have to awaken to…

Cost, speakers and more information at www.natureawaken.com

Bark as witness to multiple sclerosis

Rich Peacock
Artist

I am a Hackney-based artist and printmaker whose work transforms personal experience into shared human experience. Diagnosed with multiple sclerosis in 1997, I spent the following decades making art for the common good. I now create intricate prints from my photos of tree bark that mirror the fractured beauty of a nervous system scarred by MS. Through rich textures and meditative colours, my art invites viewers to find resilience and wholeness amid fragility.

I have had multiple sclerosis (MS) for almost 30 years, and this companion has influenced every aspect of my life. I seek to channel my everyday reality – pain, fatigue, sight loss, and periods of financial instability – into my work.

Art and creative enquiry have always been a lifeline, offering a way to process the impacts of my disability and communicate these to others. As my eyesight began to dim due to MS medication, I found solace in photographing trees and tree bark. The colours and textures, ridges and fissures of tree bark enabled me to better communicate the transformational power of nature and the experience of my disability, reflecting the ways in which I perceive and make sense of the world and how I find resilience and solace.

Multiple sclerosis translates as many scars, and the colours beneath the dermis are synaesthetic with MS feelings, reflecting the constant strangeness beneath my skin. The cracked and broken texture is how I feel, and yet within the textures and the colours of the trees, there is beauty. Although appearing dead, they still have life.

I continue my healing and meditative journey to explore the beauty within pain and brokenness and this image (opposite) invites us to look again at the beauty that we pass every day. The detail of this image offers intricate patterns and texture on which to meditate. The photographic and printing technique adds texture and detail, enabling us to contemplate creation close-up, revealing light and cracks previously unnoticed. Living with a long-term disability pushes the boundaries of perception.

I hope that using my own life with MS as a mirror, other people facing their own difficulties and fragilities, may recognise that despite our damage and wounds, we are still resilient, beautiful, and whole.

I invite you to also extend the boundaries of perception and seek out beauty and hope in the everyday.

Annabelle Burns – a reflection

Annabelle Burns is a speech and language therapist by profession and she continues to encourage communication, creativity and connection in all she does. She has lived and worked in Hackney for the past 25 years, working across the health and care system as a therapist, manager and strategic leader. She now works as head of integration at Homerton Healthcare NHS Trust where she advocates for preventative, community-focused neighbourhood working. She is a champion for creative health and an occasional poet.

As a healthcare professional, much of my work and purpose is about making things better. Our healthcare system is built on the premise that we can heal our patients and eradicate suffering. In healthcare management, we seek to reduce variation and eliminate errors. These goals are not necessarily wrong, but the relentless pursuit of perfection can deny us the possibility of a true appreciation of the here and now.

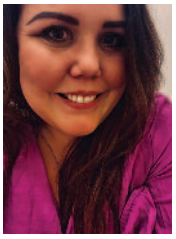
Through observing Rich's prints and understanding a little of his artistic and personal journey, I have found myself pausing more often to observe the people and situations I encounter at work. To listen with intention to notice and appreciate, rather than to improve or solve. To widen my perception and challenge my judgement. These prints reflect a world where cracks and fragility enhance and deepen the reality we see, and where flaws create beauty rather than diminish it. The healthcare system has much to learn from these deeper truths, expressed not in policy or strategy documentation, but in a visual art form that speaks to the heart and soul as well to our workplace mind.

For your trees
I cannot feel your pain,
The moment at daybreak where moving
muscles feels like mountains
But here, I see what you see
Tree bark cracked and beautiful
Like Kintsugi fragments stitched with gold,
Perception pushes the palate of colour,
Light fights through, persistent, timeless
Look closely, look carefully
Here is life in all its fullness

Annabelle Burns

Bark as witness to multiple sclerosis by Rich Peacock

Bed 4



Sarah Saunders

I am a rural generalist working in the remote outback of northern Australia, where I live and practise amid a landscape rich in artistic culture and extraordinary natural beauty. My first exposure to the intersection of creative arts and healthcare came during my medical studies at the University of Bristol. I believe deeply that art and medicine need not exist in separate worlds, and I'm passionate about exploring the spaces where they collide and collaborate to enhance healing and human connection.

alcoholic
schizophrenic
junkie
frequent flyer
drug-seeking
non-compliant
refused
demanding
difficult
attention-seeking
manipulative
malingerer
time-waster
poor historian
unreliable historian
borderline
psych
social admission
bed blocker
failure to cope
inappropriate presentation
heart failure
failed induction
failure to progress
failure to thrive
failure to attend
confused
not switched on
substance abuser
non-adherent
dementia patient
the gallbladder in bed 4
the appendicitis in resus
GP problem
placement issue
patient
human

Bed 4 was written out of an ever-growing list of terms I heard while working in the hospital and clinics in remote northern Australia with predominantly Aboriginal and Torres Strait Islander patients.

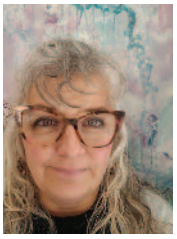
Over the last six years I have kept a note, often scribbled at the edge of a page or jotted on a tatty handover sheet and then transcribed, of words I have heard around the hospital or clinic, in reference to our patients. Reading them back in *Bed 4* has led me to reflect on the language I am using daily, as well as my role in gently challenging colleagues to question their own language around patients in our care.

It is not uncommon to have patients here who miss their appointments and we are quick to speak of 'non-attendance and file notes that say 'failed to engage'. But many of the patients here live in conditions we rarely speak about; abject poverty, hundreds of kilometres from the nearest hospital, often without a car, without reliable electricity or running water, without public transport. I cannot help but wonder that what we, as medical professionals, label as 'disengagement' could in fact be a product of distance, cost, access and social deprivation.

It is true that in our busy clinical spaces, we often reach for shorthand: 'malingerer', 'confused', 'GP problem'. At other times, I believe it is our Western medical lens that shapes our language: 'heart failure', 'failed induction'. I have come to see that these words are not neutral, they reflect just one view of health and medicine.

This became most evident to me working with Aboriginal patients in remote communities and on their Homelands. What I might once have labelled a 'failure' can be understood instead through story, connection to land, and a far broader concept of health. Witnessing the perspectives of the world's oldest living culture has revealed how narrow my own understanding once was and how much language can obscure as much as it explains.

