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Editorial

Is wisdom breaking out in medicine?

Is it ridiculous to suggest that medicine is becoming wiser? More scientific you might think; cleverer even, as medical science gets better at fragmenting the patient, treating the parts while erasing the person as a whole. But to be fair this is not the only trend we should be noticing. Though it would be easy to predict that our cash-strapped NHS will soon enough strangle good care, as it tightens its belt another notch, yet heroic staff efforts ensure there is still much wise, humane practice in the NHS. JHH wants always to celebrate it.

Those who jibe at medicine’s drug addiction have a point of course, for the profitable quest for pharmaceutical silver bullets is not about to crack healthcare’s big problems: antibiotic resistance; chronic disease; obesity; mental ill-being; environmental and stress-mediated sickness on a global scale; the end of life needs of an ever older population. Nor can there be any doubt that on the NHS frontline life is getting tougher – for staff as well as older population. NHS frontline life is getting tougher – for staff as well as those they serve.

Still, awareness of pharmaceutical medicine’s limitations and downsides is growing apace. Only thumb through late January’s issue of New Scientist (25 January 2014 pp5) to find an editorial telling us that ‘for all modern medicine’s ability to alleviate suffering and prevent premature deaths, it also causes plenty of both. Many medical interventions turn out to have unintended and negative consequences that often emerge as a result of research into better treatments. While many are obvious, we are now starting to uncover more insidious effects…. According to the most widely cited figure 225, 000 people die this way in the US each year – but that dates from 2000. We won’t know if we are fulfilling the most basic tenet of medicine – to do no harm – until we start counting more carefully’.

A sceptical editorial in the professional scientists’ favourite magazine hardly constitute a revolution, but it does declare a dawning realisation that in medicine less might be more – a once fringe opinion which is now becoming mainstream. Pincer movements around Big Pharma’s high ground are gathering their evidence-heavy troops: to name only three of the campaigns – Ben Goldacre’s heroic scepticism toward the industry’s routine manipulation of evidence (see www.badsscience.net/2012/09/did-a-talk-at-ted-about-drug-companies-and-hidden-data/#more-2641), the BMJ’s longstanding assault on its methods and ethics (BMJ 2005), and Irving Kirsch’s persistent and widely publicised demolition of antidepressant medication’s effectiveness (Kirsch 2010).

The citadel is not about to fall though, with spending on prescribed drugs predicted to hit $1 trillion this year, and forecast as rising to $1.2 trillion by 2016 (Reuters 2013). Will this soaring drug mountain stop the rising tide of lifestyle diseases and depressive illness from inundating an aging population? We might wonder whether these vast problems can be solved by the kind of thinking that created them. For if not, with a perfect storm brewing in an underfunded NHS, hospital medicine, public health, mental health services and primary care will all have to start thinking outside the (pill) box. So JHH doffs its cap to the innovators – colleagues like this issue’s authors; practitioners searching for wisdom in medicine, who dare to swim creatively against the stream.

Deputy Director of Public Health for NHS Fife Margaret Hannah has taken up the challenge of how to inspire bottom-up solutions. Social deprivation and disempowerment go hand-in-hand with chronic disease and early death, but her article celebrates the power of inspiration and community wisdom. Edinburgh GP Alastair Dobbin who co-developed and researched a powerful and cost-effective self-care programme for boosting resilience and mental wellbeing in primary care, tells us why and how he went about this. Psychiatrist Penny Campling looks squarely at what the Mid Staffs care crisis means for hospital staff and patients. She puts forward her radical response – an authentic shift away from target-driven industrialised medicine, towards a culture that can supports what she calls Intelligent Kindness. NHS clinical psychologist and compassion scientist Chris Irons explores how neurobiology is fast providing new maps of an ancient wisdom territory, and tells how he is using compassion focused therapy to treat enduring mental illness. Michael Connors, acting CEO at Penny Brohn Cancer Care, explores ways of helping clients tap into their own inner wisdom after a cancer diagnosis. Regular contributor David Zigmund offers some caveats for holists working in mainstream healthcare; wisdom seeds harvested from four decades of singlehanded general practice. JHH is proud to be their repository.

New seedlings of holistic healthcare constantly emerge in and around the NHS. So there is much to celebrate. We intend JHH and its archive to be a seed bank of wise, inventive practice – a fund of potential solutions for an increasingly beleaguered healthcare industry. Necessity is the mother of invention, and we predict wise innovations aplenty as our health systems weather the coming storm.


