

JOURNAL OF

holistic healthcare

Re-imagining healthcare



- On being a medical student
- Stories from Maggie's
- Creative therapeutic writing
- Working with biography
- Being a medical student after cancer
- A student's rite of passage
- Language is not just data
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Editorial



David Peters
Editor-in-Chief

The pandemic makes our old stories redundant

The pandemic seems to be the only story in town. We are shaken by its suddenness, by the urgency of our responses; shocked to be made so abruptly aware of our personal vulnerability. We feel powerless, fearful, angry. In our communities we have become more isolated, suspicious of strangers and prone to speculate darkly on the collapse of the world order. It's a true story of vulnerability and human limitation: of being literally locked in, unable to go out or do our normal work; of money worries and loss of social identity. At a planetary level, with borders shut down and international transport frozen, we depend more and more on technology for communication, and on the goodwill of retailers and the mercy of our health services. As we go slowly stir-crazy in lockdown, mental health, family life, friendships and community coherence suffer collateral damage. Planet-wide, already over-leveraged economics, globalised trade and the carbon-heavy costs of fuelling them have all taken a heavy hit.

I believe there is a holistic upside to all this: another way to understand this story and what the pandemic is telling us about our vulnerability, limitation and dependence. Should we not be seeing the virus as a health warning from the planet? Indeed the systems we depend on *are* very vulnerable, and we are in a crisis whose outcome we don't yet know, but we can be pretty sure it won't be business as usual. We speak of bouncing back from hard times, but true resilience grows when adversity forces us to learn and change: species, people and cultures evolve by *bouncing forward*. Realising we are vulnerable, we can boost self-care, and cultivate an inner life if we can reframe confinement as an unasked-for retreat. Accepting interdependence, we stand together, knowing that divided we fall. And how will awareness of nature deprivation change us, longing as we are for landscape as we stand gazing from our balconies? Jogging down the tarmac do we occasionally notice how quiet and clean the spring air is?

Although we prefer not to think about them human vulnerability and suffering are facts of life. A compassionate society would tackle their biological and their psychosocial roots. Austerity has been a major vector for ill-health and loss of wellbeing, yet huge reserves of altruism are rising up along with new respect for low-paid workers who keep supermarkets, online deliveries, and care homes going. And we feel profoundly grateful for the self-sacrifice and courage of the NHS frontline. Paradoxically, social limitations are renewing our friendships, neighbourliness and community spirit.

Having learned the lessons of our interdependence and vulnerability, can we drop the illusion of separateness and control? Will we see humankind for what it is, a vulnerable and limited component of the natural order on which it depends. We urgently need such stories to fire our imagination and feed the political will for a good society, where the wellbeing and resilience of all species become politicians' only compass. As we learn how better to



"Actually, these aren't bad times to be delusional."

CartoonCollectors.com

guard against future pandemics will there be renewed enthusiasm for benign state intervention, greater commitment to pro-environment policy and alternative forms of economics and trade? Will excessive wealth accumulation and exploitation have to be constrained? Will more of us have come to value spiritual time out, social creativity and freedom from the 9 to 5? Grateful though we are for acute clinical medicine are we also ready to accept that it cannot create health?

The pigeons have come home to roost. The pandemic is surfacing primordial anxieties about our mortality, insignificance and belonging - the timeless unease that goads us to seek safety and certainty at any cost. To soothe them we have narrowed the focus of science, sleepwalked into the political fantasy of taking back control, been moulded into 'consumers' and seduced into adopting fundamentalism as a defence against meaningless. Now it's payback time and we have to ask what comes next. Perhaps I'm deluded, but I believe we can start a pandemic of the imagination, cross-infecting one another with stories that create the world we want to live in.

Craig Brown – a life guided by healing and whole person care



Dr Craig Brown, our dear colleague and former BHMA Chair, died on 10 March only two months after a sudden and terminal illness had been diagnosed. He was one of the British Holistic Medical Association's first members and chaired the BHMA from 2010 to 2013.

For 30 years until 2012, Craig was in full time NHS general practice in Rustington, West Sussex. Complementary therapists, including healers, worked there too, and Craig became so interested that he helped develop the Doctor Healer Network (DHN) and even trained as a healer himself with the National Federation of Spiritual Healers (NFSH, now The Healing Trust), and ran a regular DHN group for a number of years in Hove, bringing together local doctors and healers.

While NFSH President (1997 to 2001) he wrote the influential book *Optimum Healing*, a valuable asset still to be found on many a practitioner's bookshelf. Craig was a frequent presence at the Royal London Homeopathic Hospital where the NFSH ran sessions for cancer patients with Dr Anne Clover. More recently he facilitated courses for the Royal College of General Practitioners supporting GP resilience. His gentle humour and effervescent sparkle engaged even those colleagues normally wary of discussing anything other than the hardest scientific evidence.

Healing and whole person care were his profound, lifelong concerns. They inspired his approach to medicine and drove his commitment to the next generation of doctors, and his wish to relieve the suffering he had witnessed in the profession. To pass on his immense experience of family medicine and healing, Craig began running a 'holistic medicine' student selected component (SSC) at Brighton Medical School (BMS), soon after it opened its doors in September 2003. From the outset, BMS students are introduced to general practice, a specialty in its own right. Craig's eight-week half-day course – later to be called 'Resilience' – provided a much needed opportunity for four to twelve students to talk about stress and values and share their challenges and successes. Yoga, visits to alternative health centres and walks on the beach were all part of his whole person care package which, over the programme's 12 years, involved 60 or more students.

In 2014 Brighton health authority senior managers and CEO invited Craig to contribute and co-facilitate a compassion and kindness module on their leadership programme. In that same year Craig's wife Elaine died, and the family's concerns about her end-of-life care led to their making a formal complaint. The approach was well received by the hospital involved and the *BMJ* published an article by Craig as a personal view, *Making a complaint compassionately* (www.bmj.com/content/350/bmj.g7823.full).

Craig was a valued member of the Janki Foundation for Global Healthcare's core group. Together with other members (including former BHMA co-chair Sarah Eagger and trustee Jan Alcoe) he designed an educational training pack to support healthcare practitioners – *Values in healthcare: a spiritual approach* (www.jankifoundation.org/values-in-healthcare). He was an honoured guest at the Foundation's Global Hospital in Rajasthan and facilitated many trainings in the UK and abroad. Craig was also editor of *Values in healthcare: a spiritual approach – lifting your spirits: seven tools for coping with illness* and *The heart of well-being: seven tools for surviving and thriving*, self-help patient guides published by the Janki Foundation and the BHMA in 2008 and 2010.

After retiring, Craig held mindfulness and meditation workshops and silent retreats at home and in his garden. In the last two years of his life, he produced 20 free podcasts on mindfulness and meditation and began posting a daily Instagram blog aimed at helping people realise their potential to heal themselves and others. These and his other works will continue to be a valuable resource for all open-minded clinicians. <https://soundcloud.com/mindfulnessforeveryone>.

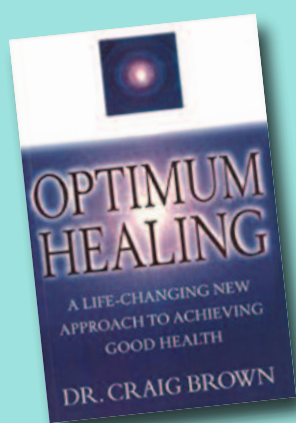
On behalf of the BHMA trustees our condolences go to his four children and grandchildren. From all those whom Craig's life enriched, and who will have been touched by his passing, our gratitude and prayers for his onward journey.

Craig's family have set up two charity pages in his memory.

St Barnabas Hospice (www.justgiving.com/fundraising/craigbrownstbarnabas)

Cancer Research (www.justgiving.com/fundraising/drcraigbrowncancerresearch)

In his last weeks Craig wrote the short piece that follows, in which he proposed a holistic approach for preparing for the end of life.



Ante-thanatos care – a holistic approach for preparing for the end of life

Craig Brown

(Greek thanatos= gentle death)

Ante-thanatos care is in many ways similar to ante-natal care. It is a preparation for a transformation; one a new life and the other a departing life. Both benefit from a holistic approach that includes conventional and self-care measures.

I felt I had made adequate preparation for my own ante-thanatos care by making a will, delegating a power of attorney, putting my financial affairs in order and leaving instructions of my various contacts and passwords on my computer. Over the years I had read much around the subject of death and dying, and attended conferences and run workshops on the subject.

On a hiking holiday two months ago with some old university friends I developed an indigestion pain. After several weeks when it did not settle I made an appointment with my GP to get some medication. She felt a mass in my upper abdomen and after investigations, including scans and a biopsy, I was diagnosed with a malignant melanoma with widespread secondariness in the liver, chest and pelvis. It was one month from being fit and healthy to a progressive jaundice. It was a shock to me and my family and my friends.

My initial fear was that I would deteriorate quickly and that I would not have the time or capacity to prepare myself on all levels of my being: physically, mentally, emotionally, spiritually, socially and environmentally.

My immediate physical problem was that I was not able to drink enough fluids and had become dehydrated and needed intravenous fluids to correct that and to drink more myself. I had been taking painkillers as required which was not really controlling the pain. With advice from the community hospice team I started a regime that controlled the pain and I physically began to feel better.

As a result of my physical improvement, I became mentally clearer and was able to work through some urgent tasks such as cancelling meetings and informing people of my illness. Emotionally I noticed I was in a dark place after being battered by one piece of bad news after another. It was not only me, but family and friends had been thrown off balance too. I needed to realise that I was not responsible for how they felt – although witnessing that was particularly upsetting – but if I began to lift myself it would help them. So through the cloud of darkness I

began to perceive a point of light which, when focused upon, slowly grew.

Spiritually I know that it is important to free oneself, which involves forgiveness and loosening attachments. In recent years following my wife's death I have been practising letting go of resentment. I feel I have made some progress as I do not really feel any anger in the situation. Generally I have not had a great attachment to material goods, but will be disappointed I will never see my newly planted wildflower beds, or be able to go on the holidays I had planned.

Letting go of people is not so easy. I have this picture in my mind of standing on the stern of a liner as it leaves port, waving to all my family and friends, knowing that I will never see, talk to, or touch them again, yet we will remain connected by our hearts in love.

The practice of meditation for me is connecting with my own inner peace and also with the universal peace and love. It is central in my preparation for my dying and transition. I do not know what is next, but am curious.

I have never been very good at receiving compliments, but the emails, letters of support and love, receiving of healing and good wishes – many very personal – have been a great condolence. When I am quiet in bed I think of all the kindness and healing sent my way, and it filling my heart and surrounding me.

Socially it is good to have the time to share memories with friends and family and be grateful for such a fortunate and full life in which I have had the opportunity to serve and love. Yet in the time that is left I am fortunate to make the space I need for myself to prepare and find that deep inner peace.

Finally, I would like an environment that is peaceful and calm where I am allowed to let go. I hope this poem I wrote will be read at my funeral.

Send me your love

When you think of me, send me your love.
Grieve if you must, but not for long.
Judge me with forgiveness and remember the good times
Help me pass on easily, by sending me your love.
My body has served me well, and my soul is eternal
Think of me as a bright star in space
Breathe in Nature's peace and send me your love
Hold it in your very being
And now breath out and let me go.

Medical education's changing story

Clare Gerada, MBE

London-based GP; chairperson of the Council of the Royal College of General Practitioners, 2010 to 2013



I have just passed my 28th year milestone working in the same GP practice in south London. I began working there having first trained in psychiatry. I have worked at the interface between mental health and primary care ever since with a special interest in the care of substance misusers, the homeless and currently mentally ill doctors. For the last 12 years I've led the largest physician health service in Europe – a service which has seen more than 10,000 doctors and dentists with mental illness present to it. I'm only the second woman in its history to lead the Royal College of General Practitioners. I trained in group analysis, obtaining the diploma of Group Analysis in 2014, and use my experience from this field to help understand why doctors are so unhappy. In 2019 I was elected the Co-Chair of the NHS Assembly and I'm proud to still be a frontline GP.

In a recent symposium for medical teachers at the University of Westminster, Clare Gerada related how her time at medical school in the 1970s had been stimulating and enjoyable. But life for students now is harder, less fun, and more pressurised. With medical students at risk of mental illness, psychological stressors need to be addressed. We cannot resilience-train our way out of this issue. It requires medical schools to address their processes and implement changes.

Introduction

In my time at medical school, close friends were made over the dissecting table, and I soon learnt to enjoy London's feast of food and arts. Of course, like most of us medics I arrived at medical school still in the throes of adolescence and with all of its age-old difficulties. Though so much has changed since then, recruitment criteria are much the same, and the late teens and early 20s are certainly no less tumultuous: if anything quite the reverse. And so, for a significant minority of students, life in our 21st century medical schools – for many reasons quite a few of them new ones – has become a lot less fun. Compared with the 1970s, today's curriculum is packed, and students even have to sign into lectures and tutorials to prove they have attended. They must work harder, and in ever larger intakes where it can feel much more difficult to make the kinds of connection I was able to make in the 1970s, when schools took in only 100 or so students a year; the generation before had been only 50. Yet today's intakes are commonly 300-plus and they face more assessments, in examinations scattered throughout

their training, rather than fixed at the end of second and final years as ours were in the 70s; plus ongoing mandatory personal reflections add to the workload. So much pressure too, in ever busier and often overstretched and industrialised hospitals, where interventions are more technical and the patients frequently more chronically ill and multi-morbid than in the far off days of the 1970s.

The mental health of medical students

A question then: were I and my colleagues more robust and resilient back then? Or were the pressures really less, or the camaraderie and fun all that stronger? Or did we feel less able to admit if we felt emotionally strained or mentally unwell? The mental health of medical students has been a topic of research for several decades. In 1986 Jenny Firth-Cozens began a longitudinal study on the wellbeing of second year medical students and followed them up over decades. At the time she found that among these students the estimated prevalence of emotional disturbance was around 30% compared with 10% in young unemployed men. Yet

despite this high level of measured distress few medical students presented themselves to treatment services, but rather they self-managed or 'coped' alone. When students were asked about possible causes of their distress, the most frequent reason given was that they did not feel valued.

Two years later Firth-Cozens (1987) questioned the same students, now housemen, this time including a measure of depression. The rate of measured distress had risen to 50% (compared with 36% in civil servants) and the level of depression that met threshold for treatment was nearly 30%. This is an extraordinarily high rate of depression. To put it in context, it would mean that of her intake of

100 students, 30 were suffering from depression by the time they were house officers. This time the most cited reason house officers gave for their distress was overwork. At the time the average number of hours worked by house officers was around 80

hours a week, but it was not unusual for some weeks when on call for this to increase to 120 hours. Quite often this meant 36 hours continuous work without a break.

Surprisingly, though the house officers considered overwork the major cause of their distress, there was no correlation between actual hours worked and scores for depression. In fact, the opposite was found in Firth-Cozens later study (1992) – and this was corroborated by other researchers. It seemed that the least depressed doctors worked longer hours and vice versa.

In these studies, the majority of doctors were men. When women were looked at separately, they were found to have much higher rates of depression than women in the general population (46% vs 15% in the general population). For young female doctors it was the conflict between their career and personal life that most strongly related to depression (Firth-Cozens, 1990).