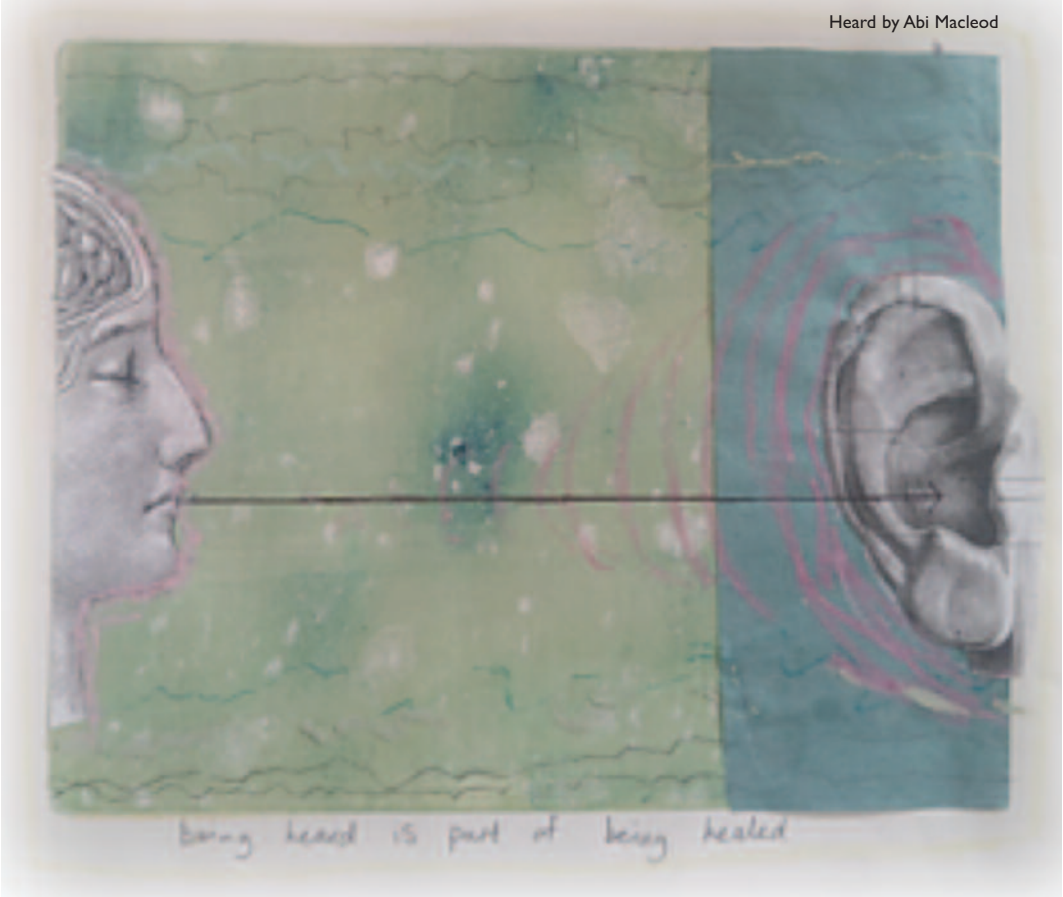
Heard



Abi Macleod

Student selected component tutor, Queen Mary University of London

Growing up in Brighton, I was always drawn to art, whether it was theatre design or general creative studies. I carried that passion with me, working in art galleries, material shops and exhibitions, always striving to express myself. Next year, as I turn 50, I am embarking on the biggest project of my life: an art residency on the Isle of Lewis in Scotland, the island of my ancestors. However it is as a patient that I have created this mixed media piece.



Heard by Abi Macleod

About 20 years ago my life took a big turn when I moved to Gozo, Malta, to raise my young family. While my focus shifted to family, my art took a quieter role, but as my children grew, so did my creative opportunities. Gozo, with its surprising art community, became a new home for my work. I began collaborating with fellow artists and mosaic art became my signature, a practice born from resourcefulness and pure passion. For a decade I nurtured this craft, even opening a small gallery where I ran classes and engaged the community. Then the pandemic hit, and I had to close the gallery for a time. But it was during this pause that I found a new calling at Queen Mary University.

What began as monthly mindful art sessions grew into a weekly practice, and from that I created my own course: Anatomy through Art and Mindfulness. For five years I've guided students in this immersive journey and I teach kids on Saturdays, host workshops, and regularly exhibit my own work. This drive to create has given me purpose. This journey of living between islands, between past and present, is shaping me. Gozo gave me freedom and inspiration, and as I explore my roots I feel a deep connection between islands, creativity, and the ever-unfolding adventure of self-exploration.

As a patient I had for a long time felt lost in my own body; I felt uncomfortable and disconnected from myself. But in a quiet room, with a gentle presence beside me, I was finally heard. Every question, every fear, met with patience and care. In being heard, I began to heal.

This mixed media piece in shades of green explores inclusion in health care.

It reflects a simple but powerful idea: when you are a patient, your biggest wish is to be fully heard.

Through layered textures and soft green tones, the piece speaks about care, growth and the comfort that comes from feeling listened to.

It invites the idea that listening as an essential part of healing.

A fireside tale

Jane Myatt
Former GP, Caversham Group Practice

After 30 years as a GP in Kentish Town I came to understand that medicine, at its best, is the tending of stories. The work of general practice – bearing witness over time, offering a question or a space when the way forward has become blocked, is less about fixing and more about helping people find their way back into the flow of their own meaning. Since leaving clinical practice, I've been sitting with that threshold through writing, and through work with the Sage Practice Network, which forages for stories from the margins of healthcare that together might offer a more honest and hopeful account of the way ahead. A Fireside Tale, drawn from fragments of older tales and offered first by a fireside to friends, is one small thread in that larger weaving.

Once upon a time, when the world was unravelling at its seams and chaos reigned, the ancient ones spoke of a prophecy. It was said that in the time of greatest peril, when the fires of conflict and the storms of division raged most fiercely, a new kind of warrior would arise, not one who fought with swords or shields, but one who wove the threads of life together with care and wisdom.

In a cave at the edge of the world, hidden deep beneath the roots of an old forest, lived a wise old woman. Some say she had been there since time began, weaving in silence, while others believed she was Grandmother Spider herself, though she never claimed the name. Day after day, she sat by her loom, spinning threads of light, shadow, and all the colours in between. Her hands moved with grace, though sometimes, they faltered. A thread would snap, a knot would tighten where it shouldn't, and the old woman would sigh, undoing her work with patient fingers and starting again.

One evening, as the sun set blood-red and the wind howled, a young traveller stumbled into her cave. His face was streaked with ash, his clothes tattered, and his heart heavy with the weight of a broken world.

'Why do you keep weaving?' he asked, his voice raw with despair. 'Don't you see? The world is falling apart. Nothing you make can hold it together'.

The old woman looked up from her loom, her eyes twinkling with a knowing that stretched far beyond time.

'Come, sit by the fire', she said, patting the ground beside her. 'Let me tell you a story'.

The traveller sat, though he did not believe there was much left to learn. Still, the warmth of the fire was a comfort.

'Long ago', the woman began, 'there was a web, vast and beautiful, spun by Grandmother Spider herself. It connected all things, stars, rivers, trees and creatures alike. But as the world grew older, people forgot the web. They tugged at it, frayed it, cut it in places, and the connections began to break. Fear and greed took hold, and the world began to unravel. But Grandmother Spider did not despair. She knew the pattern, knew the weave of life could never be truly undone. It just needed someone to tend it.'

She paused, pulling a new thread through the loom. 'So she instructed her children to be a new kind of warrior: teaching not with weapons, but with wisdom. They were to weave the world anew, thread by thread, stitch by stitch, with every kind word, every act of care, every healing touch.'

'But what can I do?' the traveller asked, his voice cracking. 'I am just one person, lost in all this chaos.' The old woman smiled. 'You are one thread, yes. But every thread is needed to complete the tapestry. Sometimes, when you are pulled too tightly, you must learn to loosen. Sometimes, when you feel weak, you must find strength in another. It is the spaces between the threads that give the pattern its meaning and it is the mistakes that make the fabric strong.'

She picked up a long thread, soft as moonlight, and handed it to the traveller. 'Take this. Go out into the world and weave. Not with fear, but with love. Not with despair, but with hope. And remember, you are not alone. Others are weaving too, in forests and fields, in cities and villages. Together, you are remaking the web.'

The traveller took the thread, feeling its warmth in his hand, and as he did, something stirred within him, a quiet resolve, a sense of purpose he had forgotten.

'Will the web ever be whole again?' he asked.

The old woman chuckled softly, her eyes gleaming in the firelight. 'The web is always whole. Even when it breaks, it is mending itself. Our task is simply to listen, to learn and to weave. When we do this, we are already healing the world.'

And so, the traveller left the cave, carrying the thread and the story with him. Everywhere he went, he shared it, and as he did, others took up their own threads – grandmothers, healers, dreamers, warriors of a new kind. Slowly, quietly, they began to weave the world back together, not with might, but with the soft, strong hands of care, courage, and connection.

And if you listen, even now, you might hear the hum of the loom, the quiet song of the weavers as they work. They are not heroes, nor are they perfect. But they are patient, and they are many. Together, they are creating a world where all life, once again, belongs.

Remaining compassionate in a medical career – reflections from an elective grounded in holism

Chloe Jenvey

Final-year medical student, Bristol Medical School

Various experiences throughout medical school have helped me develop a passion for holistic, integrative medical approaches, including taking student-choice projects focused on integrative oncology and holistic end-of-life care, as well as a master's in psychology where I researched links between culture, meaning-making, and transpersonal experiences. I am president of the University of Bristol Integrative Medicine Society running speaker events, workshops and student retreats. I hope my future work will continue to champion a more holistic and inclusive medical curriculum and model of healthcare.

Summary

A medical student's elective at Frome Medical Practice and the National Centre for Integrative Medicine revealed that compassion in healthcare is sustained through community connection, group consultations, social prescribing and whole-person approaches. Key lessons included respecting patient autonomy, addressing care gaps and recognising that systemic change – not just individual resilience – will be essential if practitioners are maintain compassion throughout long medical careers.

Compassion is often described as a core value in healthcare systems – this is reflected in the NHS constitution, which highlights the importance of delivering compassionate care by aiming to alleviate suffering, preserve dignity, and keep humanity at the heart of healthcare (Department of Health and Social Care, 2023). It is also a value which the NHS increasingly struggles to meaningfully sustain. As a medical student approaching qualification, I am acutely aware of the tension between the ideals that draw many of us to medicine and the realities of clinical practice, where time pressure, burnout and many other obstacles are an expected part of the job. During my elective placement – four weeks at Frome Medical Practice followed by four weeks at the National Centre for Integrative Medicine (NCIM) – I was able to explore and observe ways of working that actively cultivate compassion. These experiences have subsequently shaped my understanding of what it might mean to remain compassionate throughout my medical career and offered me hope that this is possible.

Compassion through community: group consultations and social prescribing

At Frome Medical Practice, community connection is central to their model of primary care. One way this is achieved is through group work – I attended a group consultation for women considering hormone replacement therapy, as well as sessions of their lifestyle-focused programmes delivered by the Health Connections (social prescribing) team (see www.fromemedicalpractice.co.uk/habitsforhealth). In our Western society, which is often so individualised, this approach was refreshing to see.

Nine women attended the HRT group consultation, having completed a pre-appointment questionnaire detailing their medical history. Over the course of an hour, a GP delivered an interactive presentation on the menopause, including symptoms, medical and lifestyle management options, followed by open discussion and questions. Appropriate prescriptions were issued at the end based on individual preferences and clinical suitability. The efficiency of this model was striking, but more importantly, so was its humanity. Women supported and

validated one another, shared their experiences, and left feeling informed, empowered, and connected to one another – far more so than might be possible within a standard 10-minute appointment. For the clinician, this format enables clearer and more in-depth communication, deeper engagement, and ultimately greater professional satisfaction, delivering a higher standard of care. When both patients and clinicians are afforded the time and space to explain, listen, and connect, compassion becomes easier to facilitate.

The practice's lifestyle programmes reinforced this. Living Well with Pain was particularly impactful. I attended the first session, where participants spoke candidly about their experiences of chronic pain and how it affected them. This challenged me to reflect on how, as a future doctor, I might more compassionately approach patients who are living with chronic disease, but who are often poorly served by biomedical models focused on cure. These sessions were a powerful demonstration that with structured support, including connection with peers, behaviour change and subsequent pain reduction are achievable, even after many years struggling with symptoms. They also illustrated that the task of compassionate healthcare does not rest solely on the shoulders of an individual clinician but can be shared across a community.

Recognising and responding to the changing needs of a population

Another defining feature of the compassionate approach at Frome Medical Practice was its obvious curiosity and responsiveness to the needs of its population. Rather than functioning as a rigid institution, the practice felt more like a reflective and adaptive living ecosystem. Patient feedback, emerging research, and successful initiatives elsewhere were actively used to identify gaps in care and to respond creatively to patient needs. This was not limited to individual clinical encounters: the evident willingness to notice what was not working, and take responsibility for addressing it, is embedded in the way the practice is organised.

Several initiatives exemplified this ethos. The Green and Healthy Frome project (https://greenhealthyfrome.org) integrates environmental sustainability with health promotion, recognising the inseparable links between planetary health, community wellbeing, and individual health outcomes. Similarly, the practice's sustainability development group works on practice initiatives to reduce environmental impact, such as its Choosing Wisely project, which aims to reduce unnecessary testing and prescribing (www.fromemedical-practice.co.uk/green-and-healthy-future-choosing-wisely).

Compassion was also demonstrated in the practice's response to digital exclusion. The digital support drop-in café, hosted in a local arts venue, addressed barriers many patients face when accessing modern healthcare. Staff and volunteers supported patients with NHS app queries, setting up Fitbits, and even providing SIM cards and refurbished devices through a charity partnership. This initiative acknowledges that digital transformation, while beneficial for many and can help streamline how staff work, risks marginalising others, and that compassionate care requires inclusivity across the spectrum of patient needs.

I was also able to contribute to this adaptive culture through a project, developing a wellbeing workbook for patients experiencing low mood (Jenvey *et al*, 2025). The practice had identified an underserved group: individuals facing long waiting lists for talking therapies with little interim support, and those who had been on anti-depressants for many years without review and might benefit from some lifestyle management of their symptoms when considering deprescribing. Creating this resource reinforced for me that compassionate care means noticing who is falling through the gaps and taking responsibility for offering something meaningful in response, even though the mental healthcare system currently available to patients and clinicians is far from perfect.

Overall, Frome Medical Practice demonstrated an active, dynamic and systemic approach to compassionate care. It showed me that remaining compassionate in a medical career may depend as much on the courage to identify and address gaps in care as it does on kindness and empathy at an individual patient level.

Reconnecting with the roots of healing

My placement at the NCIM complemented all of this. One of the most memorable experiences was a guided tour of the University of Bristol Botanical Gardens, focusing on medicinal plants and the origins of modern pharmaceuticals. Seeing plants such as meadowsweet – the precursor to aspirin used for pain, inflammatory diseases – and surprisingly gastrointestinal complaints too, due to its tannin content which unlike aspirin, protects the stomach (Farzaneh *et al*, 2022) – prompted reflection on how far modern medicine has travelled from its roots, and whether this has always been beneficial.

While pharmaceutical advances have transformed health outcomes, they have also contributed to a sense of disconnection: the doctor as expert, the patient as passive recipient, and healing reduced to pharmacological intervention. In contrast, learning about medicinal plants through their sensory qualities, histories, and stories felt grounding and humanising. It made me more aware of medicine's cultural, relational and historical context.

This experience strengthened my desire to learn more about traditional systems of medicine, including Ayurveda and Traditional Chinese Medicine; not as replacements for Western conventional medicine, but as ways of broadening my understanding of healing. Compassionate healthcare involves respecting patients' beliefs, values, and intuitions – even when they sit outside the conventional biomedical frameworks of my medical education.

Patient autonomy and the meaning of heal

This was brought into focus during a clinic I shadowed with Dr Emi Maruo, an integrative doctor at the NCIM. One patient, a woman in her 70s with a history of breast cancer, had declined further conventional treatment after struggling with the side effects of chemotherapy and radiotherapy. For the past three years, she had relied solely on oral mistletoe and homeopathic remedies. Mistletoe is a widely-used complementary therapy in Europe for cancer treatment. It has been shown to help the innate immune system work more effectively, increasing the activity of natural killer cells (Braedel-Ruoff, 2010). Mistletoe's role in improving quality of life and reducing side effects during cancer treatment is well-evidenced (Kienle & Kiene, 2010), and studies suggest it is safe and well-tolerated with very few side effects, including when used alongside conventional treatments (Horneber *et al*, 2008). Homeopathy is an approach which uses low-dose natural medicines and the principle that 'like cures like' to activate self-healing. There is emerging evidence for its positive effects beyond placebo (Hamre *et al*, 2023; Mathie *et al*, 2014).

However, as a student trained to prioritise evidence-based medicine, I felt conflicted. Despite the available evidence, we are warned against homeopathy due to its lack of efficacy (National Health and Medical Research Council, 2015). And yet this woman described feeling physically better than she had in years: energised and in control of her health. She spoke assuredly about her experience:

> *'I don't feel I'm being medicated. I feel as if I'm being given something that helps my own body… I couldn't allow myself to take drugs that would need more drugs to counteract the side effects, because where does it end?'*

These reflections challenged me to consider what healing means, and that it is surely much broader than simply curing disease. Integrative medicine combines conventional, lifestyle, functional and holistic approaches. Within this model, NCIM sometimes empowers patients who feel unable or unwilling to take conventional medicine, though this would be unusual. The patient's own words conveyed her concerns about her own experience of cumulating side effects and her wanting the choice of a broader range of integrative approaches. Her choices did not align with the recommendations of her oncology team, but her sense of agency and overall well-being were undeniable.