Fast forward 30 years

Mental illness among medical students is as prevalent today as it was in the early 1980s though the difference is that we are more aware of it, more able to talk about it and hopefully to do something to address it. It is not just

a feature of the UK but a global phenomenon. A meta-analysis (Rotenstein *et al*, 2016) of nearly 200 studies of medical student depression and suicidality from 43 countries found the estimated overall pooled prevalence of depression was nearly 30% with a range from around 10% to 56%. The estimated pooled prevalence of suicidal ideation was 11% and ranged from 7% to 24% depending on assessment modes. These are high levels of distress.

Australian data on medical students (https://issuu.com/amsa-publications/docs/the_orange_guide_print) found one in five medical students in the previous 12 months had thoughts of suicide; half of medical students suffered from emotional exhaustion and

nearly 20% have been diagnosed with depression. Other studies from countries ranging from the UK to Portugal find similarly high rates of depression. Most of the studies find that the prevalence of mental illness tended to improve as graduation came closer.

As with studies on doctors and

mental illness various methodological problems could have led to an over-representation of mental illness. For example, there is likely to be a significant publication bias towards reporting symptoms of high psychological distress. Better quality studies tend to report lower prevalence. Nevertheless, on balance, research suggests that medical students have a higher rate of depression, anxiety and other psychological problems than an age-matched population and that the level of mental illness tends to improve closer to graduation.

Why are medical students more at risk?

Various confounders make it difficult to explain why medical students might be more at risk of mental illness. Medical students selection tends to favour candidates who have personality factors that foster some known antecedents of mental illness: perfectionism ('I must do this right, mistakes are intolerable'), and obsessionism ('I must do this, and I can't give up till I finish'). Even altruism ('I care for my patients more than myself, and my needs are secondary to those I treat') has obvious downsides. In fact, medical schools prospectuses are



The UCLMS library in the 1970s

scattered with adjectives like *motivated*, *committed* and *resilient* as selection criteria for entry. These personality traits, however, can lead doctors to become more self-critical, less tolerant of errors in themselves or their colleagues and to never feeling good enough. This can result in a vicious cycle of failure, procrastination, checking and seeking constant reassurance.

Perfectionism – a drive for flawlessness and for setting extremely high standards for themselves and others – is one of the most pervasive of personality traits found in doctors. But perfectionism is probably the single most significant predisposing personality trait for mental illness. In healthy amounts it makes for good doctors but overdone it can instead lead to hypervigilance, anxiety and a fear of making errors. A study of perfectionism in young people across different countries and over a 16-year period found that levels have increased year on year.

Training and resilience

Resilience is about bending with pressure and bouncing back. Despite the current moral panic that medical students and young doctors lack the resilience of yesteryear's doctors, there is no evidence that they are more nor less resilient. Yet when put under enough external pressure, anyone will reach a point where they can take no more. It is most likely that it is the external pressures that have changed over the years rather than the individual. Medicine is a long and more than ever gruelling training, where students and doctors in training are in a perpetual cycle of assessment, scrutiny, grading, and comparison with peers, where their 'coping reserve' is constantly being depleted. As such if today's medical students have less time and energy to form and sustain relationships and for self-care this may partially explain their vulnerability to depression.

Addressing students' mental health problems

Medical schools might want to consider decluttering the curriculum. A study conducted at St Louis Medical School in the US researched adaptations to the pre-clinical curriculum that aimed at reducing levels of depression and anxiety in students. Over a four-year period, the changes included introducing a pass/fail grading (rather than scores), a 10% reduction in curricular time, efforts to reduce the amount of detail taught, longer electives, theme-based community learning and spaces for peer-group reflection. The medical school implemented a confidential option to track depression and anxiety and those students who screened positive for moderate to severe symptoms of depression or severe symptoms of anxiety were contacted by a mental health provider.

The effects of these interventions changed as students progressed through their training. The impact of the changes was greatest for first-year students. Objectively (as compared with a questionnaire administered to all

US medical students) and subjectively (on free text comments) these students had lower rates of mental illness and better 'satisfaction' with their training. However, as students progressed, the interventions appeared to have less effect: in fact, rates of depression and anxiety did not fall as far for final year students as they had in their first year. As students progressed to their clinical attachments it became harder to control the negative effects of external stressors, which were beyond the control of the medical school.

The authors attributed inability to reduce rates of mental illness as being due to four main factors. The first, *the learning environment* which students rotated through involved multiple posts, making it very difficult to provide a consistently supportive offering. Second, the *poor mental health of residents and physicians the students encountered* might have had a contagious effect on their mental health (if everyone in a restaurant complains of poor food, the expectation will be of poor food). Third, the key source of stress in the third year was the *competition for future residency posts*. Finally, 'resilience' training in first to fourth years did little to counteract the psychologically stressful conditions students were exposed to in their clinical posts.

Ways forward

Until a way is found of reducing these psychological stressors, high rates of mental illness in students will persist. We cannot resilience-train our way out of this issue. It requires medical schools to address their processes and implement changes more seriously throughout students' training. This is not about molly-coddling students – it is about removing extraneous causes of pain from an already strenuous training and ensuring that they have the support, space, time and adaptive energy needed for a (usually) young person to make the difficult transition from student to fledgling doctor. The GMC has recently published an independent report on mental health of doctors (GMC, 2019). The findings are just as relevant to students. What doctors want, what will help their wellbeing and stop them getting burnt out are three things: authority, belonging and competence. This is about adding back control to highly intelligent, committed students and stopping treating them as school children needing to be shepherded through their training.

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Creative words for health and wellbeing

Larry Butler



Larry Butler is a poet who works as facilitator of expressive writing at Maggie's Centre in Glasgow. Here he shares a selection of stories told by people living with cancer, and a flavour of the healing that can be found in giving such intimate experiences a voice. Maggie's is a network of drop-in centres across the UK and in Hong Kong, where anyone affected by cancer can find caring support and information. The Glasgow Centre is a beautiful purpose-built space whose staff have the skills and insights – and crucially the time to complement the clinical expertise of the nearby specialist cancer centre.

I was born in the US, and have been living in Glasgow since 1981. I teach tai-chi in healthcare settings and lead expressive writing groups at the Maggie Cancer Care Centre. Some recent publications include *Butterfly Bones* (Two Ravens), and *Han Shan Everywhere* (Survivors' Press). I edit pamphlets for PlaySpace Publications and I recently became a grandpa and a knitter (plain & purl).

That's the way writing often starts, a disaster or a catastrophe of some sort, as happened to me... And I think that's the basis for my continued interest in writing, because by writing I rescue myself under all sorts of conditions, whatever it may be that has upset me, then I can write and it relieves the feeling of distress.

William Carlos Williams, MD

Introduction

For 20 years I've been facilitating expressive writing groups at the Maggie Cancer Care Centre in Glasgow. What I hear each week is often raw and inspiring, and I've often wished it could be shared more widely. Of course all our writing groups at Maggie's honour and respect confidentiality so we need to be sensitive about what is published. With permission I collected many letters, stories, and poems. These extracts are a few taken from an anthology of expressive writing – *Bundles of Bog Cotton* – which I put together with Morag Anderson and Terry Durkins for PlaySpace Publications. <https://playspacepublications.com/bundles-of-bog-cotton>.

In our expressive writing groups we follow the precept 'whatever you write is right, you can't writing the wrong thing', a notion taken from

Gillie Bolton's writing prescription as piloted in a GP surgery in Dumfries and Galloway. In these groups some have written through their fears while others have raged on the page. We have made lists of the things we want to do, and then gone and done them. Sometimes we made a list of things we didn't know, then researched – read – and wrote to find out.

'Aren't we lucky' said one writer receiving palliative care, 'we know we are going to die soon, so we have time to get ready and say our goodbyes.' When I visited her in a hospice, and read Finlay's booklet *Today Today Today* which was given to patients and staff at Beatson Oncology Department in Glasgow, she turned towards me in her bed with a wry smile and spoke these words: 'They're sending me home, Larry.' Why is that I asked. 'I'm not dying quick enough!' she said, and we both laughed.

What Matters

Let me tell you how words sometimes don't matter as when gestures connect need with need then giving is receiving receiving giving it's all about change – how blank faces light up when you get what you want without asking.

through my world seen through my
wound healed through my

A growing list of resources drawing on a wide range of books, websites, and journals which promote expressive writing and reading for wellbeing has been published online. The Lapidus Scotland website has integrated these on-line resource in a growing list of prompts: www.lapidusscotland.co.uk/lapidus_prompt.

How to behave with the ill

Approach us assertively, try not to cringe or sidle, it makes us fearful.
Rather walk straight up and smile.
Do not touch us unless invited,
particularly don't squeeze upper arms,
or try to hold our hands. Keep your head erect.
Don't bend down, or lower your voice.
Speak evenly. Don't say
'How are you?' in an underlined voice.
Don't say, I heard that you were very ill.
This makes the poorly paranoid.
Be direct, say 'How's your cancer?'
Try not to say how well we look,
compared to when we met in Safeway's.
Please don't cry, or get emotional,
and say how dreadful it all is.
Also (and this is hard I know)
try not to ignore the ill, or to scurry
past, muttering about a bus, the bank.
Remember that this day might be your last
and that it is a miracle that any of us
stands up, breathes, behaves at all.

Julia Darling

Ode to inarticulateness

I want to drink a toast
To the half
Formed thought
The phrase that gets stuck in the
Throat:
The pause
And... well... and...

The stammer
The hiccup
The hum
The er...
The failure of courage
At the last small point
Before the utterance.
That is where most of the words
Of most of us get lost,
Most of the time.
And yet we need
Every one of everybody's
Never uttered utterances,
Half-formed thoughts,
Unspoken speeches;
Not necessarily articulated
Into well-made flowing richly metaphored meaningfully
pregnant sentences
But simply recognised, acknowledged,
Actually utilised.
I resolve (please help me to carry out
My resolution; please, will you resolve also?)
Not to think too much
Or fear
Or most of all
Judge too much
To close my mouth
And all the many mouths
On what we want from
And
With each other.

Thom Osborn

The magic of writing at Maggie's

A group of people sit in a circle. Prompted, they write and talk. In modern parlance, the person guiding the group is a facilitator; but she's really a magician.

The circle contains people who are strangers outside of the room. But once there, something mysterious happens: we come in wearing our worries, and gradually, as she welcomes us, we begin to shed them: the fears and furies, the frustrations and despairs all drop off and pile up behind our chairs. And, like strangers after a second glass of wine, we feel the urge to share, and the intimacy of sharing. 'Sharing' is a word that's used a lot: we share our thoughts and deepest feelings along with the chocolate biscuits, and every word we offer up is valued and never found wanting. She says, 'Whatever you write is right'.

The strangers often say things they don't say to partners, children, closest friends. We write down our fears and secrets, then read them aloud; we betray ourselves, and it feels good. We laugh at morbid jokes, and we often cry: words that seem mundane on paper can be powerful when spoken. We apologise for crying, and she tells us 'It's fine. You can read and cry at the same time'. Every emotion is welcome in this room. She lights the charge and we explode; she reads a quiet poem and stillness spreads around us. We learn to embrace and feel each other's pain; we cheer small triumphs; we laugh at ourselves.

Creative words for health and wellbeing

In the circle we feel supported, understood. And at the end of the session as we pick up our worries from the floor and struggle into them, they feel lighter than before.

As they say in Glasgow, she is pure magic.

Pat Sutherland

We read William Stafford's poem, *The Way It Is*, in the Maggie's writing group and were asked 'What is your golden thread? What threads do you follow?'

Threads

From our birth we construct a narrative for ourselves, and that's the thread we follow from one day to the next. It's spun from fibres of pain and hope and trouble and love and happiness, all twined together, many-coloured. Some people weave coir into the fabric of their lives, and others weave gold thread. They all combine to create something beautiful and unique: all the threads of humanity.

Often our thread gets hopelessly tangled, and the fingers of our minds and hearts fumble despairingly to untie it. We make connections with it between ourselves and the people we love; we bind them to us. There are times when our unkindness stretches the thread between us until it frays, or, drawn out to the thinness of a hair, it breaks, and with it our hearts. Others draw us in with threads long enough to let us wander with an illusion of freedom but strong enough to bring us to them with one twitch on the thread.

We lose the thread sometimes and find it hard to find again, forcing us to weave another that takes us along a new path. Or an unwanted, undreamed of thread, tough and burning as rope, suddenly and shockingly presents itself, forcing us to accept it in the weave and live with its painful reality.

I've followed threads of worry, ambition, love, fear, and dreams, that have led to places where I've found sometimes resolution, sometimes pain. I've learned that the strongest thread is hope; it's silky and elusive, often slipping through the fingers, but once in a strong grasp it draws us towards better days.

Pat Sutherland

Why writing?

It says the unsayable.
Gives voice to the voiceless.
It's a lifetime's work –
Handwork, whole body work.

It gives form to chaos.
It reflects the present moment,
Changes the past
And creates the future.

It can exist forever
Or completely disappear.
It is what it is.
It can always be changed.

It's where the impossible
Becomes the possible.
It takes us out of ourselves
And into ourselves.

It is where we live our un-lived lives,
Where we can surprise ourselves.
It is fire.
Only we can write our writing.

Victoria Field from *Writing Works: A Resource Handbook for Therapeutic Writing Workshops and Activities* (Jessica Kingsley, 2006)



Writing guidelines

Whatever you write is right
You can't write the wrong thing!
It doesn't have to be in proper English nor Scottish

This writing is only for you to read, at first.
You might want to reread it later, share it
with a relative, friend, someone in this group;
even tear it up or burn it!

It may seem odd at first, writing like this.
Write when and where you feel like it: day
or night, in bed, in a café (difficult on a bike)

Write only two lines, or lots – in a notebook
on scraps of paper, perhaps in a folder:

1. Scribble whatever comes into your head for 6 minutes
– don't stop to think!
– it might be a list. Or odd words or phrases
– spelling and proper sentences don't matter!

2. Either carry on
Or: Write about: a dream, a memory, a time of loss...
Or: Make a list of all the important people in your life,
it doesn't matter if they are alive or dead now.
Choose one to describe. What did they say?
Write a letter as if you were talking to them.

Gillie Bolton

What I really want to say

From *Room To Write* by **Bonnie Goldberg**

When you are writing along and after a few phrases or a few pages; you still aren't getting at the words that quicken your breath, dry out your mouth, and make you lose all sense of place and time, you can reach a deeper, more authentic level by interrupting the part of your mind that is playing it safe, and give your guts a little room to speak out.

Interruptions are most effective when they are impolite. This emboldens the voice of truth looking for an opening. Give yourself the message: truth doesn't have to wait its turn. That can be enough encouragement to let it escape uncensored by propriety.

Before you begin, mark the middle of your page. Then, start writing about any topic that interests you. Once you start, don't stop. When you reach the middle of the page, no matter what you're in the midst of, write the phrase: 'What I really want to say, then write whatever comes up until you fill the rest of the page. If the writing loses energy before you reach the middle of the page, use the phrase as soon as you notice the shift.

It always comes down to the same necessity; go deep enough and there is a bedrock of truth, however hard.

May Sarton

Flowers – for Angela

I don't want flowers
not now
all celebration and beauty
frivolity and extravagance
cut off from their roots...

Now I want
daisies, out in the grass
under my (bare) feet
and long years of sunshine
to enjoy them in.

I want months of gorse
filled lanes and kissing gates,
weeks of sea thrifted beaches.

I want bundles of bog cotton,
wild orchids, bog myrtle,
blaeberry, even heather,
wrapped in peat bog
(tied with bracken).

Oceans of this please.

I don't want expensive
fragile, hot housed
flowers
because I'm ill
because you care.

Love me in other ways.
Help raid me thyme.

Alison Gean Davis

This poem was written in response to the Angela of the title's comment about the absurdity of being sent flowers in response to a cancer diagnosis.

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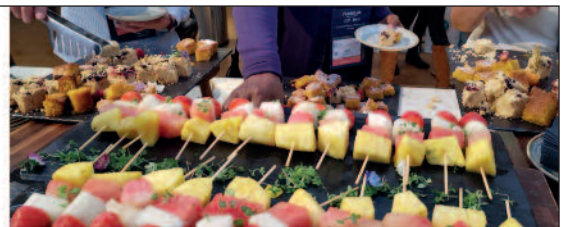
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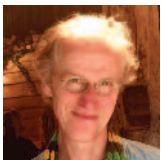
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Expressive writing

James Hawkins

Holistic doctor; integrative psychotherapist



Doctor and psychotherapist James Hawkins summarises for patients the use and benefits of expressive writing. Research suggests that people who keep a trauma secret are more likely to have a variety of health problems, possibly because holding back powerful emotions, thoughts, and behaviours, causes a long-term, low level of stress that disturbs autonomic and immune function. Writing about traumatic, stressful or emotional events has been found to result in improvements in both physical and psychological health, presumably by lowering internal stress, restoring perspective and a sense of control. Improved understanding and integration of experiences, and reduced feelings of isolation may also play a part.

My background trainings are in medicine, psychotherapy and meditation. For many years I worked through a small charity I set up in Edinburgh. Back in the 1980s I was on the working party that launched the BHMA. I now work primarily as an integrative psychotherapist. For many years I've been interested in therapeutic applications of writing and the importance of narrative. The *Good knowledge* section of my Good Medicine website contains a number of free information sheets about different approaches to therapeutic writing as well as much other information.

'The greatest discovery of my generation is that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives.'

William James

'Fortune favours the brave.'

Traditional proverb

What is expressive writing?

Expressive writing is the best known and most widely researched approach to using writing as a form of self-help. Expressive writing has been shown to be a surprisingly powerful way of coping with past traumas, current life stresses and worrying future events. Typically one writes for 15 to 30 minutes about anything one feels particularly upset about. It is often helpful to write about things that one has mostly kept to oneself. If one writes about the topic on several occasions the emotions are gradually processed. This working through can benefit our health both psychologically and physically.

When writing 'expressively' don't think too much about what words you're going to use. Don't worry about style or spelling or how the writing would sound if read out. It's sometimes helpful to start by simply describing what happened chronologically, keeping the writing matter of fact and historical. Wait a day or more, then write again about what

happened, but this time describe as deeply and honestly as you can what you thought and felt during the time you were experiencing these events. Finally after another day or more, write deeply, personally and self-reflectively about your current feelings and thoughts when you look back on these events. How do you feel you and your life have been affected? What can you learn from it all? Is there anything at all positive that's come from it? What, if anything, do you want to do about it now?

Feel free to be creative. Try writing about the feelings you experience in your body. Sometimes, if what you are writing about involves someone else, it is useful to frame the writing as a letter to them (whether they are alive or dead). You can imagine and write their reply as well. The writing though is to help you, so it is usually best not to post these letters. Writing knowing that someone else may read what you have written tends to affect what and how you write, so think twice before showing it to anyone else. It's fine to destroy what you have written. It is the process of writing itself that is therapeutic.

When is it most useful to use expressive writing?

- If you have had difficult or traumatic experiences – currently, in the past, or potentially in the future – expressive writing may well help

you. This is particularly so if you find that you worry or ruminate a lot, or if you tend to avoid things that might trigger off feelings about your difficulties.

- Expressive writing is also likely to help if you are facing current stresses or you are muddled over some issue. You may have thoughts and emotions churning around inside, but you're not necessarily clear what it is you want or what you should be doing about your situation. Expressive writing is likely to help you understand better.

How does expressive writing help?

Expressive writing can help us in a number of ways. These include reducing internal, chronic stress; helping us to understand and integrate what has happened; giving us a sense of perspective and control which helps us to move on with our lives; and maybe too allowing us to speak more freely to others about what has happened:

- Expressive writing can help by **releasing internal stress**. If we are holding onto powerful emotions without really expressing them, then the work involved in this inhibition produces internal stress on our bodies and minds. It can wear us down and increase our vulnerability to disease. Although initially expressive writing may be upsetting, it has been shown that it can reduce physical and psychological illness in the weeks and months after you use it.
- Expressive writing helps us to **understand and integrate** what has happened. The act of putting thoughts and feelings into words is surprisingly powerful. Our minds move so quickly that it is often hard to follow a train of thought right through to a clear conclusion. We may well be left with a mound of disorganised reactions which continue to churn inside. Speaking or writing slows us down and keeps us on a particular aspect of what we are facing. Confronting and expressing our deepest thoughts and feelings about a situation helps us to assimilate and learn from what has happened.



- Expressive writing gives us **perspective and a sense of control**. By using expressive writing on a series of occasions, how we see and feel about an event or problem gradually changes. Less relevant aspects tend to drop away and the important learnings are highlighted. The problem becomes more manageable and we gain perspective and a greater sense of control. This allows us to work through what has happened and move on with our lives.
- Feeling less overwhelmed and having a clearer sense of perspective can allow us more easily to speak with others about what has happened. Whether we want to do this or not will depend on us and on who is available. It can however sometimes be very helpful in **reducing feelings of isolation**.

Expressive writing is likely to be most useful if it digs deep. It is not meant to be a chance to daydream about revenge or other fantasies. It aims to explore our deepest thoughts

and feelings in a self-reflective, questioning, open way. If you have a tendency to put yourself down or see things very negatively, be careful that you don't fall into this pattern when you are using expressive writing. Ask yourself what you can learn from all that has happened. How can the outer situation be improved? Maybe it is changes in

your inner psychological state that are now more important? How could you view what has happened in a way that doesn't hurt you so much? What small or bigger steps can you take to move forward in your life? Expressive writing is a self-help method. It supplements rather than replaces the value of talking to others. If you don't find it is sorting out the situation you are facing, do please consider getting other help. This might involve talking to friends, particularly if they are likely to be accepting and non-judgemental. This may be hard for them however if they feel awkward with emotions or are involved in some way in what you are talking about. Professional help from your doctor or some other therapist may also be very useful.

For more details on the health benefits of writing and self-disclosure in general, see: J.W. Pennebaker *Writing to Heal*, New Harbinger (2004) and Louise DeSalvo *Writing as a Way of Healing*, The Women's Press (1999).



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The golden thread

Maria Hancock

Second year medical student



I'm a second year medical student who is rooted towards the artistic end of scale, driven by a love of narrative, creativity and a sense of 'the bigger picture'. My Russian heritage has shaped my love of language and culture. When I'm not experimenting with unusual flavour combinations in the kitchen, I enjoy swing dancing, calligraphy, singing and writing poetry. I also run the Bristol medical student magazine, the *Black Bag* and have been involved in writing and directing the annual medics' satirical comedy show (Medics' Review).

I lead University Engagement for the Bristol branch of Nutritank, a nationwide organisation of medical students who promote more nutritional and lifestyle education within the curriculum. We have recently worked with the National Centre of Integrative Medicine to run a Food for Mood course for students. We believe that educating ourselves and our patients about preventing illness before it happens is one of the most powerful changes we could make, as the power of food as medicine tackles the root cause of numerous chronic illnesses. For my student choice placement in my second year of medical school, I was fortunate enough to spend three weeks at Penny Brohn in Bristol. This place empowers people with cancer and their supporters using integrative medicine. During my time there, I was struck by the profound impact of cancer on all aspects of a person's life, and how a doctor must look beyond medicine alone to support them. These realisations came through a collection of specific words, phrases and images. Reflecting on each day, I would write these down, and they formed a makeshift diary of my time at Penny Brohn. For our final presentation, I wanted to infuse the most memorable words from the clients I had the privilege to speak to, so I compiled my fervid scribbles into a more structured poem. I hope it can tell the story of the people I met; the final verse then offers my response as a student.

I would like to thank Dr Catherine Zollman and Dr Derek Chase for their support, insight and wisdom.

The golden thread

The gavel takes a final fall, the jury turns and flees.
A poison, hushed and silent is injected into me.
The sand timer turns over, spilling faster than deserved
Yet Nature brings no justice with her iron, final word.

We are mere servants to Nature's command,
Her ruthless, destructive and whimsical hand.
Yet the very same Nature that inflicts this ordeal
Has the power to transform, to restore and to heal.
We are caught up in cycles, inescapable tides

Each spirit unique, yet inextricably tied.
To glance in a circle of candlelit eyes
Is an ancient reminder to the art of our tribes
Who delighted, like us, in the light through the leaves
And that blissful moment to pause and just breathe.

But we power on, like cyborgs; barely human, we suppress
For denial is protective from grief writhing in our chest.
But there comes a time when the human soul can only bear
so much weight.

To be human, and not perfect, is our one unchanging fate.

Because sometimes, there's nothing.

Nothing to say

Only the weight of unquenchable pain.

If you realise the horror of the cards you've been dealt,
It seems wiser for feelings to never be felt.

But there's a time and a place to uproot the false smile,
And acknowledge despair and the strife for a while.

Where, doctor, where, is your powerful skill?

This parasite won't flinch at ointment or pill.

It consumes me invisibly; an eye cannot see

The destruction of my whole identity.

The treatment eviscerates me to my core,
A treatment that brings me more pain than before.

To cut, burn, or poison; a generous choice
I dissolve to a number, a body, no voice.

I do not need your pity

Or a lump of half-felt words.

Just make me feel like I'm human,

Give me hope that you have heard.

Because I need more than medicine to heal mind, body and soul.

Show me how my story unfolds into a greater whole.

Cancer is not all that I am; it is just a part of me.

For if I see it as a war, how can I make my peace?

Thank you, cancer, for strengthening me.

For I dare to feel flickers of ecstasy

At the tiniest joys which I wouldn't have known

I take solace in darkness, bringing light of my own.

We must shake hands with Death to know Life as a gift.

To stand at the edge of that mighty abyss,

And to sit at Death's doorstep can bring you to learn

A gratitude no other plight can unearth.

I met you once, but you took root in me.

You brought me to utmost humility

To cling on to whatever life we have left

And weave tapestries with a Golden Thread.

To make a constellation from a scattering of stars

I'll delight in the truth that Medicine is most of all an art.

Our souls at peace, immortalised, our stories I shall tell,

Of how we came to be here and how we started living well.

Uncertainty and resilience – a medical student's story

Max Williamson

First year medical student



First year medical student Max Williamson tells of his own illness and the journey that led him to switch his studies and career path.

I am a young cancer patient, diagnosed aged 15 with testicular cancer. For the last three-and-a-half years I have also been working in patient advocacy in health research, ranging from priority setting to clinical trial design, in groups like the National Cancer Research Institute, National Institute for Health Research and the European Society for Paediatric Oncology. In this field, my interests in particular are on survivorship, supportive care and health communication research. On the other side of this coin, I have spent the last three years at University College London studying biomedical sciences with a focus on cancer cell biology, and I have now, aged 22, moved to Oxford University to take on medical school. All being well, I will graduate 10 years after receiving my diagnosis.

My story

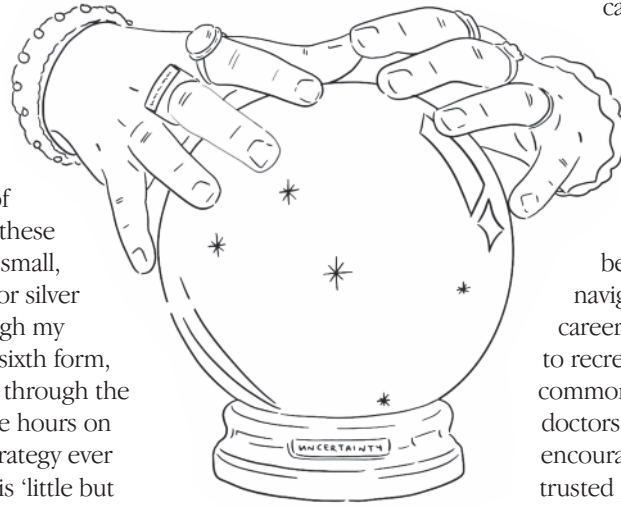
For me, medicine began with a lump. The diagnosis of a testicular germ cell tumour threw me into a precarious world full of immense physical and mental challenges, and relentless exposure to modern medicalisation. Suddenly, aged 15, my 'success' was being measured by tumour size, or 'burden'; biological outputs like fitness, function and fertility became the tools against which my performance was measured, and I still frame myself by them. The metrics that had mattered to me before my illness – my social networks, my academic ability, and my sport – necessarily fell by the wayside.

Adjusting to normal life after two operations, three months of chemotherapy, and six months out of school, was by definition impossible: the deviation away from health into the sick role had affected all my peer relationships, and I was seen as someone 'in recovery'. My mysterious affliction (or rather, its treatments) left me bald, pale and thin. At an impressionable time when social

identity is totally paramount and totally plastic, most of my peers must have seen me as a terrifying figure, a ghost of my former self, stalking the school halls between classes. It will come as no surprise then, that at the time the thought of entering medical school was sickening. But now, as a new graduate-entry medical student at the University of Oxford – someone just beginning their journey into the medical workforce – I believe we should look to our patients as sources for resilience.

Before my illness I had dreams of leaving school and studying history of art. A fully planned life in curation was ahead of me until the uncertainty of cancer crashed through that expectation. After my illness, I felt driven to switch to science, to enter research and understand cancer biology and pharmacology. Of course at first these ideas of studying medicine were hastily swept under the 'I'm not good enough' rug. I felt I lacked the resilience, the compassion and the communication skills that my doctors and nurses had shown towards me. On the paediatric

oncology ward I had come to know just how difficult, how truly difficult, a career in medicine could be. I had seen its best and its worst sides, and while revelling in (and benefitting from) the best of it, I felt I lacked the strength to work with the worst. But in reality, when ill we are forced to deal with existential issues, whether that be our fertility or our capacity or our mortality. So growing up ill has given me strength, and a strong sense of perspective, for in the face of these challenges I was forced to set small, achievable goals and to look for silver linings in order to work through my illness. And so for instance in sixth form, 'go for a three kilometre walk through the village' became 'work for three hours on chemistry'. I have used this strategy ever since because I have found this 'little but often' goal-setting approach to be a helpful way of partitioning work and overcoming workload burnout.



Source: natalie@natalieharney.com

“ I realised that what I and my family had most appreciated was the time and space that staff had made available for this compassion. ”

The care I received from the doctors and nurses at my hospital was exemplary. I trusted them implicitly, and their competence and openness were essential elements in building that trust: the way they always took time to listen to me and my concerns. Time is becoming a luxury that is harder and harder to afford in the current NHS climate, yet it was exposure to this professionally caring attitude that motivated my switching to medicine. Once released from hospital I realised that what I and my family had most appreciated was the time and space that staff had made available for this compassion. I believe this willingness to hear each other's concerns and let them improve our care should be extended to medical students. Can we create environments where students can safely and effectively express their worries and concerns without fearing that they will be inappropriately judged? Medical schools across the country are doing a better job of this than ever before, but there is still much work to be done.