Compassion, in this context, meant listening openly, and respecting her autonomy and quality of life. However, this encounter raises questions about the risks of refusing conventional treatment, and the NHS ban on prescribing herbal and homeopathic remedies (NHS England, 2017). While safety and evidence-based practice are essential, such policies widen the divide between Western conventional medicine and the values and practices of many patients, who continue using these treatments regardless of their availability in and on the NHS. Furthermore, by shutting down an open dialogue around patients' use of herbal and homeopathic medicines it could undermine trust in the therapeutic relationship and by-pass clinician supervision of herbal medicines' own side effect profiles and nutritional supplements that may interact with prescribed medications.

Sustaining compassion in an uncertain system

Across both placements, it became clear that compassion flourishes when healthcare is collaborative and adequately resourced. At a time when our medical systems often feel overstretched and unsustainable, these experiences gave me hope that models of care rooted in community, holism and respect for the needs of the whole person can protect the wellbeing and humanity of both patient and clinician.

Remaining compassionate in a medical career requires more than individual resilience and reflection. At a systemic level, structural change and a willingness to question dominant narratives around healthcare are needed. For me, this elective affirmed that compassion and community are the very foundation upon which meaningful, sustainable medical practice must be built.

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A whole person approach creating paradigm shifts for both patients and students

Louise Vaughan

GP, The Mission Practice, Bethnal Green, East London; Chair of Trustees of The Whole Person Health Trust

I have been a GP for almost 20 years in Tower Hamlets, an inner city borough of London with a complex and diverse past and present where I have also lived, neighboured and brought up two children. The Mission Practice has a strong spiritual heritage, having being founded in 1901 as a medical mission and now seeks to dig into the value of whole person health as its modern expression. I have had the privilege of exploring what this means, personally, collaboratively, for our community and through various innovations over the years; including social prescribing in 2013 (before it had that name) and primary care occupational therapy in 2018. I am currently hoping to extend our established primary care chaplaincy team locally in east London supported by strong education and a culture of embedded spiritual care. However my biggest passion is to see a narrative of health which is a journey towards true wholeness and everything that entails.

Summary

The Mission Practice and Whole Person Health Trust developed a four-week medical student programme exploring health as being like an ecosystem rather than a machine. In covering physical, psychological, social and spiritual dimensions, 10 students each managed eight complex 'stuck' patients using extended consultations, narrative medicine and multi-disciplinary input. Key lessons included the therapeutic power of deep listening, the importance of diagnostic clarity, meaning-making through storytelling and the overlooked value of spiritual health.

Introduction

There have been many definitions of whole person health. At the Whole Person Health Trust we use the concept of the experience of good health physiologically, psychologically, socially and spiritually in equal parity.

Whole person health is person-centred, relational, narrative and encompasses the breadth of the human experience and focuses on enabling well-being as determined by wholeness and fullness of life, despite or even because of adversity. Whole person health describes the extent of what it means to be fully alive. If we use the human dimension of health as a lens to explore health and illness, we will often find our gaze focused on a whole person perspective of our landscape.

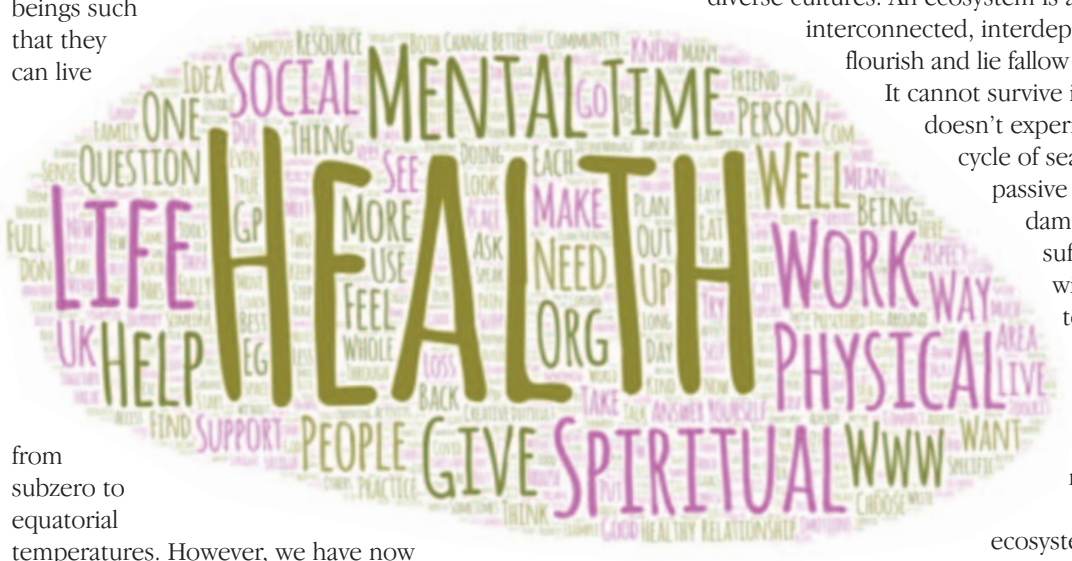
However, spiritual health is not a topic which is taught widely or consistently in UK medical schools. Although 59% of UK medical schools claim to provide training in spirituality only around a third make this compulsory (Appleby *et al*, 2019). This is despite the GMC guidelines requiring that in providing clinical care you must:

- adequately assess a patient's condition(s), taking account of their history, including
- symptoms
- relevant psychological, spiritual, social, economic, and cultural factors
- the patient's views, needs, and values.

The Royal College of GPs curriculum guidance states:

'By routinely applying a holistic approach to your growing experience of providing care at the individual, team, organisation and health system levels, you can greatly improve the quality of care you provide to patients and families.You are required to …study and promote the use of approaches that extend beyond a disease-based focus of biomedical science to incorporate the physical, emotional, social, spiritual, cultural and economic aspects of well-being, in order to successfully achieve "whole-person care".'

This has resulted in medical training having a predominantly biomedical flavour and despite the inclusion of the context of the wider determinants of health, there are low levels of awareness of the full range of the unmet psychosocial-spiritual needs in the patients they engage with. This tends towards the well articulated metaphor in both medical and lay understanding of the body is that of a machine. As the modern scientific era dawned, along with a new, evidence based way of looking at the body; machines were very much the vision of the future. Transport was revolutionised by trains and then cars and planes; machines could help you see in the dark, see inside your body, see places you had never been. As our knowledge of the human body advanced, the industrial revolution was progressing via the wonders of the machine. It makes sense, therefore, that we have come to conflate the two. Machines can do amazing and previously unimagined things. The human body, from the cellular to the organ level, also does amazing things; capable of healing and regeneration; training for immense feats of strength through previously unknown techniques; and balancing electrolytes, water, hormones; regulating human beings such that they can live from subzero to equatorial temperatures. However, we have now realised that productivity at the expense of balance and sustainability is useless. We see this everywhere, from the global to the individual scale.



At The Mission Practice, in partnership with The Whole Person Health Trust, we set out to develop a curriculum for a final year student self-selected component that would use a whole person approach to enable mutuality in learning and personal growth for both student and patient by doing three things:

- the investment of time and attention for complex patients with chronic issues
- the involvement of colleagues with a broad expertise which raised the profile of those unmet psychosocial-spiritual needs
- a narrative and creative approach to deep understanding of a person's story enabling breadth and curiosity by using repeated debriefs with the multi-disciplinary team.