During my first degree, I began to work as a patient advocate for young people with cancer. Along with this came opportunities to work with cutting edge researchers, using my experience and skillset to make a genuine difference to research strategies in a field I care so much about. But there was also a certain catharsis in being empowered to point out concerns and take part in rectifying them. These experiences have led me to conclude that, whether as students or doctors, we must begin to support one another as we navigate the many uncertainties of our careers. If we are to do so, we will need to recreate safe shared spaces: the common areas, coffee rooms and the doctors' messes, that I imagine used to encourage reflection and to express with trusted peers our worries and concerns, as well as our triumphs and delights. I though I recognise that structural issues in the NHS

mean this will be harder than it sounds, such communal spaces are essential to medical life, for as clinicians we hold this burden of uncertainty in common so, if we are to cultivate the resilience that a long medical career requires, we will need to find the time and space to speak to one another about the many uncertainties of our victories and inevitable defeats.

It was through my patient advocacy work that I realised medicine was the right path for me. Being ill gave me a unique perspective, and one that has prepared me (I hope) for caring for others, be they patients or other colleagues. I also had the chance to shadow doctors in many different departments, where I saw from the other side of the bed just how much integrity it takes to be a doctor. All this has given me immense hope that a career in medicine can be a rare privilege. As a medical student, I hope my exposure to uncertainty, and the resilience I have had to cultivate through illness and recovery, will help me understand and learn from patients and the colleagues I interact with. There is a long way to go until I qualify, and right now all I can be sure of is that I must continue to learn more about myself, my story and my good and bad qualities. Speaking at the September 2019 Medical Teachers' Resilience Symposium was a great opportunity to reflect on these qualities, on my own sources of resilience and on how the many parallels between our patients' predicaments and our own, can show us how to build a truly empathetic, compassionate health system.

See Max Williamson's resilience symposium reflections on page 35.



A new *free* app to counter life's stressful challenges for health care professionals

'Happidote' supports the wellbeing of health professionals around the world. Think 'happy antidote'. It's been designed as a quick and easy way to access simple guided meditations to help calm the mind and ease the stress of work.

'Happidote' is the creation of a group of concerned health care professionals – GPs, consultants, nurses, social workers and therapists. They are all members of The Janki Foundation for Spirituality in Healthcare, a registered UK charity that seeks to promote spiritual values in healthcare in the UK and worldwide. All those who designed, wrote, built and performed in the Happidote app practise meditation in their day-to-day working lives.

Dr Sarah Egger, Chair of Janki Foundation explains how it came about:

'We've noticed over the years how providing healthcare in a climate of underfunding and cuts can be damaging to the health and wellbeing of those expected to deliver it! This is especially relevant at this time when health services everywhere are under unprecedented strain.'

The team agreed on 10 typical stress-causing scenarios based on experiences they'd had that regularly caused distress at work. They then recorded three-minute meditations that would act as the antidote to each situation....

'We considered which situations at work we found most challenging and

what words of spiritual guidance have helped us personally at those times. What we needed was something we could use on the job – short, succinct 'first aid' commentaries of spiritual wisdom that we could listen to and which could protect us from further stress.'

The top 10 stressful situations the app offers an antidote for are:

- 1 Stressed and overwhelmed
- 2 Colleagues need support
- 3 Overworked and trying to be perfect
- 4 Unsafe and surrounded by chaos
- 5 Bullied and harassed
- 6 Anxious about giving bad news
- 7 Drained by complaints
- 8 Attacked and defensive
- 9 Losing hope
- 10 Fearful and afraid

It's a bit like the concept of recovery, as used in sports to build resilience. Players take a few minutes out to recover from the stressful situation and build inner strength. With the Happidote app you just click on one of the above scenarios to hear the situation in full. You ask yourself, 'How do I feel?' and the antidote corresponding to that situation is revealed through a short meditation of gently-spoken words and quiet

background music. For each meditation there are beautiful, original images reflecting the changing mood. Your state of mind transforms from negative to positive, bringing you back to a state of balance. A **slogan** then helps you focus on ways to support yourself.

In addition, the app has **three core meditation** practices that can be used anytime, anywhere, and a *Spin the Value Scope* feature, with one of 20 personal values to inspire and guide you, depending on where the pointer randomly lands.

The Happidote app, available for Android and iPhone formats, is absolutely **free** for all time, but donations are welcome for the ongoing work of the charity. You can download it from Appstore and Google Play and jankifoundation.org/happidote.

Psychotherapist Renée van der Vloodt said:

'What an exquisite gift to the world this pocket collection of meditations is! A wonderful resource to have to hand to guide us and for immediate use when we need to press the pause button for a few moments. Beautifully produced, and I love the Value Scope to lift us onto higher ground when we are getting too bogged down!'



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Crossing the threshold: my story of liminality

Michael Zervos

Foundation Year Two doctor in Devon



Anthropologists view ceremonies marking important transitional times in a life as rites of passage. They typically involve rituals and teachings intended to strip individuals of their original roles and prepare them for new ones. A recently qualified doctor explains how this anthropological perspective helped him see medical education as a prolonged rite of passage into doctorhood. Yet medical education pays little attention to the impact of the liminality of ambiguous and disorienting experiences that many students go through as they leave their 'lay person' behind but have yet to take on the peculiar status awarded to medical doctors.

Although I only studied anthropology for a year, it has profoundly changed how I view the world of healthcare. As my professional identity matured from medical student to doctor, I have grown to appreciate the privileged position that we occupy, and how we can use this to help our patients and colleagues. As a doctor, I am driven by a desire to build connections with those around me, and to that end am heavily involved in clinical education at my trust, combining teaching and simulation with the facilitation of reflective practice. I hope to work in mental health, and am endlessly fascinated by the myriad ways that humans relate to each other.

Social anthropology is the study of human societies and the relationships that make them up. For example, political anthropology – the study of relationships of power and hierarchy – allows social scientists to analyse why and how certain people have control over others. Similarly, medical anthropology is a broad field that looks at relationships based in and around health and healthcare. Studying social anthropology at the University of Cambridge became a crucial feature of my education.

One of the most important concepts I learnt about was that of 'liminality' – the ambiguous and confusing position that exists in the middle of events that anthropologists consider to be rites of passage. The term liminality, which comes from the Latin *limen* meaning threshold, is one that anthropologists have used for a wide range of cross-culturally translatable rites of passage surrounding for instance birth, death, religious rites, marriage, coming of age etc.

I found this resonated with me as a medical student who – having carved up a cadaver in anatomy – was no longer a layperson, but had not yet become a doctor with the faith in

myself or the qualification to represent myself as one. It was also disorienting for me to be the only 'scientist' in lectures full of arts students. This position of tension and uncertainty continued throughout my medical school experience, so to me, it seemed thereafter that medical students are constantly faced with the issue of 'where do I belong'.

Applying the anthropological lens to this question helped me understand more about the process of 'becoming a doctor', that it involves something more than a course we study at university. In order to do the job of a 'doctor', we must go through a fundamental change. Where once I was socialised to not cause harm to others, as a medical student I was taught to divorce the brutal reality of stabbing someone with a needle from the act of doing harm. The medical humanities literature offers a wide range of metaphors for this process (Hafferty, 1991; Davis, 1968): of being melted down and recast in the mould of a doctor: of being cut and trimmed into a topiary shape; of being indoctrinated and brainwashed into the 'cults' of physicians and surgeons. All of these analogies make sense to me, and all of them help me tolerate

the complexity and uncertainty of each day in my life as a (necessarily) resilient junior doctor. Naming this process has been the first step in managing its impact on my life, and reconciling the work I do, with the person I view myself to be.

If we return to the anthropological idea of liminality, we can analyse the medical school experience as a rite of passage. Van Gennep (1960) posited three steps in any rite. First come rites of separation (leaving home and going to university), then transition rites (procedural education and yearly exams and so forth), and finally rites of incorporation (final year apprenticeship, graduation, induction as a foundation year 1, 'Black Wednesday'). The symposium panel on which I spoke had representatives of the three stages – someone about to begin at medical school, another in the midst of her undergraduate medical education, and myself just out on the other side and now having to reintegrate into society as a doctor.

Little of this journey is addressed explicitly in a curriculum necessarily filled with anatomy, pharmacology or neurology. Yet it is something we are supposed to glean between clinics and ward rounds, because this process of tolerating uncertainty is a key feature and without it we are unlikely to develop resilience. And our ability to distance ourselves emotionally from every patient who deteriorates is arguably a key to a long and happy career. Schwartz Rounds (SRs) (Barker *et al*, 2016) fulfil a similarly reflective role but in an opposite and complementary way. Rather than asking us to dissociate and distance ourselves from these difficult feelings and the risk of objectifying our patients, SRs ask us to empathise skilfully with people's suffering and to bear witness to our own emotional responses. As a student I was fortunate to attend a Schwartz Round on the theme of courage. This was the first time I had seen clinicians discuss the real emotional hardship our work in medicine entails, and I found it groundbreaking that a senior practitioner could openly talk about an episode of failure that had stayed with them throughout their career. I realised that one need not sacrifice one's humanity in becoming a doctor. Since that Schwartz Round, I have trained as a Schwartz facilitator and helped develop the student Schwartz Rounds at University College London Medical School.

Themes of liminality, of not belonging and of the emotional burden of working in healthcare, are often echoed at the student rounds. One of our rounds focused on the cancer patient pathway, where over a year students follow a patient through their cancer journey. The student is asked to develop rapport, attend appointments, and try to understand what living with cancer and undergoing treatment might be like from a patient, not clinician, perspective. This pathway is incredibly powerful for

students. They gain a true insight into their patient's journey, and the discussion at this particular round revolved principally around a student's role alongside that patient. Students spoke of the 'in between' position they occupied – sometimes like a friend, sometimes like a doctor, sometimes feeling like a nobody – and what it was like to be expected to shift seamlessly and rapidly from one state to the other.

On the day before I took part in the symposium I was involved in a peri-arrest call for a patient who was having a massive gastrointestinal bleed. At the time I spoke at the meeting, I still had no idea what had ultimately happened to that man, for the last I had seen of him was as he was wheeled urgently off the ward and the elevator doors closed behind him. Even though my colleagues and I had been there at a crucial moment in this man's life, and possibly just before his death, I was at an academic meeting without answers or any sense of closure. Though we seldom talk about it, this uncertainty is a fact of life for doctors and we are expected to cope with it, manage its impact and somehow learn to live with it. And adding to the poignancy of this typically challenging event, was the presence of a medical student who had run down with me to that peri-arrest situation. She spent the entire time hovering in the doorway; not of enough use to help, but reluctant to leave. In so many ways she embodied the very essence of liminality – a young woman unsure of her place, on the threshold of both the room and of being a doctor.

Once applied, it is very hard to remove the anthropological lens. As a student, I was fortunate to learn these lessons about perspective and my place in this scary medical world. As an educator, my greatest hope is that I will give to scientific young minds a glimpse of this perspective, and that it will help them navigate the academic and emotional challenges of a career in healthcare.

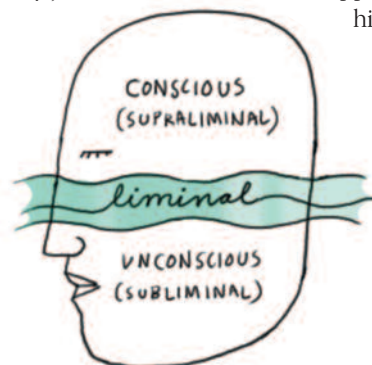
Many thanks to Dr Faye Gishen for inviting me to participate in the symposium and for her ongoing support and mentorship, and to Professor David Peters and Dr Chris Horn for organising the symposium.

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Source:
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What can anthroposophic psychotherapy contribute to our understanding of human distress and sickness?

John Lees

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I have been in private practice since 1987 and have worked as a clinical supervisor since 1995. I have worked in community counselling agencies in Hampstead and Waterloo, as a GP surgery in Brixton and in student service departments at the Universities of Middlesex, and Greenwich. My teaching has mainly been oriented towards psychodynamic therapy, attachment theory and intersubjective theory but has also included a range of other persuasions, particularly humanistic therapy, and cognitive-behavioural therapy. My international work has involved lecturing and working as a visiting scholar in Australia at Edith Cowan University, in India and in the Netherlands at Leiden University of Applied Sciences.

Mainstream medicine limits its focuses to biological processes, ignoring what cannot be measured. This is to its detriment but how, instead, to incorporate soul and spirit into a new story for healthcare? In anthroposophical medicine a person's biography is but one chapter in a soul's longer story of embodiments. Spiritual science proposes a radically non-dualistic model in which a spiritual dimension is inherent in the material world, and where a person emerges through spiritual-physiological-psychological processes.

Introduction

This article examines the contribution of anthroposophic psychotherapy to our understanding of human distress and sickness.¹ I begin by examining the relationship between the counselling and psychotherapy (therapy) profession and healthcare systems including conventional biomedicine. In so doing I take a broader view of biomedicine than is usually the case in order to develop a more 'humanistic' complementary and alternative medicine (CAM) perspective on it. The reason for this is that there are many similarities between CAM and the therapy profession and this offers an opportunity for thinking across boundaries and promoting a cross-fertilisation of ideas between these disciplines. The Jungian therapist, Andrew Samuels, looking from the point of view of politics, aligns CAM with psychoanalysis, psychotherapy and counselling, environmentalism and the efforts of those supporting the rights of ethnic and sexual minorities.

He does so because in his view they all exhibit 'political energy', share an 'emotional rejection of big ideas' and adopt the values of 'living intelligible and purposeful lives in spite of the massive social and financial forces that work against intelligibility and purpose'. Anthroposophic psychotherapy is both a form of CAM and a holistic approach to therapy. It forms part of an interdisciplinary approach to healing which includes anthroposophic medicine and other therapeutic disciplines and is bio-psycho-social-spiritual in orientation.

Many therapy practitioners are critical of the medical model – for instance, of its emphasis on pathogenesis, or a 'disease model' which Rachel Freeth (2007) warns sacrifices 'the humanistic ideals that have guided the counselling profession for decades' together with its abandonment of a relational paradigm, in favour of a relatively ineffective, technique-oriented emphasis that discourages clinical judgement, innovation, and adaptation to the individual client. In his long-

standing, more general and fundamental critique, Illich (1975) refers to how the medicalisation of everyday life, by destroying 'the environmental and cultural conditions needed by people to live a life of constant autonomous healing', is responsible for 'social iatrogenesis'.

Our materialistic medical system largely developed out of the Enlightenment materialistic scientific tradition, which began in the 15th century and culminated in the 'victory of official modernity in the scientific revolution of the mid-17th century'.

But what came to be called medicine began in ancient Greece in the temples dedicated to the god Asklepios, the god of healing. So medicine is not inherently materialistic, but it has been colonised by the assumptions of materialism and rationalism over the last 500 years and, more recently, constrained by the systems and protocols of managerialism.

History tends to ignore these traditions, yet even within the last 500 years, doctors have included marginal approaches that are now far from widely known: systems for instance devised by Paracelsus and Robert Fludd in the 16th and 17th centuries, the work of Samuel Hahnemann forefather of homeopathy in the 18th and 19th centuries, and of Rudolf Steiner, the originator of anthroposophic medicine and therapy, in the early 20th century. With the advent of complementary and alternative medicine (CAM) both within and alongside conventional biomedicine, these hidden approaches to medicine re-emerged in the West. So biomedical systems do not constitute a homogeneous and undifferentiated materialistic mass.