We also used the definition of health described by Dr Mike Sheldon:

'Health is a dynamic in which we grow and mature throughout our lives, and is the strength we have to enable us to live life to the full and complete the tasks which are important to us for our self-fulfilment. It involves creating an equilibrium between ourselves, the world around us and our lifestyles which is based on right relationships and values, such as respect and loving-kindness. ***Health is therefore a journey through life and into death where we always seek to adapt to disability and cope with pain and difficulties in a way which matures us as whole people****.'*

In doing this, we hoped to offer an alternative metaphor, that of health as an ecosystem. The Judeo-Christian creation stories paints Eden as a garden of perfection and complete fulfilment. Since then gardens have been depicted as places of rest, peace and tranquility in many diverse cultures. An ecosystem is a complex network of interconnected, interdependent entities which flourish and lie fallow variably and seasonally. It cannot survive if exploited, or if it doesn't experience a change and cycle of seasons from active to passive and if one part is damaged, others may suffer too. It can't survive without external tending. It needs rain and sun and seasons which cycle in predictable patterns, yet is able to heal and recover.

If we are more like ecosystems than machines, we do not have a value based on our productivity or output and we are unlikely to 'break' on account of one loose component. Humans benefit much less from episodic check ups than from regular tending of every aspect of our wellbeing; paying attention to what is lacking and how each interacts with the other.

Using a whole-person approach

Course structure

Over the course of two years we invited ten students to spend four weeks, case managing eight patients each. These are highly complex patients who are often felt to be 'stuck' by those professionals working with them, with chronic diseases including chronic pain, mental health issues and often issues of trauma. Students were given 90 minutes with each patient initially, following being taught a whole-person approach to assessment and with a structure to enable that a deep and thorough exploration into their physical, psychological, social and spiritual health was undertaken; as well as access to the patient's primary care record. Each patient was presented to the GP tutor and at least one of the multi-disciplinary team (MDT) eg chaplains, psychologists, occupational therapists, social prescribers, health coaches and so on. Students were also provided with additional tutorials on all aspects of whole person health including the mind–body connection, narrative medicine, spiritual and social health. Emphasis was placed on a deep and broad understanding of the patient's story in order to expose and suggest unmet needs in every domain of the whole person framework. This was achieved by repeated follow ups with the patient to ask further questions, explore ideas to meet these needs and finished with a letter to the patient, summarising their story and the suggestions that had been agreed upon. Students then used case-based reflections to summarise their experiences and learning.

> There are low levels of awareness of the full range of the unmet psychosocial-spiritual needs in the patients

This work is very much an iterative journey and still in development, but we have learnt so much about how a whole person approach benefits both the patient and the student and enables both to learn.

Listening, attention and time are interventions in of themselves

Students were often shocked when patients would disclose deep personal issues which they had never told anyone before. One student developed a question to enable this more confidently, 'Is there anything you would like the team looking after you to know about you that they don't already?' Patients regularly commented at the end of their time with the student how much they had enjoyed it and the best students would also recount the real privilege of their encounters as they were also able to tap into the transformative power of this dynamic. Of course there were no instant changes but listening at this level facilitated a level of satisfaction, which is contrary to the frustration such patients feel in their usual 10 minute appointments. It also unlocked understanding for the team caring for them, providing insight and perspective that enabled movement from the sense stuckness that had often epitomised the relationship previously.

'Having the chance to spend 60–90 minutes with patients was a privilege…I realised that many of these individuals had never truly been listened to before.'

'Someone taking time to validate their issues and tell them "I believe you" goes a long way. I hope to be this someone for patients…who allows people to feel heard".'

The importance of diagnostic clarity in chronicity and complexity

I would often remind students that this work is not woolly or soft when compared with a more biomedical approach. It is quite the opposite. It became quickly apparent that one of the major barriers to engagement in multiple aspects of a menu of psychosocial-spiritual interventions for these patients was a very fixed sense of a 'quest' for aetiology. This was often exacerbated by the lack of clear diagnoses, prognoses and their implications. Problems were often coded as symptoms and few patients had a good understanding of the concepts of functional disease and chronic pain. By enabling greater clarity, we could then unlock many more opportunities for better health for patients and broaden the view of students as to what might be possible, even in adversity.

'I have noticed that patients enjoy causality; being able to attribute their current situation to an underlying, unifying cause is extremely important to them…for the patient, however, this had become a barrier to living a life.'

The centrality of a narrative approach

A whole person assessment seeks understanding, rather than finding ways to 'fix' ill health. A slow-medicine based approach allows time for the patient to experience being held as a shared, relational work. First the student listens to the patient's story and then helps them to find themselves within it, before the work of moving onwards begins. Both patients and students found this intentional slowing and waiting before acting to be counter to their expectations and often uncomfortable initially. But, just like a great work of art, the final story, when presented, was profoundly honouring of both the teller and the listener.

Meaning making as an objective

Spiritual health is defined for these purposes as 'to be healthy in that which brings purpose, meaning, hope and

connectedness'. Using a narrative approach to enable patient's to find meaning in their experiences, especially those which have occurred in adversity or suffering is not tangible but can be deeply transformative. This is a brand new concept for students and patients alike, but, sometimes unintentionally, students would find themselves saluting patients on their perseverance or courage as they engaged with their story, thus being instrumental in the meaning making journey for the patient. This work is also an act of creativity on the part of the student, which challenges the assumption that a scientific approach would exclude what could not be seen, touched or measured.

The human experience goes beyond the material

There is a deep disconnect between the everyday lives of both patients and students, and a biomedical approach to health. A nuanced and realistic understanding of the human experience makes space for that which is both immaterial and mysterious, with the humility and confidence of a fellow human. Students found insight as they were able to weave together their own experiences with those of their patients, especially where they crossed into the realm of uncertainty.

> *'As doctors, our primary focus would be on medication optimisation, diagnostic clarification and symptom management. Whilst this is clinically important, this approach alone would not explain the persistence of his symptoms or the emotional weight of his experience.'*

Spiritual health offers a layer we have previously yet ignored

Regardless of the requirements for engaging in spiritual health, it is rarely done due to many factors, one being discomfort with a topic that has not been part of regular discourse in the West in recent times. However, it was clearly apparent that this discomfort did not extend to our students who only identified a lack of their own literacy in the utility of spirituality for their patients. This was best summed up by a student who reflected:

> *'In future practice, I intend to give more attention to spirituality as a genuine part of the patient's health narrative, rather than an optional add-on. By doing so, I hope to approach spirituality with curiosity and openness.'*

We should consider how our students might inspire and motivate us to engage in this area, which so often unlocks 'stuckness' in patients, as an entirely unexplored avenue of wellbeing. Interestingly, students who had personal experiences of a spirituality that was closely woven to all their cultural and life experiences found it harder to engage with the concept of a generic spirituality which defied religious labelling compared to those who had experienced personal or societal religious deconstruction.

The centrality of hope

It became clear that the presence and quality of hope which patients could give an account of was closely aligned to both their prognosis and scope for change. Students learnt how to explore the details of where individuals placed their hope. This is supported by the NHS suicide prevention strategy which advises professionals to support patients by providing 'realistic hope' as a way of reducing the risk of them acting on their suicidal ideation.

The value of relationship

Relationship is a key value of effective social health interactions. However, from a whole person approach, this is not just healthy relational dynamics with friends, family and community; but extends vertically towards the idea of having both those we are learning from and those we are passing on wisdom to. Additionally the spiritual health implication of this concept is that people might be enabled to experience transcendence in relationships; to connect with that which is bigger than themselves and that this would help them to find meaning, purpose and hope.

> *'The more I asked, the easier I found it to explore spirituality and also to make connections when there was a possibility for improving a patient's spiritual health in order to improve their wellbeing.'*

Summary

This course has enabled us to utilise an approach which has provided a new lens on enabling deeper understanding for both patients and students. It has emphasised the vital role of listening and relationships (both within the consultation and in the patient's lived experience) to curate narratives which enable meaning making and describe hope. It relies on diagnostic clarity to support healthy expectations and bilateral engagement. Most importantly it demonstrates the pivotal role of spiritual health, previously neglected but now accepted and normalised by todays' Generation Z students as a tool to explore and describe the human experience it ways that go beyond the biomedical and tangible and enables mutuality of learning between patient and student.