Dr Peter Toon, GP and clinical ethicist, identifies three types of doctor: the *bio-mechanical* doctor, the doctor who uses *humanistic* models and the *anticipatory* care doctor. Humanistic doctors arguably resemble psychotherapists in that they have in common a concern for the purpose of life, and the development of patients' understanding of their illness and symptoms. According to a report published by the European Committee for Homeopathy in 2008, about 150,000 doctors in the European Union have taken training courses in one or other CAM therapy, including anthroposophic medicine. So what can anthroposophic psychotherapy, which forms part of the anthroposophical CAM system, contribute to our understanding of human distress and sickness? In order to begin to answer this question I will give a brief overview of anthroposophic psychotherapy and its application in practice.

Anthroposophic psychotherapy

With its holistic and uniquely *bio-psycho-social-spiritual* principles, anthroposophic psychotherapy, is now coming into its own. There are two primary reasons for this. First, towards the end of the 20th century many leading therapists developed psycho-social perspectives on therapy – for instance the work of John Bowlby and Donald Winnicott who incorporated a relational, social and contextual approach to psychological problems. This was followed by

research into trauma which linked therapeutic work with social and political factors, as in Judith Herman's statement that the increased awareness of sexual abuse came about because of the feminist movement in the 1980s. In her words: '*The study of psychological trauma is an inherently political enterprise because it calls attention to the experience of oppressed people.*' Thus therapy becomes psycho-social (and political) in



Downland path, Michael Newgass. From South Land, West Wind, Michael Newgass, 2019

orientation. But Steiner had incorporated this perspective in his approach to healthcare early in the 20th century in a lecture on trauma in January 1917 (at a time when presumably he was observing traumatised soldiers returning from the World War I battlefields). In the lecture he referred to three distinct types of trauma based on the model of human development on which he had previously enlarged. The type of trauma occurring within the first seven years resulted, he said, in extreme states of mind which take over the client and can lead to psychosis. The second, where traumatic events happen during the next seven years when the child is beginning to learn about social life in interaction with peers, may lead to extreme polar emotional states. The third kind of trauma having impacted in adolescence, Steiner suggested, would lead to extreme self-preoccupation. In a situation where a trauma has occurred very early, all three states can co-exist. Anthroposophic psychotherapists, by adopting these ideas in their work, have been in the forefront of bringing the psycho-social element into psychotherapy.

The second set of supporting factors for anthroposophic psychotherapy arrived in the 1990s as new technologies allowed novel ways of investigating brain states. Dubbed the 'decade of the brain', there were important developments in neuroscience with the work of such researchers as Antonio Damasio. With the first 'text book' on neuroscience for therapy practitioners – Babette Rothschild's *The Body Remembers*, in 2000 – psychotherapy became *bio-psycho-social* in orientation. The impact of infant trauma on the whole of the body rather than just

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the brain was expanded by notions such as allostatic load out of further research.

It is now quite mainstream to view the individual's mind as emerging in relation to its social world and to understand that it develops through and in parallel with the biological changes that support the brain's maturation and integration. Yet many years ago Steiner had anticipated this narrative by proposing that the primary problem facing the health of human beings is brought about as an essentially immaterial, spiritual self struggles as it comes into the world after birth and in the early years of childhood to inhabit a physical body. In recent years as anthroposophic psychotherapy has taken up this view, its part in the treatment of illnesses and psychological problems is to help make sense of the individuality's efforts to adapt to and 'inhabit' its hereditary body. Furthermore it sees the problem as exacerbated by the difficult and challenging materialistic conditions on the earth today. It is for this reason that Steiner was unequivocal, in his first set of medical lectures, in saying that: 'To talk of mental disease is sheer nonsense. What happens is that the spirit's power of expression is disturbed by the bodily organism'. In taking up this idea, anthroposophic psychotherapy is not just psycho-social but bio-psycho-social-spiritual.

The practice of anthroposophic psychotherapy

Andrea, in her early 30s, was the third of four sisters.² She had a frightening and violent father and, as a consequence although she was very clever and artistic, brilliant even, she was chaotic and her attachment style was of the disorganised kind. Of the three trauma styles I took the view that the traumatic problems were present from birth and consequently, in adult life, she was frequently overcome by extremely chaotic states of mind but, because of her natural inner spiritual strength and brilliance, was not psychotic. However, she just couldn't get a grip on her life.

In one session we explored how she was offered a free ticket to a concert by a friend, but for various reasons could not make a decision and so ended up saying 'the problem just grew up and I couldn't make a straight decision'. More generally she spoke about her difficulties managing her thoughts: 'They just come out and it is a continuous and stressful work to value them. It's like having dogs in your brain, biting each other and I'm scared to get lost in this battle.'

Andrea's spiritual individuality (or her 'I' in anthroposophical terms), which was pure, moral and undamaged, was having difficulty in 'inhabiting' her hereditary body because of the difficult conditions into which she had been born in her family. In Steiner's terms, her 'power of expression' was disturbed by her 'bodily organism'. After trying to help her for about three months, I was just about maintaining the therapeutic alliance through the chaos, almost becoming traumatised myself in the process of the therapeutic relationship. This entanglement is almost

inevitable during in-depth trauma psychotherapy when the historical trauma repeats itself in the counter-transference dynamics of the therapeutic relationship. But because of her brilliance, I over-estimated her capacity to manage as we reached a crisis point just before a break. She texted before the final session: 'Hi John, I will be 10 min in late. Sorry'. Then one minute later: 'Hi John, I'm still at home looking for the keys that I can't find. I'm in the middle of a panic attack', then another minute later 'I don't know what to do, I'm panicking'. At this point I suggested a session on the phone, and we down-regulated the acute anxiety that had been triggered by the break, and could deal with the dynamics taking place and so everything settled down.

To move the work forward I realised that to bring about true healing I needed some help. So I referred her to an anthroposophic doctor to help with the disturbances to her 'bodily organism'. He prescribed many medicines. These included iron, the metal of Mars, to give her courage to incarnate her ideals on the earth without fear of the judgement of others; another was quartz, a very formed substance which helped her to form and structure her life to prevent it deteriorating into chaos; another was conchae, or the oyster shell, to protect her thoughts from getting overwhelmed by events. The medicines were intended as organising templates for prompting a biological level of self-education aimed at addressing the embodied disturbances that were disrupting her soul life. This brought the problems more clearly into her consciousness, thereby enabling the psychotherapy to help her to feel, face and think more clearly about the inevitable challenges that arose out of her unconscious fearful and insecure early experiences. The recovery state of course then brought about yet more challenges as in any recovery state, but there was movement where before there had been dissociation and stagnation.

Final thoughts

In this article I have attempted to give an introduction to anthroposophic psychotherapy and its contribution to our understanding of human distress and sickness. In so doing I have given a merest glimpse of how a complex form of therapy may help with an extremely complex case. It is not always necessary to collaborate with a doctor. But, in the case of traumas which begin in the first seven years, at a time before children can more reliably reflect and form inner narratives, it usually is necessary.

- 1 Anthroposophic psychotherapy is inspired by the work of Rudolf Steiner.
- 2 Andrea has given written consent to use the work for the purposes of research and publication.

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Language is not just data: it is a custodian of our humanity

David Zigmond

Physician in psychological medicine; retired GP



This article was written seven years ago, in response to my long experience of changes in our NHS culture. In brief these are predominantly secondary to ever-increasing expectations of, then directives to, industrial-type mass production and standardisation: computerised and cybernated algorithms and micromanagement edicts are then inevitably unleashed to ensure 'compliance' to these now highly engineered and machine-like plans. The cost of such 'modernising' reforms to our human culture has been enormous and egregious. The losses are indicated by changes in how and what we signal to one another. The implications of this extend far beyond the conventional form of language.

It is now 50 years since my medical graduation. I have worked for this half-century as an NHS psychiatrist, psychotherapist and inner city GP. Much of my attention has been devoted to what I consider much-neglected social and psychological aspects of healthcare. As these neglects have increased with each of our NHS serial reforms, I have, in recent years, become a kind of humanistic (thus holistic) healthcare activist. My mission? To chart and understand these losses, and then to restore and secure our better human sense and sensibility in our NHS.

Many articles exploring similar themes are on my website www.marco-learningssystem.com.

Computers and informatics have become central to NHS healthcare. All experience and activity are now subject to official technical designations. This changes our communications: language becomes increasingly lack-eyed to the computer's requirements. Much else is lost. What?

My first mentors in general practice and psychiatry – galvanised by the just departed 1960s – were all nourished, enlivened, then enlightened by literature and philosophy. Such proclivities were not ponderous or self-conscious postures, but pursuits that were shared with a mien of quiet and unaffected pleasure. I remember many conversations where, in order to understand others better, we made wefts of contemporary pragmatic practice with illuminated threads from drama, philosophy, literature or mythology.

The then-fresh Balint movement encouraged us to step up and out from our scientific base of standard diagnoses and treatments; while we recognised that these certainly helped us, they could do so only with *generalities*. So grounded, we were spurred to thoughtful experiment: to engage with the humanly speculative and imaginative – for these could help us, instead, with the *individual*: *this* person and *this* situation. To do any of this we needed to draw from a panoply of human thought and testament. Imaginative understanding of others is a kind of 'play', and for

any successful foray into play we must encourage an expanded, rather than constricted, language. For sometimes it is an unusual word, simile or metaphor that catalyses greater understanding and then rapport.

Even at the most pragmatic levels of service this previous broader and richer language was more likely to capture and convey the uncodifiable untidiness of real life, the crucial vicissitudes of Practice. I recently had an unexpected reminder of this, and it is a good example. While seeing Matthew, an amiably direct, stalwart and un-nervously jocular 35-year-old, I rummaged through his old manual records, where I found a mechanically typed letter from a hospital casualty department. It was written to me in 1980 about a toddler, Matthew. Here it is:

Dear Doctor

Matthew P, age 2 years

This delightful little boy was brought here on Sunday morning by his very anxious and solicitous mother. Mother was worried by an alleged fever and cough of two days' duration. Matthew himself was alert, bright-eyed, active and playful. He had no signs apart from a very mild catarrhal cough, which he didn't seem to notice!

Mother seems a sensible and intelligent woman, but inordinately anxious about Matthew's minor

Language is not just data: it is a custodian of our humanity

symptom. In talking to her it came to light that her own sister has recently been diagnosed with acute leukaemia. Understandably this has shocked and shaken the family. I had a long discussion with Mrs P in which I told her that Matthew is perfectly well apart from having a slight cold, and that her very real anxieties about her sister have unintentionally spilled over onto Matthew. I hope I have been able reassure her. I have taken the liberty of asking her to see you for follow-up.

*Yours sincerely
Dr TS, CSO*

All these years later I remember a couple of phone conversations I had with Dr TS – a warm, friendly, bantering northern voice that conveyed intelligent pleasure in his work, its people and their welfare. Reading this letter, more than 30 years later, brought me both joy and sorrow.

The joy was humble though clear; it was the memory of such quiet, subtle suffusions of personal interconnectedness: here Dr TS had shared with me his brief connection with – but growing understanding of – Matthew, Mrs P and all her family. Matthew's slight catarrhal cough was thus given much greater human – and thus healing – meaning. This sent a gentle benign ripple across the whole matrix: we all felt better about ourselves, one another and our work. This is well-fared welfare.

But then came my sorrow, for the massive yet little-voiced loss of such things. For it is almost impossible that I would receive such a letter now. Both because of, and in spite of, the endless blizzard of electronic, data-particled emails transmitted from my local airport-like hospital, I have with them almost no conversations enlarging my understanding of people. Dr TS's personally sentient letter would now be replaced by an anonymised electronic, templated format. This would machine gun me didactically with tabulated impersonal data itemising myriad aspects of the (normal) physical examination; the healthy child's measurements of oximetry, temperature and respiratory rate; the immunisation status; the social status of the child and whether social services' involvement has been triggered This surfeit of (usually) unedifying administrative detail would have neither space nor vocabulary for the brief glimpse of the importantly unobvious; the human story that gives this (non) medical scenario significant and compassionate meaning. We have lost both the personal language of healthcare and its colleagueal discourses.

Such losses coalesce, then anchor. Eventually a restricted language and format will not merely confine description, it will – hypnotically – limit our thinking and actions too. Language, thought and action are often less divisible than our analyses of them. Expansion or contraction, encouragement or proscription, nourishment or impoverishment – influence one and the others will probably change in a parallel way.

The more complex the human activity, the more this matters. We have seen, with Matthew, how language can service or disservice a relatively simple, yet humanly-complexed, medical problem. Let us take a more intricate and chronic problem. Geoff is a troubled diseased man in his mid-30s. Here are two accounts from an encounter he has with a psychiatrist.

A: patient as object. Language as designation

G has a long history of agitated depressive illnesses with marked anxiety/panic components. Although his questionnaire depression scores were high, they were discrepant from the multi-disciplinary team staff's assessment. He has a poor record of maintaining work and long-term relationships. He also has problems with anger management: this was evident to the clinic staff when I was unavoidably delayed. This inconvenience was clearly explained to G, who nevertheless was unacceptably angry and rude to the staff in response. It is thus likely that G also has a personality disorder.

B: patient as person. Language as understanding

G has never recovered from the childhood terror and sorrow from his experience of father's raging cruelty, brutality, and then final desertion. G's life has been spent yearning for, but mistrusting, male support, esteem, affection and affiliation. He wants comfort from others, but fears betrayal, so disguises his needs. My lateness for his appointment seems to stir in him ancient residues of imperilled dependency, uncertainty and abandonment. His response to my greeting is staccato, flushed and tense: he seems both angry and afraid. I sense in him a conflation of fight and flight, and I think again of his wounded, early childhood.

*

If it were you that was distressed, which doctor would you wish to tend you?

*

One definition of the success of a specialty is that it replaces vernacular language with its own vocabulary. Thus specialisation both colonises and shortcircuits common speech, replacing this with its own distillate. The losses involved vary greatly: the dehumanising potential of 'megaloblastic anaemia' is negligible, that of 'depression' considerable.

Archimedes' notion of displacement is instructive far beyond the physical world: it often operates in the realms of human culture and language. The overgrowth of the technical and the schematic can all too easily – without malign design – extinguish the organic and the human. Our world of ever-increasing mass production has many hidden taxes. There are hungry conundrums, too: how do we safeguard literature in our language, art in our (medical) science and heart in our practice?

'A man is hid under his tongue'

Ali Ibn-Ali-Tabib, Sentences, (7th century)

Schwartz Rounds

Sharing stories, humanising healthcare

Paquita de Zulueta

GP; therapist/coach



Humans tell stories to make sense of experiences and of the world we live in. Stories give us meaning and coherence. A strong line of research shows that if story-tellers can derive redemptive meaning from suffering and adversity in their lives, they tend to enjoy higher levels of wellbeing, psychological growth and other indices of successful adaptation (Fivush, 2017). Schwartz Rounds offer protected, confidential forums for shared reflection and support, to tap into this rich source of strength and resilience, and enable compassionate care and staff wellbeing.

I have worked for 35 years as a London-based GP and have a special interest in mental health, migrant health, clinical ethics and professional wellbeing and development. I am honorary senior clinical lecturer at Imperial College, a cognitive behavioural therapy (CBT) therapist, and a qualified coach and mentor. I am a Schwartz Round facilitator and member of the clinical ethics committee of Imperial College NHS Trust. I worked for three months as GP lead for the NHS Grenfell Outreach Team following the disaster in 2017 and for 10 years as clinical volunteer for Doctors of the World London Clinic.