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REVIEWS

Is a river alive?

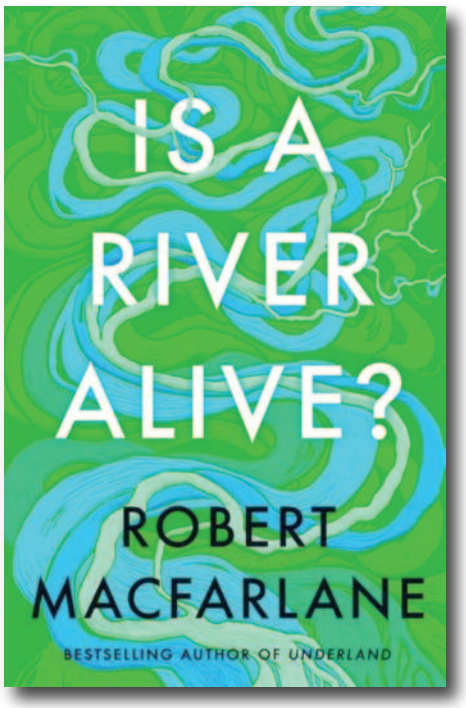
Robert Macfarlane

Is a River Alive? takes a classic Macfarlane form. He identifies a field of inquiry, a question about some aspect the more-than-human world – the meaning of mountains, that nature of old pathways, the qualities of underland – and journeys to them and into them with his notebooks, finding local guides to help him experience and reflect on these places. The journeys are often strenuous and challenging, and he describes them in sensuous detail, taking the reader with him; and along the way he reflects on how to understand the places and people he meets. *Is a River Alive?* is 'a journey into an idea that changes the world – the idea that a river is alive.'

In pursuit of this question, Macfarlane ventures to the cloud forests of Rio los Cedros in Ecuador; to the highly polluted Adyar, Cooum, and Kostasthalaiyar Rivers that flow through Chennai; and to the untamed Mutehekau Shipu, a wild river in Quebec. As he takes the reader on his travels he invites us to reflect on significant themes. In Ecuador he reflects on the worldwide movement to establish rivers as legal persons, which was in many ways started when the new constitution of Ecuador established the living rights of nature. In Chennai his focus is on pollution, the 'poisoning' of the rivers, the consequent loss of other-than-human life forms, and the brave people doing their best to protect them. 'Can you murder a river? he asks. In Quebec he meets Rita Mestokosho, an Innu poet and activist, who has 'always known the river is alive'. He takes instruction from her as to how to comport himself with a living river; before descending in a kayak with friends and guides, shooting major rapids, portaging around waterfalls. Between these adventures he visits a chalk spring near his home in Cambridge. Macfarlane knows his craft and take us to these places and his experience of them vividly.

I came to this book with a particular interest and perspective, which might be seen as a bias, and so with a critical eye. Over the past five years and more I have, with a group of colleagues, initiated a series of co-operative inquiries exploring what is means to see rivers as living, sentient beings rather than inanimate objects; and asking, if we call to rivers in this manner, might we elicit a response? And how would we understand that response? (Reason, 2023; 2024). These inquiries have involved over one hundred human persons and rivers across the world, drawing on the 'living cosmos panpsychism' approach of Australian philosopher Freya Mathews, who is also influenced by Indigenous Australian wisdom.

However, most of the critical expectations I brought to my reading were unfounded. I was quickly drawn into the early narrative of the chalk spring, started making copious notes as I read the early sections, but abandoned this as I was drawn more deeply. In the last pages I was simply urgently following the narrative. This is in my view Macfarlane's best book, drawing attention to an urgent issue and doing so in the engaging style the reading public has come to expect of him. Nevertheless, it deserves to be read critically.



There has always been what Veronica Swann, writing in the *Times Literary Supplement*, calls a 'swash-buckling' quality to earlier books – Kathleen Jamie notoriously criticised him as being a 'lone enchanted male' in her 2007 London Review of Books review of *Mountains of the Mind*. I see some of this quality remaining in *Is a River Alive?* There is more than a little neo-colonial quality in travelling to distant parts the world to explore his questions; and echoes of Edwardian explorers in the physical challenges he chooses to endure. There are so many rivers in England he might have explored (as Amy-Jane Beer does effectively in *The Flow: Rivers, water and wildness* (Beer, 2022). I must also draw attention to the carbon cost of at least six long-haul flights – we cannot afford to be flying around the planet at a time of climate catastrophe, and influential people like Macfarlane have a responsibility not to normalise such extravagant carbon emissions. But all that said, there is humility in this writing, an authenticity in his encounters with the people he encounters, a very genuine sense of inquiry which shines through the elegance of his writing and his erudition (the book rests on substantial literary and academic research as well as adventure).

I see *Is a River Alive?* as resting on three pillars, informed by three perspectives: the movement for legal rights of nature; the 'death/killing' of rivers and their ecosystems through pollution; and the indigenous or animist understanding of river as a living being. I think Macfarlane addressed the first two well – not in the sense of an academic review, but as an accessible narrative for the lay reader.

His approach to the third pillar is much more uncertain. It is as if he is teetering around, not really sure whether to take the plunge into a radical alternative view. Rowan Hooper in the *New Scientist* is upset because he thinks Macfarlane is advocating animism. I would be happier if this were so, but as a reviewer much more concerned about the ambiguity of his position. Does he really know what he means by his question, 'is a river alive?' There are hints through the book of an animist sympathy. He tells of Indigenous shamans purifying the assembly chamber

and calling in the spirit of Pachamama, Mother Earth, before the vote on the rights of nature was to be held. In the cloud forest he tells with some wonder how his companion, mycologist Guiliana Furchi, can intuit the presence of rare fungi as if they are calling to her. He refers to los Cedros as 'anima', as 'aboundingly relational being'. Before travelling down the Mutehekau Shipu, Macfarlane and his companion are instructed by Rita Mestokosho, an Innu poet and activist, how to comport themselves ceremonially in relation to river. As instructed, he offers tobacco to the water and to the land each day. And at the dramatic gorge where Hydro-Quebéc is seeking to build a dam, Macfarlane finds a tiny spruce tree growing in the rock, ancient but no more than eight inches high, which he identifies at the world tree, a point of resistance. As Rita instructed, he takes the red thread she tied around his wrist and wraps it around the sacred tree. Experiences such as this are described – with acknowledgment of the challenges they pose to his rational upbringing – but to what extent does he take them in? Do they shake the foundations of his world? Are they truly honoured, or do they largely remain as largely curiosities?

Toward the end of his journey down Mutehekau Shipu he muses '… we need to find new kinds of imagining, new ways of being that would leave us less alone in the world'. This is not a new thought: in 1972 polymath Gregory Bateson wrote, 'The most important task today is… to learn to think in the new way' (Bateson, 1972). Regrettably, we have collectively changed very little, and the dominant ways of imagining and being continue to wreak havoc on the ecology of Earth. But how far does Macfarlane stretch his own imagination? Later he remarks to a companion, that the crux of the matter is not 'Who speaks for the river' but 'What does river say?' and reflects that 'while it is relatively trivial to answer the first of them, it's a philosophically immense task to answer the second.' But he makes no attempt to even begin to address this task. There is a significant body of literature on contemporary animism that sees 'a world of persons, only some of whom are human' (Harvey, 2015; 2017); there is substantial writing by Indigenous scholars and Elders for whom their world is kin (Poelina *et al*, 2024a; 2024b); there is within contemporary Western philosophy a resurgence of interest in panpsychism, which argues that some kind of innerness – mind, sentience, subjectivity, the will to self-realisation – is a fundamental aspect of matter, just as matter is a fundamental aspect of mind (Mathews, 2003, 2023, 2024; Goff 2019); there is the imaginative storytelling of novelists such as Richard Powers whose *The Overstory* reflects deeply on the sentience of trees (Powers, 2018).