Setting the scene

Healthcare in the UK is in crisis: doctors and nurses are experiencing very high levels of stress and burnout, with the attrition rate of junior doctors and nurses rising (GMC, 2019; Beech *et al*, 2019). The current coronavirus (COVID-19) pandemic is imposing further enormous strain on an already stretched NHS. Health professional burnout is global and not confined to Britain (Lemaire and Wallace, 2017; *The Lancet*, 2019). Authorities such as the General Medical Council (GMC), having recognised that the medical profession is under great stress, are now making welcome recommendations on how to support doctors. The GMC document *Caring for Doctors, Caring for Patients* (West and Coia, 2019) acknowledges that prioritising clinician wellbeing leads to better care and improved patient experience. The Point of Care Foundation (POCF) in its document *Behind Closed Doors* (Cornwell and Fitzsimons, 2017) highlights the need for staff to feel positive and engaged with work and 'that staff experience should be given equal priority with patient experience at all levels of the healthcare system'. There is also evidence that enhanced staff wellbeing translates into improved patient outcomes (*The Lancet*, 2019).

The NHS has been 'starved' of funding for several years and this is causing increased stress to the health-

care system and for those working within it (The King's Fund, 2019). Yet lack of money and resources, albeit important, is not the only problem: NHS workplaces are often found to be uncondusive to staff and patient wellbeing with unacceptable levels of bullying and undermining of healthcare professionals (West, 2020). Dysfunctional leadership, team conflict, and steep hierarchies have been identified as predisposing.

The industrialisation and fragmentation of healthcare

In the last decades medicine and healthcare in general has become more bureaucratised and industrialised with emphasis on efficiency and transactional goals (De Zulueta, 2013). Healthcare is increasingly 'marketised' and viewed as a commodity with clinicians as 'providers' and patients as 'consumers' or 'customers' (Henderson and Petersen, 2002). 'Care' is disaggregated into discrete, monetised and measurable processes. This trend is accelerated and inflated by the advent of 'big data', machine intelligence and more broadly artificial intelligence. We are now in the age of the digital – the algorithmic – way of life. This restores the biomedical disease-focused decontextualised model with a vengeance – the focus

is on accurate diagnosis (preferably with the use of algorithms) of a clearly defined condition and of finding a targeted treatment in the form of medication, surgery or manualised limited-session psychotherapy; all this to produce predictable and measurable outcomes. For diagnosis and treatment choice, the idea is for the machines to churn through huge amounts of information (data) and the clinicians to be left to do the relational work – the ‘soft stuff’ – listening, empathising. The problem with this approach is that it assumes that the art of deciding which treatment (or non-treatment) would be appropriate for the *individual* patient, and which would entail attuning to their needs and values – is something separate from the intellectual *scientific* work of diagnosis and prognosis. This compartmentalisation is erroneous, for these processes are welded together in a dynamic, iterative whole arising from reflection in action (Schön, 1991) and dialogue in the context of a healing relationship (Emanuel and Emanuel, 1992). One cannot cleanly separate the art and science of medicine – they co-exist in an inseparable whole (Kleinman, 2008). In the digital age true reciprocity is threatened, although those who promote ‘chatbots’ will argue that this is not the case. Care in modern healthcare is often fragmented: a lack of cohesive teams in hospitals and the loss of continuity of care in primary and secondary care provides few opportunities for building relationships between caregivers and their patients (Jeffers and Baker, 2016; Sudhakar-Krishnan and Rudolf, 2007). Modern (or post-modern) healthcare has created barriers to the development of trusting relationships and the erosion of compassionate care ((De Zulueta, 2013; Mannion, 2014).

So how are doctors and other healthcare professionals to work, within these fast-moving, task-intensive, depersonalised, fragmented and technocratic systems? The evidence suggests not very well; in this cultural milieu many experience ‘moral distress’, burnout and avoidable suffering (Dzeng and Randall, 2018).

I will now explore how Schwartz Rounds can mitigate harm and generate more positive, humane systems.

What are Schwartz Rounds?

Schwartz Rounds are named after Kenneth Schwartz, a lawyer and father diagnosed at the age of 40 with an aggressive, and ultimately fatal, lung cancer and who, before his death from the disease in 1995, founded the not-for-profit Schwartz Center for Compassionate Care. He describes the treatment that followed the diagnosis as an ordeal that was ‘punctuated by moments of exquisite compassion’. He describes how acts of kindness – ‘the simple human touch from my caregivers’ made ‘the unbearable bearable’ Schwartz recognised the emotional load that healthcare professionals had to carry and their need for support. He also recognised how difficult it was for caregivers to retain their humanity in a busy, emotionally laden organisation: ‘Looking back I realize that in a high-volume setting, the high-pressure atmosphere tends to

stifle a caregiver’s inherent compassion and humanity’ (Schwartz, 1995).

The Schwartz Center is dedicated to supporting caregivers and healthcare leaders, to strengthen relationships between patients and caregivers and to bring ‘compassion into every healthcare experience’. Rounds provide opportunities for individuals to share lived experiences by telling authentic stories that reveal their vulnerability and suffering as well as acknowledging the pride and joy that their work can offer. Schwartz rounds were rolled out in the USA from 1997 onwards and are a feature of hundreds of healthcare institutions (around 400). They were introduced in the UK by The King’s Fund in partnership with the Point of Care Foundation (POCF) in 2009. At the time of writing, the POCF now supports more than 220 organisations in the UK to deliver Rounds. These occur in hospital trusts, hospices, care homes, primary care centres, ambulance centres, and even in prisons and police settings.

Benefits include greater empathy and compassion for colleagues and patients, reduced isolation, enhanced peer support and improved teamwork

Schwartz Rounds aim to enable compassionate care and staff wellbeing. They offer protected, confidential forums for shared reflection and support. Typically they are an hour long and are held monthly in the middle of the day with food and refreshments for attendees. Rounds are open to staff from all disciplines, including clinical and non-clinical. They come together and reflect on the social, ethical and emotional challenges they encounter in their work within a safe and supportive space. Superficially Rounds have the format of the hospital ‘Grand Rounds’ but diverge sharply in content and form. The emphasis is not on clinical details or on problem solving but on the emotional contours of ‘the case’. The format consists of a ‘panel’ of speakers – usually three to four individuals from the same team, but from different disciplines and varying levels of seniority, talking about an experience which affected them at a deep level. For example, you may have a senior consultant, a junior doctor, a nurse, and a physiotherapist each giving their personal experience of caring for the same patient. Each story is of equal worth. The facilitator sets the ground rules and an explanation of how the Rounds work. Before the meeting the panellists meet up with trained facilitators (usually psychologists) who help them to hone their stories to around five minutes each, highlighting the key moments, the emotions and conflicts raised, and the lessons learnt. The panel members are not expected to justify what they did

or did not do – in fact a key role of the facilitator(s) is to deflect and shield the panel from problem solving questions such ‘Did you think of doing X?’.

Topics vary – such as a patient’s unexpected or poorly managed death, a patient who refused treatment, ‘difficult’ relatives, miscommunications. A typical theme could be ‘A patient I will never forget’ or ‘When things go wrong’. After the panel members have shared their stories, the facilitator(s) open up the conversation to the audience asking them if the stories resonated with them, or if they have their own related stories and reflections that they wish to share. Towards the end, the facilitators will give the ‘last word’ to the panellists and then wrap up the session, offering a synthesis of the themes that have emerged. Numbers of participants vary and can be more than 100. They are asked to fill in standard evaluation sheets which are then processed and disseminated to the facilitators and panellists as well as to the Schwartz Round steering group.

Personal experience

My interest arose when I began my journey as an academic activist promoting compassionate care and leadership in healthcare by writing articles, running workshops and seminars and building connections (De Zulueta, 2013, 2016). I read about Schwartz Rounds and was intrigued. By invitation, I witnessed a round at the Royal Free Hospital, then a pioneer trust for Schwartz Rounds in the UK. There must have been around 100 people in the audience. Having been part of GP Balint groups as a young principal, I was sceptical that reflective sessions could ‘work’ with such a large number of participants (Balint groups typically are small and close-knit – also facilitated by a psychologist or therapist). To my surprise I sensed a powerful collective engagement and solidarity in the room. Everyone was listening attentively, not looking at their phones or falling asleep. The facilitator was highly skilled and conveyed warmth and wisdom, ensuring that the panel and audience remained focused on the emotional, not the clinical issues. Later on (2015) I decided to join the Schwartz Round initiative at Imperial College NHS Trust to which I am affiliated as a senior clinical lecturer. My qualification and skills as a GP specialised in mental

health, group teaching and facilitation were of value. I then trained as a Round facilitator to become part of the multidisciplinary team.

Over the years issues other than challenges in patient care have emerged, such as coping with racism and homophobia from patients as well as colleagues, or trying to balance home and work life. Cases and themes included ethical dilemmas in paediatrics, choosing a career, dignity in dementia care, death and dying on the wards, mental health crises, developing team bonds and ‘emotional labour’. One of the most powerful and poignant Rounds I facilitated with a colleague was the first anniversary of the Grenfell fire. 142 people attended including many doctors and nurses. The pain in the room was palpable. Some people said they had not talked about the disaster since that fateful day in June 2017. The evaluations were outstanding. Another more recent Round concerned the tragic consequences of knife crime and the sorrow of treating both the attacker and his victim (who later died). Both of them only 17 years old – young lives lost or ruined in a moment of thoughtless rage.

The evidence of benefit for staff, patients and the organisation

Schwartz Rounds are not the panacea for some of the entrenched systemic problems in the healthcare service, but they undoubtedly create a more nurturing environment and help to humanise healthcare, steering it away from a depersonalised system to acknowledging, as well as honouring, the care in caregiving.

Schwartz Rounds have now been running in the USA for more than 20 years and have been independently evaluated and found to decrease stress and isolation, improve understanding of colleagues’ roles and contributions, increase feelings of being supported and empowerment to provide compassionate person-centred care (Lown and Manning, 2010). Researchers in the UK also found that Rounds improved communication, trust,



Staff at a Schwartz Round

openness with colleagues and enabled more compassionate care (Farr and Barker, 2017).

A more recent realist-informed large-scale mixed method (qualitative and quantitative) evaluation conducted in England for the National Institute for Health Research (NIHR) by Maben and colleagues showed that attending and contributing to Rounds was associated with statistically significant improvements in staff wellbeing, and this effect was 'dose dependent' – the more Rounds attended, the greater the positive impact. They also found a significant reduction from stress from 25% to 12%. 10 key themes were identified:

- 1 Trust, emotional safety and containment.
- 2 Group interaction.
- 3 Countercultural 'third space' for staff.
- 4 Self-disclosure.
- 5 Storytelling.
- 6 Role modelling vulnerability.
- 7 Contextualising patients.
- 8 Contextualising staff.
- 9 Shining a spotlight on hidden stories and roles.
- 10 Reflection and resonance.

Other reported benefits included greater empathy and compassion for colleagues and patients, reduced isolation, enhanced peer support and improved teamwork, work engagement and communication with patients. The researchers concluded that Schwartz Rounds offer unique elements of support compared to other interventions.

Cath Taylor and colleagues undertook a systematic review of studies showing the impact of Schwartz Rounds on staff and compared Rounds with other interventions designed to provide staff support such as Balint Groups, mindfulness-based stress reduction (MBSR) training, critical incident stress debriefing (CISD), resilience training and reflective practice groups (Taylor *et al*, 2018). The evidence base regarding effectiveness of these interventions is weak overall, but the researchers (rightly in my view) assert that employers should still provide supportive interventions and that clinical supervision should be available for doctors and nurses, just as it is for mental health nurses, psychologists, midwives and social workers. They point out that non-clinical staff such as hospital porters and cleaners who have frequent contact with patients are even more neglected. The researchers emphasised the importance of skilled facilitation for successful Rounds. They conclude that, 'Rounds offer a unique organisation-wide "all-staff" forum to share stories about the emotional impact of providing patient care'. Organisation-wide interventions are arguably more likely to change cultural norms and attitudes towards vulnerability. They can also break down silos, developing cohesion between and within groups, and nurture compassionate cultures.

Are Schwartz Rounds 'counter-cultural'?

Rounds are counter-cultural in a number of ways. Firstly, they are grounded in the social, emotional and relational aspects of care rather than the more functional, transactional and rationally calculable 'performance monitoring markers' (targets, efficiency, etc) characteristic of the new public management (NPM) and prevalent in NHS health policies (Farr and Cressey, 2015). Secondly, they allow for the disclosure of vulnerability – a rare phenomenon in healthcare institutions, perhaps more so in some specialties such as surgery, where the mythical imagery of invincible heroism, or the promotion of military stoicism, are prevalent. These 'metaphors of practice' can create unreasonable expectations both from clinicians themselves and from their patients. When a senior clinician reveals his grief and even cries in a Round, the impact is considerable – junior staff realise to their relief that they are not alone in experiencing distress, but more importantly this distress does not prevent the clinician from being a competent professional able to deal with emotionally laden emergencies. These disclosures also create a sense of common humanity and shared compassion – a recognition that we are all subject to suffering and are to a greater or lesser extent wounded healers (Egnew, 2009). Thirdly, Rounds eschew unhelpful linear solutions to complex problems and don't even attempt to 'fix' things – a mindset that is prevalent in modern medicine. Fourthly they encourage 'slow medicine' – giving space for reflection (and even silence) rather than the normal fast, efficient task-focused approach. Finally, but importantly, Rounds are subversive as they can flatten hierarchies. A hospital porter's story may be valued as much as that of a senior clinician. A medical student has the opportunity to voice her concerns and will be listened to respectfully and seriously.

The power of stories

Humans are natural storytellers (Gottshall, 2012). We tell stories to make sense of our experiences and the world we live in. Stories give us meaning and coherence. As Arthur Frank in *The Wounded Storyteller* tells us, 'Thinking with stories is the basis of narrative ethics... Stories are the ongoing work of turning mere existence into a life that is social, and moral, and affirms the existence of the teller as a human being' (Frank, 1995). A strong line of research shows that if storytellers can derive redemptive meaning from suffering and adversity in their lives, they tend to enjoy higher levels of wellbeing, psychological growth and other indices of successful adaptation (Fivush, 2017). Schwartz Rounds tap into this rich source of strength and resilience.

Practical aspects and further developments

Schwartz rounds can take time to become mainstream in healthcare institutions and senior management support is essential for success. Timetabling has to be organised so that people are not locked in shifts that preclude attendance. Positive feedback via word of mouth has led to a snowball effect with rising popularity and attendance. Smaller, briefer ‘pop-up’ Rounds can be organised for those who have difficulties attending the usual venue. Rounds are being held in settings other than hospitals, such as hospices or primary care. Administrative and mentoring support is needed for the smooth functioning of the system and for facilitators to confidently develop in their roles. Medical schools are now developing and running Rounds increasing the likelihood of cultural shifts from the ground up (Barker *et al*, 2016; Stocker *et al*, 2018). More research is needed to explore further the impact on organisational cultures and individuals as well as patient outcomes.