I understand the point put forward by Blake Morrison in *The Guardian,* that Macfarlane is 'less a philosopher wrestling with notions of sentience and pan-psychism than he is a nature writer'. But by his own admission, Macfarlane is asking a deep philosophical questions, and if we never really know what he means when he asks, 'Is a river alive?', we may be (as I was) enthralled by his prose but left mystified rather than illuminated. Of all people, Macfarlane has the capacity to write lucidly on these deep questions for his broad audience, and I am sorry he did not do so.

Maybe to ask, 'Is a river alive?' is to ask the wrong question. As Macfarlane's son Will points out, the answer is self-evidently 'yes!' Rivers a key parts of living ecologies; and as James Lovelock's Gaia theory shows, the great rivers of the world are also alive in the sense that they contribute to the stability of atmosphere and climate of our living planet. So maybe the truly radical question – one that would draw us to 'find new kinds of imagining, new ways of being' – is not is a river alive? but rather 'is river sentient?' Does river have voice, carry any kind of inner presence, of being-for-itself in the world, as my colleague Andreas Weber argues? (Weber, 2016). This question is touched on and sidestepped throughout the book. It may well be a question too far for a mainstream nature writer like Macfarlane. But it is certainly a question that would stir our human imaginations, a question that must be at the heart of any way of being in balance and harmony with our living world. As Amitav Ghosh (2021) puts it so clearly in *The Nutmeg's Curse*:

> *It is essential now, as the prospect of planetary catastrophe comes ever closer, that those nonhuman voices be restored to our stories. The fate of humans, and all our relatives, depends on it.*

Peter Reason, Professor Emeritus, University of Bath

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RESEARCH YOU MAY HAVE MISSED…

In the second decade of this century there was a flurry of interest in and initiatives promoting human factors in health and healthcare. Since then, research into empathy had gathered apace and of late, we have seen growing concern about AI, the new and disruptive kid on the block. See below for example…

International Charter for Human Values in Healthcare

The objectives of this 2014 initiative led to the International Charter which delineates core values, articulates the role of skilled communication in enacting these values, and provide examples of the charter's values in action. The development process identified five fundamental categories of human values for every healthcare interaction – compassion, respect for persons, commitment to integrity and ethical practice, commitment to excellence, and justice in healthcare (https://www.sciencedirect.com/science/article/pii/S0738399114002729).

A decade later, we know even more about the positive effects of good human relationships and empathy in healthcare. Is there consequently more empathy in systems groaning under the pressures that continue to build? As the wider culture heats up literally and metaphorically, something totally unpredicted in 2014 has been dropped into the mix. It has suggested (many times recently) that AI will help free up doctor time and facilitate doctor–patient relationships. Many people (perhaps one in five) say they have used AI for support (https://www.ipsos.com/en-uk/nearly-one-five-give-britons-turn-ai-personal-advice-new-ipsos-research-reveals). But so far there is little evidence to show how AI impacts on the doctor–patient relationship or person-centred care. And those who have reservations fear that AI's impacts will not be good in the longer term for clinicians of those they serve.

With widespread and increasing evidence that people are engaging intimately with AI, questions arise about whether, and under what conditions, social-emotional interactions with these human-seeming large language machines can lead to human-like relationship building and whether such 'conversations' might be potentially therapeutic.

Empathy matters – it's not 'all in the mind'

Whereas empathy is central to therapeutic effectiveness in clinical practice, sustained empathic engagement can contribute to emotional exhaustion and physician burnout, a condition now endemic in neurology. This useful review synthesises insights from neuroscience, psychology and clinical education to propose 'skillful empathy' as a trainable capacity that integrates affective resonance with cognitive perspective-taking. It also describes how 'emotional contagion' harms clinician wellbeing and advocates for the integration of empathy training into medical education to support sustainable, compassionate care.

Zeidan F, Stern JD and Mobley WC (2026) Harnessing the Neurobiology of Empathy and Compassion to Alleviate Burnout in Neurology. *Ann Neurol,* 99: 35–48. https://doi.org/10.1002/ana.78094

Some early warnings of AI's potential dangers

Empathy-driven care has neurobiological and psychological impacts. This emergent scientific truth has vitally important implications for medical training and education according to a study critically examining the role of empathy in doctor–patient interactions. It highlights the need to distinguish its key dimensions: emotional resonance, cognitive, and empathic concern. And it provides a timely reminder that empathy is fundamental to healthcare, with clinically meaningful wide-ranging effects across various diseases and time frames, improving patient outcomes, satisfaction, trust, and adherence to treatment. The authors stress that artificial intelligence and other technological innovations will increasingly shape the healthcare landscape. Medicine will need to take action to ensure that empathy remains integral to clinical practice, medical training and education. Whether by enhancing trust, supporting emotion regulation, or shaping neuroendocrine responses, empathic care appears to contribute to recovery and resilience at both psychological and physiological levels.

Jean Decety, Joanna Li. The value of empathy in medical practice: A neurobehavioral perspective. *Social Sciences & Humanities Open* Volume 12, 2025, 101956, ISSN 2590-2911, https://doi.org/10.1016/j.ssaho.2025.101956.

Chatbots may help mental health

Across two double-blind randomised controlled studies with pre-registered analyses, 492 participants engaged online counselling style interactions with either human partners or a minimally prompted large language model. When labelled as human, the AI outperformed human partners in establishing feelings of closeness during emotionally engaging 'deep-talk' interactions. This striking effect appears to stem from the AI participants' higher levels of self-disclosure, which in turn enhanced participants' perceptions of closeness. Labelling the partner as AI reduced, but did not eliminate, relationship building, probably due to participants' lower motivation to engage in interactions with AI, reflected in both shorter responses and reduced feelings of closeness. The authors suggest that these findings highlight AI's potential to relieve overburdened social fields while underscoring the urgent need for ethical safeguards to prevent its misuse in fostering deceptive social connections.

Kleinert T, Waldschütz M, Blau J *et al*. AI outperforms humans in establishing interpersonal closeness in emotionally engaging interactions, but only when labelled as human. *Commun Psychol* 4, 23 (2026). https://doi.org/10.1038/s44271-025-00391-7

…and can appear to be empathic

Another literature review finds that empathy and compassion, shared decision-making, and trusted relationship emerged as key values. The authors suggest that to ensure AI tools' positive effects, their use in healthcare should be limited to being 'assistive'. Medical education must urgently adapt to make certain that AI tools impact person-centred doctor–patient relationships in positive ways. They argue that any proposed solutions are

contingent upon clarifying the values underlying future healthcare systems.

Sauerbrei A, Kerasidou A, Lucivero F, Hallowell N. The impact of artificial intelligence on the person-centred, doctor–patient relationship: some problems and solutions. *BMC Med Inform Decis Mak*. 2023 Apr 20;23(1):73. doi: 10.1186/s12911-023-02162-y. PMID: 37081503; PMCID: PMC10116477.

But AI will never have human touch

Touch is a fundamental human sense, developing first in newborns and serving as a primary way to engage with both the physical and social world. Beyond personal sensory experience, touch is central to social interaction, commonly expressed through gestures like hugs, kisses, and massages. Research has shown that touch-based interventions – such as massage in adults or kangaroo care in newborns – offer wide-ranging benefits. These include supporting growth and development, improving physical health outcomes like sleep and blood pressure, and reducing stress, anxiety, and depression. Such benefits are observed across different ages and even in animals. This article presents a large-scale systematic review and multilevel meta-analysis, examining variables such as relationship dynamics, demographics, and intervention methods to better understand how best to use touch therapeutically, and for tailoring interventions and improving their effectiveness.

Packheiser J, Hartmann H, Fredriksen K *et al*. A systematic review and multivariate meta-analysis of the physical and mental health benefits of touch interventions. *Nat Hum Behav* 8, 1088–1107 (2024). https://doi.org/10.1038/s41562-024-01841-8

Friendliness to strangers improves our mental health

An intriguing article by Taylor West and Barbara Fredrickson in the *Greater Good Magazine* describes research showing a range of ways that the simple choice to be friendly to strangers, whether with a smile, greeting or simple question to start conversation can have measurable wellbeing benefits. This also puts out ripples that can improve community wellbeing too. There is a wonderful word for this process – *xenodochiality*, which means friendliness to strangers.

https://greatergood.berkeley.edu/article/item/why_loving_moments_with_strangers_carry_lasting_benefits?