Conclusion

Schwartz Rounds act as containers and crucibles. They are containers in that they offer a bounded, safe space for articulating and regulating emotions that would otherwise be suppressed, hidden or ignored, and they enable individuals to create and listen to powerful healing stories and to share perspectives. They are crucibles for creating new ways of looking at oneself and others, for exploring in more depth the healing work of medicine, for witnessing both suffering and joy and for fearlessly accepting the light and the dark side of working in healthcare. They also act as mirrors, enabling greater self-awareness and shared reflection. Rounds enable one to see more clearly the patient in the person and the person in the healthcare professional. They remind all those working in an organisation that they share a common humanity and a common purpose.

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Some reflections on stories in general practice

Andrew Morrice

GP and Human Givens psychotherapist



The stories we tell ourselves about life have the power to transform our experience for good or ill. The therapeutic story can open the hearer's mind to a rich web of metaphor and bypass the need of their conscious mind to rationalise and argue with their content. But to be enabling and stimulating it must match well enough to the pattern of a person's life situation, so the map it offers feels to the hearer to be unfolding and constructing itself inside their own imagination. The teller of the story chooses the stimulus, and the hearer is free to respond in their own way.

I am a GP, educator and Human Givens psychotherapist, and have been involved in the BHMA and holistic approaches since 1988. In 2018, after 20 years as three-quarters time GP, I left my partnership to start JoinedUpHealth, which provides education for clinicians and the public as well as psychological therapy.

The Tesco ad campaign sums up our primary human preoccupations: food, love, stories. For, like all animals we are intensely concerned with food and love, and with the stories our brain-mind creates to make sense of the world through symbol, metaphor and narrative. Simple everyday phrases and modes of thought imply we are constantly asking ourselves, 'what is the story here?' Yet modern medicine has largely set its face against the subjectivity of stories as a way of learning about our work or ourselves, or for drawing conclusions, or for communicating about standards or as ways to evidence particular therapeutic approaches in practice. In doing so, medicine has marginalised a core function of our minds. As doctors or as patients we are right to be wary of what is being lost here, for the stories we tell about ourselves are significant and we tend to believe them. Even when we suspect they are not totally truthful we intuit that there is a valuable baby in our narrative bathwater.

One obvious paradox is that for centuries 'history-taking' was a core activity in medicine. 'Historia' in Greek means enquiry. This enquiry into a patient's symptoms and life experiences is asking, 'what is the story here, of how this came about, and how can I make sense of this?'. The questions we ask are at best aimed at helping both

patient and practitioner make sense of the situation at hand. In the old-fashioned doctor-patient model, when a clinician failed to make sense of a patient's story, the phrase 'the patient was a poor historian' might appear in the notes. This of course is a terribly misleading (and victim-blaming) form of words and, if anyone is the poor historian, it is the doctor whose enquiry has failed to spin the threads into a meaningful yarn (pun fully intended).

Masterful invisibility

Of course most patients have already made their own enquiry: in our time, probably online. In the past it would have been by talking to friends, or to anyone with experience of illness, or to the wise woman down the street. Today, people often come to doctors having fitted their symptoms whether consciously or not, into a narrative perhaps improvised, sometimes pre-formed. Often their version is unspoken for fear of annoying the doctor. Nor is it at all unusual for people to know that these narratives are restrictive or even disabling. Yet at other times, when these ideas actually point to solutions, all the skilful doctor need do is play a walk-on part in their internal drama as constructively and unobtrusively as possible. In such ways

general practice at its best can have a quality of masterful invisibility, of ensuring that certain things do not happen, that harm is not done. For it has always seemed to me that we therapists appear at brief – though they may be key – moments in a person's unfolding narrative. We should be on stage no more than necessary. Even if we become major characters in some of our patients' lives, their long narrative arc will always have started somewhere way beyond our point of view, and it will continue far into a future where in our mobile and unstable communities we doctors are unlikely to play much of a part.

“A story can be enabling and stimulating if it matches well enough to the pattern of a person's life situation.”

Since the meaning we find in the world is active not just in our psychology but our physiology it follows that stories could be used to help and heal. Having had the great pleasure of being taught about the psycho-therapeutic power of stories by Pat Williams who directed the College of Storytellers in the 1980s, I looked for ways to incorporate these into my work as a GP. Yet it seemed a less than ideal context in which to use the full-on technique of story-telling, with its brand of gentle trance induction – the standard repetitive language, the use of cue phrases such as ‘once upon a time’, the evocation of all senses. All of this, according to Pat and others interested in the therapeutic power of stories, allows the mind of the hearer to engage with a rich web of metaphor. The advantage of this way of engendering helpful change is that there is no need for the hearer's conscious mind to engage in a rationalising argument with any of the content; indeed the whole point is not to reveal what the teller believes the point to be. A story can be enabling and stimulating if it matches well enough to the pattern of a person's life situation. Then the map it offers feels to the hearer to be unfolding and constructing itself inside their own imagination. The teller of the story chooses the stimulus, and the hearer is free to respond in their own way.

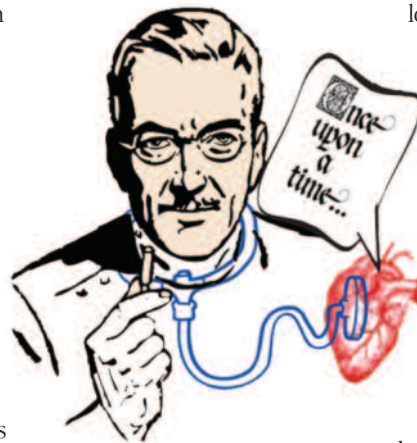
My friend John

So most of the time in my work as a GP, and for obvious reasons, I found myself relating mini-stories; simple stories about what had happened to other people in similar situations, and as time went on one of the most useful

techniques is one known to many as ‘My Friend John’. The idea behind this technique is you tell a story about someone in a similar situation to the person you are speaking to, and in the story you can suggest solutions and changes.

My favourite ‘My Friend John’ experience stems from a time before I knew this was what it was. A patient, who has now passed on, presented back in the early 2000s, shaky, red faced and bloated, with deranged liver function tests and everything pointing to heavy drinking. I had a great deal of sympathy for this man. He had lived through the years when his sexuality was illegal, and I imagined he had faced a good deal of difficulty in the past. In his generation drink was almost universally the self-medication turned to. Gentle but clear enquiry about alcohol produced a stout and consistent denial, so I dialled everything back and started to describe the various possibilities including that standby of general practice, the ultimately unexplained but transitory abnormality. But along with this, a very clear account of what I would tell patient with these tests results who was a drinker: how vital it would be to stop for instance, and how these tests would be a clear warning. We checked him from time to time over the next few months and although he seldom looked any better his bloods did improve. Then the silly fashion for discontinuity of care and rising patient demand meant that

I didn't see him for several years, maybe as many as five or six, and when I did I seemed to be looking at a different man. Having dealt with whatever it was he'd come about, I said, ‘You look an awful lot better than when we last met’. ‘Well doctor, I did as you said and stopped drinking!’. ‘Ah but I never did tell you to stop, did I?’ He grinned broadly. ‘True, but I heard you anyway’.



Stories about stories

Now this story has become my standard way of describing the technique when time allows, and every now and then I've told it to a patient, effectively as a ‘My Friend John's Friend John Story’. Another story about stories concerned a patient of mine who was dying of a tumour in a nursing home. I'd known this lady a while and we both knew (but never mentioned the fact) that had she consented to have a colonoscopy two years previously she would have almost certainly been curable. And now she was having a torrid time of her terminal phase, with hard to control symptoms of liver enlargement ascites and jaundice along with a terror of dying. It is sometimes easiest to simply reassure people ‘it's going to be alright’ when they are closest to death, but on this particularly evening when I was called out to help with her palliation, she was very restless and anxious, and something more seemed to be required. After doing all I could with her medication I decided to tell her a story. The story

was of Eben Alexander's near-death experience, which he recounts in the misleadingly titled *Proof of Heaven*. I have no idea how 'truthful' this account is, but this in a way suited my purpose.

Today many of our patients are faced with a profound difficulty making sense of their suffering.

She had her eyes closed and I started to tell the story of this neurologist who contracted severe fulminant meningitis during which, while he was in a deep coma and on intensive life support, he had a vivid journey through many extraordinary 'other worlds'. I told her how he had concluded that death was nothing at all to be fearful of, that death is not the end and that our next stage of life is beautiful, and that indeed he had been sorry to come back to his wretched body once started on his long process of recovery. And I said if the story didn't mean anything to her that was fine. Then I quietly left. Next morning I was told that she had immediately become very peaceful and died without needing any of the further analgesia or of the other medicines I'd arranged. The doctor who'd been called to certify in the early hours morning seemed most put out that she'd not been on a huge dose of diamorphine.

Toxic stories

The stories we tell ourselves about life have so many ramifications, and the power to transform our experience for good or ill. Whilst we can appreciate the earnest and good intentions of militant atheists and materialists, on another level it can seem that the implied or even stated narrative – that our life is ultimately accidental, insignificant, brief and ends with oblivion – leaves many people in a narrative vacuum. An idea that your life has no ultimate purpose may appear scientifically sound, but this may be of little use when the going gets tough. Some Eastern religions and philosophies have been based on

similar materialist ideas, but always embedded in a far richer and more supportive matrix of practice and belief. To be sure our Western mediaeval ideas of misfortune and sickness as punishments or judgements, or even curses had little to recommend them from our perspective. But today many of our patients are faced with a profound difficulty making sense of their suffering. And into this space we step with our narrative dose of diagnosis fix: a double-edged fix if ever there was one, for we speak of diagnosis as if it turns diseases into 'things', which ultimately are just due to bad luck, or to our modern form of fate – our genes. Consider the grammatical structure of the phrase 'I was diagnosed with polymyalgia': it's the same sequence as for example 'I was poked with a stick' or 'I was issued with a uniform', as though diagnosis is something done to us. And thus the complex web of causes, responses, and maintaining factors behind the 'doing' is bundled up into this neat term and rendered invisible may lie unexamined perhaps forever. So whilst diagnosis is necessary in many ways and can unlock so many resources, it can also create a new kind of prison of meaning for both practitioners and patients, by simplifying and channelling the narrative; particularly if the diagnostic label gives the difficulties implied a false impression of weight or permanence. It supposes that the monolithic pre-formed one size fits all diagnostic category is a close enough fit for the patient at hand.

Which reminds me of one last story, traditionally told of the sage-fool Mullah Nasrudin;

Nazrudin found a weary falcon sitting one day on his window-sill.

He had never seen a bird like this before.

'You poor thing', he said, 'how ever were you to allowed to get into this state?'

He clipped the falcon's talons and cut its beak straight, and trimmed its feathers.

'Now you look more like a bird', said Nasrudin.

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Annual resilience symposium for medical teachers

A reflection from first year medical student Max Williamson

The third national medical teachers symposium on student wellbeing organised by the University of Westminster's Centre for Resilience focused on educating for uncertainty, complexity and loss, with an emphasis on how undergraduate educators, by responding to these issues, can prepare the next generation of doctors for the unpredictable demands of practice. I was invited to the resilience symposium to give the views of someone just opening the doors into the medical profession. I hope what I offered to the day was useful (if naive) advice on how to relate the difficulties of being a patient to the difficulties of practicing medicine, and where to draw strength from the two.

Recent findings reveal that doctors' and medical students' wellbeing is being placed at risk, in what may be developing as a mental health crisis among the workforce (BMA, 2019). Research suggests that mental health deteriorates during medical school years and continues to decline as trainees enter the workforce (Dyrbye, Thomas, Shanafel, 2005; Moir *et al*, 2018). The focus of this year's symposium was on educating for uncertainty, complexity and loss, with an emphasis on how undergraduate educators, by responding to these issues, can prepare the next generation of doctors for the unpredictable demands of practice in an increasingly complex profession and unstable world.

I've just begun medical school. In my first month, I've already had the privilege of meeting patients in the primary and secondary care setting: a man struggling through the early stages of multiple myeloma, only knowing that it would progress, but with no knowledge of when; a self-employed patient with a congenital vascular malformation who, after a recent major bleed in his brain, had no idea when he could return to work; an elderly couple, each the other's carer, both with multiple complex mobility, cardiovascular and gastro-intestinal difficulties. All the while, in my lectures I've been learning about the cell biology of haemopoietic lineages, or the neuropharmacology of myasthenia gravis and nicotinic acetylcholine receptor antagonists. I think every medical student is staggered at times at the difference between what we are taught (or

what is teachable) and the reality we face when we first enter clinics. So what was so useful about the recent resilience symposium for me was the outward acknowledgement of, and reflection on, the uncertainty that we will all face as we go through medical school and into our careers as doctors: it was an essential opening to what will be a long, difficult, and rewarding journey.

I was one of the three people who presented at the opening panel, giving an early career perspective on resilience. To my right were two essential speakers; Alexandra Adams, a fourth year medical student at Cardiff (and the face of the *Faces of the NHS* campaign, designed to exemplify the diversity of all those who work in the health service) and Michael Zervos, a Foundation Year 2 doctor who studied social anthropology while at medical school. I began the discussion with a talk about my own experience of cancer as a teenager. I argued that being ill at that age allowed me to cultivate resilience, and to understand uncertainty, but that also it has given me sensitivities that other medical students may not have. Drawing from my time in hospital, I also argued that the logistical and psychological pressures on medical students and junior doctors are in a sense similar to those posed by chronic illness, and the remedies to these issues are more alike than they are different: encouraging the development of peer-support and shared spaces; supporting students when they feel they need to express an issue to a senior teaching or clinical figure, as a patient would to a doctor; and setting of goals outside of medicine. And only one month into medical school, I have found all of these social remedies to be effective ways of dealing with my own current uncertainty and avoiding burnout.

Alexandra discussed her experiences of disability as a medical student with incredible poignancy. Hearing of her experiences of prejudice in medical school, from issues in accessibility to downright discrimination, showed us all how many barriers still exist within our health system. And throughout it all, her determination to succeed and to improve her own schooling was self-evident: finding solutions to dissolving these barriers will be an essential step in making medical school truly accessible for all.

Lastly, Michael discussed the concept of liminality; that medical students exist in a precarious space between layperson and professional, and that this intrinsic

instability can make the crossing through these states uncomfortable. A poignant example of a medical student on Michael's ward standing unsure in the doorway during an emergency procedure brought this point home. When is it appropriate for a medical student to help in a clinical setting? Do they need permission from a professional, or should they act on their own initiative? We aren't (and arguably can't) be taught the answers to these questions, but reflections on their answers should be an essential part of medical school.