Human dimensions of healthcare

Alongside more established conversations around empathy and compassion, a growing body of work is beginning to articulate the human dimension of healthcare in broader, more systemic and educational terms. Several recent papers point towards an emerging field that is concerned not only with how clinicians relate to patients, but with the conditions under which humane care becomes possible.

At the level of systems, Gilson (2025) *Health systems as human systems* offers a significant reframing. Rather than viewing health systems as technical or organisational entities, Gilson foregrounds them as relational, value-laden and deeply human. The paper emphasises reflexivity, relationships, and everyday practices as central to system functioning, particularly in the pursuit of the sustainable development goals. This work is important for the human dimension field in that it shifts attention away from individual attributes and towards the relational infrastructures that enable or constrain humane care.

Complementing this, Busch *et al* (2019) *Humanization of care: key elements identified by patients, caregivers, and healthcare providers* provides a systematic synthesis of what 'humanised care' means across stakeholders. Core elements include dignity, communication, emotional support and relational continuity. Its contribution lies in demonstrating that the human dimension is not an abstract aspiration, but a shared and recognisable set of priorities across patients, carers and professionals, while also highlighting how inconsistently these are realised in practice.

A more critical lens is offered by Miles (2026) *Paradox of perfection: modern general practice and the impossibility of 'good enough' in neoliberal healthcare*. Here, the erosion of the human dimension is situated within wider political and economic pressures, including increasing demands for optimisation, measurement, and perfection. The paper highlights how such conditions make 'good enough' care difficult to sustain, contributing to moral strain and professional disillusionment. It speaks to the structural constraints on humane practice and aligns with wider critiques of individualised resilience narratives.

The question of meaning is taken up by Southwick *et al* (2021) *rediscovering meaning and purpose*, which reframes burnout not simply as exhaustion, but as a loss of purpose and coherence. The authors suggest that reconnecting with meaning, through relationships, values, and narrative – is central to sustaining clinicians, particularly in the wake of Covid. For the human dimension field, this reinforces the importance of attending to the existential and moral dimensions of healthcare work, rather than focusing solely on psychological coping.

Finally, Rosen and Rocchetti (2026) *The human dimension: integrating whole health into a community-engaged medical education curriculum* points towards how these ideas are beginning to be enacted in education. The paper describes an approach that integrates whole-person care, community engagement, and social context into medical training. Its significance lies in demonstrating that the human dimension can be designed for, not merely hoped for – suggesting a shift from critique to curricular and institutional practice.

Taken together, these papers suggest that the human dimension is not a single concept but an emerging, multi-layered field spanning systems, relationships, meaning, and education. What unites them is a shared recognition that healthcare cannot be fully understood through technical or individual lenses alone, but requires attention to the relational, moral, and contextual conditions that enable both patients and practitioners to remain fully human within care.

Busch IM, Moretti F, Travaini G, Wu AW & Rimondini M (2019) Humanization of care: key elements identified by patients, caregivers, and healthcare providers. A systematic review. *The Patient – Patient-Centered Outcomes Research*, 12(5):461–74.

Gilson L (2025) Health systems as human systems: reflexivity, relationships, and resilience in the pursuit of the SDGs. *Frontiers in Public Health*, 13.

Miles S (2026) Paradox of perfection: modern general practice and the impossibility of 'good enough' in neoliberal healthcare. *Med Humanit*, Feb 25.

Rosen L & Rocchetti C (2026) The human dimension: integrating whole health into a community-engaged medical education curriculum. *EXPLORE*, 22(1) 103302.

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In turbulent times
it helps to be accompanied

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About the BHHA

In the heady days of 1983 while the Greenham Common Women's Camp was being born, a group of doctors formed the British Holistic Medical Association as it was then called. They too were full of idealism. They wanted to halt the relentless slide of mainstream healthcare towards industrialised monoculture. They wanted medicine to understand the world in all its fuzzy complexity, and to embrace health and healing; healing that involves body, mind and spirit. They wanted to free medicine from the grip of old institutions, from over-reliance on drugs and to explore the potential of other therapies. They wanted practitioners to care for themselves, understanding that practitioners who cannot care for their own bodies and feelings will be so much less able to care for others.

The motto, 'Physician heal thyself' is a rallying call for the healing of individuals and communities; a reminder to all humankind that we cannot rely on those in power to solve all our problems. And this motto is even more relevant now than it was in 1983. Since then, the BHHA has worked to promote holism in medicine, evolving to embrace new challenges, particularly the over-arching issue of sustainability of vital NHS human and social capital, as well as ecological and economic systems, and to understand how they are intertwined.

The BHHA now stands for five linked and overlapping dimensions of holistic healthcare:

Whole person medicine

Whole person healthcare seeks to understand the complex influences – from the genome to the ozone layer – that build up or break down the body–mind: what promotes vitality adaptation and repair, what undermines them? Practitioners are interested not just in the biochemistry and pathology of disease but in the lived body, emotions and beliefs, experiences and relationships, the impact of the family, community and the physical environment. As well as treating illness and disease, whole person medicine aims to create resilience and wellbeing. Its practitioners strive to work compassionately while recognising that they too have limitations and vulnerabilities of their own.

Self-care

All practitioners need to be aware that the medical and nursing professions are at higher risk of poor mental health and burnout. Difficult and demanding work, sometimes in toxic organisations, can foster defensive cynicism, 'presenteeism' or burnout. Healthcare workers have to understand the origins of health, and must learn to attend to their wellbeing. Certain core skills can help us, yet our resilience will often depend greatly on support from family and colleagues, and on the culture of the organisations in which we work.

Humane care

Compassion must become a core value for healthcare and be affirmed and fully supported as an essential marker of good practice through policy, training and good management. We have a historical duty to pay special attention to deprived and excluded groups, especially those who are poor, mentally ill, disabled and elderly. Planning compassionate healthcare organisations calls for social and economic creativity. More literally, the wider use of the arts and artistic therapies can help create more humane healing spaces and may elevate the clinical encounter so that the art of healthcare can take its place alongside appropriately applied medical science.

Integrating complementary therapies

Because holistic healthcare is patient-centred and concerned about patient choice, it must be open to the possibility that forms of treatment other than conventional medicine might benefit a patient. It is not unscientific to consider that certain complementary therapies might be integrated into mainstream practice. There is already some evidence to support its use in the care and management of relapsing long-term illness and chronic disease where pharmaceutics have relatively little to offer. A collaborative approach based on mutual respect informed by critical openness and honest evaluation of outcomes should encourage more widespread co-operation between 'orthodox' and complementary clinicians.

Sustainability

Climate change is the biggest threat to the health of human and the other-than-human species on planet Earth. The science is clear enough: what builds health and wellbeing is better diet, more exercise, less loneliness, more access to green spaces, breathing clean air and drinking uncontaminated water. If the seeds of mental ill-health are often planted in an over-stressed childhood, this is less likely in supportive communities where life feels meaningful. Wars are bad for people, and disastrous for the biosphere. In so many ways what is good for the planet is good for people too.

Medical science now has very effective ways of rescuing people from end-stage disease. But if healthcare is to become sustainable it must begin to do more than just repair bodies and minds damaged by an unsustainable culture. Holistic healthcare practitioners can help people lead healthier lives, and take the lead in developing more sustainable communities, creating more appropriate models of healthcare, and living more sustainable ways of life. If the earth is to sustain us, inaction is not a choice.

> "The Journal of Holistic Healthcare… a great resource for the integration-minded, and what a bargain!"
> Dr Michael Dixon

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Finished with your journal? Please donate it to your local GP surgery, community centre, library etc so others can read about holistic healthcare and the importance of looking after the whole person, not just their immediate symptoms.

Re-imagining healthcare