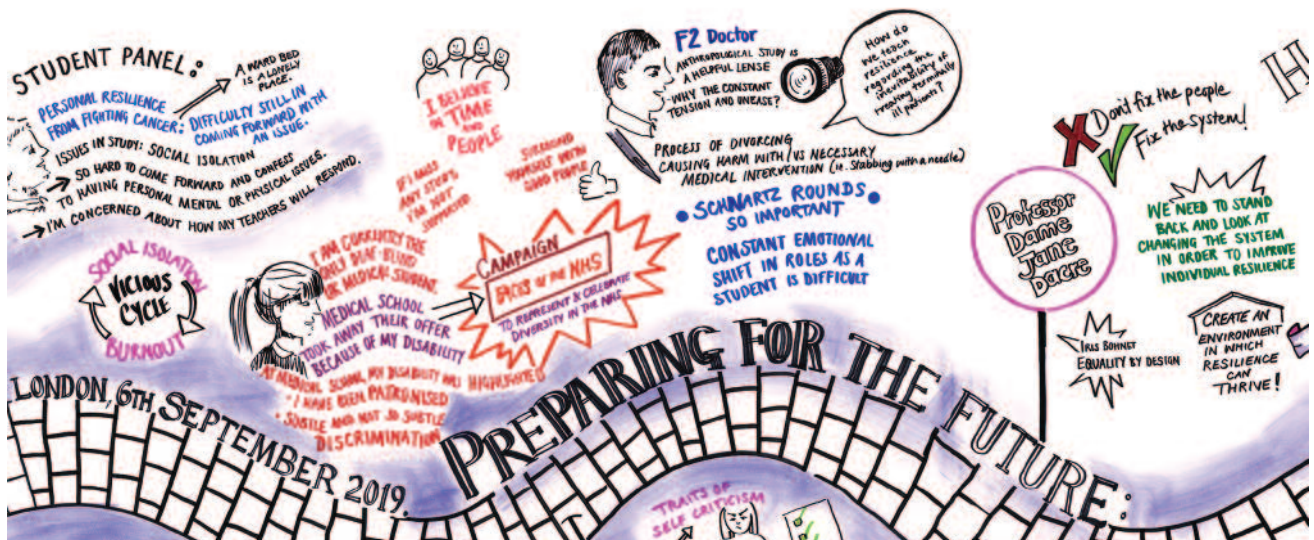
We also heard from some highly esteemed keynote speakers: Dr Clare Gerada MBE, Professor Joanne Harris, and Professor Dame Jane Dacre. Each discussed the potential ways of reducing the burden of uncertainty we place on medical students. One fascinating talk was by Professor Harris, discussing the anxieties that fitness to practice generates in medical students and early career professionals – how do we let these groups integrate themselves in a healthcare system with this constant reminder of watchdog? When mistakes seem completely prohibited, the pressure to be constantly correct, and certain in that correctness, is extremely high: I have already felt this pressure in my medical school. Discussions about the structural pressures of medicine also appeared in Professor Dacre's talk, in particular the junior doctor contract strikes in 2015. I was left feeling, in a way that I hadn't recognised before, that this is a difficult time to be a medical student. As we know more about physiology and disease than ever before, we are expected to learn more than ever before. Proper conduct and safeguarding are more important than ever, but with that comes a fear of mistakes and uncertainty. And as medicine becomes more and more expensive, the cost of our labour is valued less and less. But with each of these talks came solutions, be they small coffee break conversations between students and staff, or entire cultural changes in the NHS, and I was reminded that these difficulties are also an inevitable outcome of imperfect progress, of the kind that I can only hope to deliver as a doctor.

The afternoon continued with a pivotal Schwartz Round. It was my first experience of this type of session, where cases were presented with a focus on the pressures they placed on the caregiver. They are designed to allow for reflection, a collective breath, about the difficulties and burdens of working in healthcare. We heard from junior doctors and senior sisters, each with their own entirely unique story that were in the most part taken from 'just another day' in the NHS. Two examples which stayed with me: one expression of guilt about waking an elderly lady up in the early hours of the morning for routine observations, and the utter disturbance that healthcare interventions pose on people's lives; another discussing the importance of debriefing and compassion towards other members of staff in the context of a catastrophic paediatric emergency. The group's conversation afterward was enlightening, compassionate and full of human warmth. In highlighting the diversity of experience and common compassion of all those who attended the conference, and all those who work in healthcare, I was reminded that I have been accepted into a community with one common goal; improving the care we provide for patients, and recognising the burdens that this goal can bring.

So the third resilience symposium was a remarkable event, and I'm glad to have played a small part in it. It was an essential reminder of how difficult and uncertain the road ahead will be for me, but also of the immense rewards that medicine can provide, and the strong shoulders I will have on my side to share the burden with. I would like to thank the conference organisers for preparing me, and the rest of the conference attendees, for a complex and uncertain future within the rare privilege of practicing medicine.

BMA (2019)
 Dyrbye, Thomas & Shanafel, 2005
 Moir *et al*, 2018

See Max Williamson's personal story as a cancer patient and junior doctor on page 16.



Part of the graphic record of the symposium, by Inky Thinking.

The language of caring

William House

Retired GP; Chair of the BHMA

Sir Luke Fildes' famous painting *The Doctor* has always given me a warm feeling of gratitude to the artist for capturing on canvas this intimate, but tragic, moment. The painting was made in 1887 when general practice was very different to the way it is now. Yet the loneliness of the doctor amidst the distress of the family will be familiar to most doctors. I feel it still, despite having retired from practice as a GP 10 years ago. Using the visual language that he has mastered, Fildes has told us a story that rings true. Unsurprisingly, this image is still frequently used to portray the qualities of a good doctor. Yet, like most things in life, the reality is a little different.

In a carefully researched and eloquent article published in the *British Journal of General Practice* in 2008, the writer Jane Moore reveals the story behind the painting's creation (<https://bjgp.org/content/bjgp/58/548/210.full.pdf>).

'Sir Luke Fildes (1843–1927) was a well-known Victorian painter of the social realist movement. He was a contemporary of Charles Dickens ... and provided the illustrations for Dickens' last novel The Mystery of Edwin Drood (1870). Although in his early career, Fildes made his name depicting the plight of the poor, like other painters of his era, most of his income came from painting portraits for wealthy clientele. This included Sir Cecil Rhodes and several members of the royal family.'

Moore goes on to explain that *The Doctor* was commissioned by Sir Henry Tate for the then princely sum of £3,000. It is likely that this painting was at least in part inspired by Fildes' memories of the tragic death of his own eldest son, Phillip, on Christmas morning, 10 years prior to the painting's creation. Phillip was ... 'attended by a Dr Murray, who impressed Fildes with the care and attention he gave to his dying child'. Moore quotes other possible influences behind the painting, and then she goes on to describe how the painting was based on, what amounts to, a stage set in the artist's London studio....

'...where he had carefully constructed a cottage interior with the doctor "played by" a professional model who is thought to bear some physical resemblance to Fildes himself. Therefore, this picture, though based on a real event in the artist's experience, was as fictional and romantic an account of a doctor's activity as that found in novels of the period which include George Elliot's Dr Lydgate in Middlemarch... or even Mary Shelley's Dr Frankenstein (1818).'

So have I 'fallen prey' to this artist's fiction? Have I been drawn into an unrealistic and romantic idyll? I have been called 'a romantic old sod!' in the past, but surely, I must protest that there is more to medicine than academic knowledge, rapid availability and diagnostic skills! Emotional detachment soon becomes coldness, aloofness. If this is so, as I believe it to be, the challenge for the doctor



becomes a balancing act: connected with the patient enough to form a therapeutic alliance, but detached enough to avoid being drawn into an unhealthy complicity.

Moore goes on to muse upon the apparent indulgence of the doctor in the painting: remaining with the stricken family when there is no medical treatment available, and effectively using his presence and his time to support them in their tragic plight. She contrasts this with the introduction of the NHS Direct telephone consulting service in 1997, nine years before her article was written. Later, in 2014, this nurse-staffed advice line was, in its turn, replaced by the NHS 111 service which seems to be aiming at minimising direct human contact. More recently, this is coinciding with the now widespread use of recorded advice messages on GP appointment lines in England suggesting alternatives to a GP appointment. It seems to me that the key loss from all of this has been the minimising of the human relationship between the one who suffers and the real, live human being offering (whatever else they may be able to provide) a caring contact. Of course, this is the very service depicted by Fildes in his painting, and by the caring Dr Murray attending the premature illness and death of Fildes' own son. The endurance of these bedside scenes surely tells us that caring human contact really matters.

End note: The painting can still be seen hanging in the Tate Britain Gallery in Central London.

You can see the picture at https://commons.wikimedia.org/wiki/File:The_Doctor_Luke_Fildes_crop.jpg

Reviews

The poetry pharmacy returns: more prescriptions for courage, healing and hope

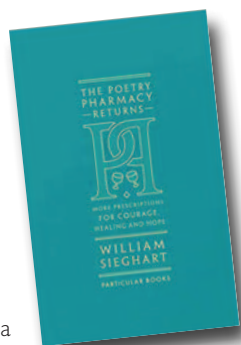
William Sieghart
Penguin 2019
ISBN 978 0 24141 905 2

We are lost, out here in this apparently quiet corner of the galaxy. Lost to fully knowing, our vision impaired in the glass darkly. And yes, there are many purposes we can choose from but it is perhaps a risk to believe in any of them. *The Poetry pharmacy returns* is a beautifully crafted collection of jewels; it is the treasure in the field. As a book its power and presence rests in the truth that if we are bold enough, lucky enough and foolish enough we will find ourselves at some point in our lives in the company of the greatest of teachers. William Sieghart openly states these are the teachings given by suffering. Suffering he says is 'an access point into poetry' and the best of poetry, of poesis, is an access point, they are doorways into depression, into grief, into the wounds of betrayal, into the hall of loneliness.

What I love about this book most of all is its unpretentious humanity. There are poems for agonising over weight, for love growing stale, for shyness. These islands that human beings become marooned upon, alone, the secret of the deep depths we keep, all the elephants we have tried to bury. They are all here, roaming around on the page out in the open and I can see yours and you can see mine now. It is an undertaking of important work, this public declaring and above all honouring of pain, of uncertainty and brokenness.

Feelings are notoriously difficult to put into words. Much easier to describe the working parts of an engine than to describe the emptiness bereavement leaves. But this is the work of the poet, to uncover, to distil, to reveal, to go there. And Rumi and Hafez, Mary Oliver, John o'Donnaghue, they love like you, they break like me. There is nothing as reassuring in the midst of sadness to find a fellow traveller in this stark realm, someone else beside you at 2.45 in the morning, who is saying I hear you, I see you, I weep with you.

The internet is surely proof of how disconnected, how isolated we have become. That the roots of disenchantment lie within as William Sieghart suggests, the quietening of 'the liturgies that many of us, in this secular society have increasingly left behind', and it is too simplistic to name Facebook, Snapchat and Twitter as the dark angels of loneliness. But this book restores perhaps time-tested wisdom back to its place as the companion on our human journey. Acting as waymarkers, pointers and oases in our experience of the lost lands. The fact that this is a sequel is evidence enough that the succour it provides is real; that within these pages we are found, we are welcomed and known around these fires.



Above all there is healing within this book and as a priest most of the time I, along with doctors, consultants and therapists, am alone with the door closed taking the tears, the confusion and the anger. But when I put this book in someone else's hand I am giving them a community to belong to, introducing them to others who have travelled the road they find themselves on. Part of human being means we all experience at some point what the poet Aracelis Girmay says is 'a bird suddenly stunned by the glass partitions of rooms'. I am so glad she named it and grateful to William Sieghart for bringing this line and many more into the light.

Peter Owen Jones, Anglican clergyman, author

To hear William Sieghart speak (beautifully) about his experience go to www.youtube.com/watch?v=9Q6terFZ8EQ

Transformative innovation: a guide to practice and policy

Graham Leicester
Triarchy Press 2016
ISBN 978 1 91119 300 5

This inspiring book was launched in Edinburgh at a reception to mark the 15th anniversary of the International Futures Forum (www.internationalfuturesforum.com) and it represents an excellent summary of many of its key insights into social and learning processes over this period. *Transformative innovation* represents a 'fundamental shift towards new patterns of viability in tune with our aspirations for the future'. This contrasts with sustaining innovation that fixes the existing system and disruptive innovation that shakes it up. Following the introduction, the book consists of six chapters on knowing, imagining, being, doing, enabling and supporting.

It outlines 10 characteristics of transformative innovation derived from IFF praxis: balance, in terms of operating in both the old and the new world; inspiring and hopeful; informed by a longer term perspective; pioneering a process rooted in discovery and learning; grounded; personally committed with our full self; responsible; revealing hidden resources; maintaining integrity and coherence of means and end; and maintaining a pioneering spirit even in the face of success. At this point, the reader will find a useful analysis of the evolution of a more adaptable way of providing care and support to old people. One tension is the need to measure outcomes on a short-term scale when the effects are slightly longer term and the project is not yet ready to be scaled.

Given our world of boundless collectivity, information overload and rapid change, we need flexible approaches to knowing,



Here there are five principles: seeing ourselves as subjects and participants in a relational universe, expanding what we consider to be valid knowledge and therefore our context of learning, respecting a dynamic pattern of relationships and the emerging integrity that it brings about, taking a cyclical view of time enabling us to complete and close processes so as to make space for the new, and moving from fragmentation and separation to wholeness and connection – summarised as holism with focus. Then there are the two loops of fear and love.

Imagination comes next, and here the reader is introduced to what I consider a crucial conceptual tool, the three horizons framework. The first horizon – H1 – represents current dominant systems and business as usual; the second – H2 – is a pattern of transition activities and innovations, some of which may prop up H1, while others enable the transition to the third horizon – H3 – embodying our deeper aspirations for the future. These are represented respectively by the manager; the entrepreneur and a visionary. The beauty of this framework is that it can be used to set up a creative conversation of potential scenarios and patterns without people becoming too attached to a single perspective. H3 provides some imaginative space and may help resolve dilemmas in the present as we seek to attain the best of both worlds. The whole process is encapsulated in one of the 'prompt cards' encouraging us to 'develop a future consciousness to inform the present' (attractors pull from the future).

Being involved the human system and its patterns as we seek to embody a transformative response by bringing together what the IFF calls a creative integrity configured around personal commitment and expressing wholeness and relationship. Its principal axes are being and doing and it moves between

autonomy and integration, focus and holism, creating a distinctive culture. Social learning is an iterative process involving action and reflection. Importantly, this is not just an abstract technique, but is embodied in learning from experience – hence the learning journey as an essential component of the IFF process. The chapter on doing also explains Jim Ewing's strategies of Impacto and Implemento, which have been used successfully in a school project. This involves a sequence of steps to consider purpose, urgency, destination, success path and commitment, with an emphasis on clarity of purpose that can then be reflected in clarity of communication.

Enabling entails a compelling vision of the third horizon while supporting pioneers trying to implement the process. This also involves a realistic view of policy landscape and new forms of evaluation – how does one flourish in the presence of the old? Finance has its own challenges due to the nature and timing of transformative innovation and the ever present fact of continuous change and evolving contexts. If these insights resonate with your own challenges, then you might like to consult a further set of resources at www.iffpraxis.com.

Finally, we can give ourselves permission to get going, and Graham provides a nice framework for this based originally on Al Gore's reinventing government programme. The permission slip gives us authority and responsibility to help shift our systems towards an aspirational third horizon vision of the future after we have asked ourselves a series of pertinent questions. If we are able to answer yes, then we don't need to ask for permission, we just need to do it. Pioneers in every field will find this book a rich resource.

David Lorimer, Programme Director, Scientific and Medical Network

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Author of *Seven Ways to Build Resilience*

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Professor David Peters

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in a Time of
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JOURNAL OF

holistic healthcare

Re-imagining healthcare

About the BHMA

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 (BHMA). 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 BHMA 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 BHMA 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 pharmaceuticals 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.

Journal of Holistic Healthcare

**"The Journal of Holistic Healthcare...
a great resource for the integration-minded,
and what a bargain!"**

Dr Michael Dixon

Want to contribute to the journal? Find our guidelines at:
<http://bhma.org/wp-content/uploads/2016/07/JHH-Essential-author-information.pdf>

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