Yoga and health: a match made in heaven?

This year’s yoga research conference, Yoga and Health: Research and Practice (3–6 April 2014, London) will be an interface between the worlds of healthcare and yoga, building on Confer’s 2012 sellout conference on yoga and the brain. Programmed by Heather Mason of the Minded Institute, it will be bringing together yogis and medical practitioners to share research, practices and knowledge on how to provide yoga as part of the care of clinically ill patients. This is a unique opportunity for healthcare workers to develop a deeper understanding of the healing properties of yoga as an example of mindbody practices, both in terms of the scientific evidence and psycho-physiological mechanisms that underpin its curative effects. Keynotes will be combined with practical workshops. Speakers include Dr Luciano Bernardi, Dr Lorenzo Cohen, Professor Sat Bir Khalsa, Dr Kim Innes, Heather Mason, Dr Robin Monro, Professor David Peters. Full details and online booking: www.confer.uk.com

Action for NHS workforce wellbeing

In response to national reports (such as Boorman, Francis and Berwick) and workforce burnout and satisfaction studies of medical students, GPs and hospital physicians, a group of concerned healthcare professionals led by Dr Chris Manning have set up the Action for NHS Workforce Wellbeing Group. This exists currently and primarily as a Basecamp-enabled internet group to enable sharing of work, documents, research, activities, events and thinking, as well as to provide mutual support.

Many of the group are qualified physicians and/or accredited trainers already delivering approved, evaluated and accredited programmes to medical students, GPs and other physicians in academic and clinical settings. The group is assisting as far as possible all those individuals and organisations active in the field of physician health to enable collaborative, collated and sustained action for the optimal health and wellbeing of the NHS workforce. It is also now linked to a similar group, run by Mike Bush, focused on the health of the social care workforce.

Beating burnout
A one-day event for doctors

If you’re feeling depressed, withdrawn and disengaged you won’t be much help to your clients and patients. Yet the 2012 Pulse Burnout Survey showed that is how a lot of our GPs are feeling. So what’s to be done? Many approaches have been suggested – from high-level organisational change all the way to mindfulness classes and Schwartz Rounds.

Biofeedback has hardly taken off over here, but in the USA it has been widely researched and put to clinical use. And in the States one particular biofeedback approach has been used widely for reducing the stress of everyday medical life. HeartMath has been taught in the Stanford School of Medicine, the Health Improvement Program, Kaiser Caritas Consortium, Mayo Clinic, Duke University Health, and Blue Cross Blue Shield to name only a few.

The great plus of biofeedback is that it enables you to see what’s going on physiologically in real-time. HeartMath does far more: the app on an iPhone or iPad analyses your heart rhythm, looking for shifts in heart rate variability that indicate a boost of parasympathetic charge. For some, it can be an astonishing experience to actually see how slow breathing, visualisation and positive emotion change the body.

So if you are curious about an effective, potent (if slightly techy) approach to ‘cyber-meditation’ you could do worse than join us for a very low-cost one-day workshop at the University of Westminster on 8 March. The cost is £60 including a snack lunch – BHMA doctor-members get a £10 discount.

To book go to www.eventbrite.co.uk/e/biofeedback-neuroscience-and-resilience-a-workshop-for-doctors-tickets-6945184233?aff=eeivtefrnd

Mental health first aid rolls out training for armed forces community

Mental Health First Aid England is asking members of the armed forces community to engage with a new initiative which will see 6,600 people trained to spot the signs and symptoms of mental ill health and guide those affected to appropriate professional help. The Armed Forces Mental Health First Aid (AFMHFA) programme is a collaborative initiative that also includes support organisations including the national military charity SSAFA, Combat Stress and the Royal British Legion (RBL).

Once trained, AFMHFA Instructors will be fully qualified to deliver the specifically designed mental health first aid training to the wider armed forces community.

Fully funded spaces for 2014/15 are available in Durham, Bristol, Birmingham, London, Manchester, Cardiff, Belfast, Glasgow, Leeds, Exeter, Liverpool.

For further information and how to apply to join an instructors course, go to www.mhfaengland.org/armed-forces

Congratulations

In last year’s spring issue of JHH (JHH 10.1 pp 34–37) GP James Fleming told of how his Green Dreams project was mixing counselling and multi-agency support, alongside gardening and social projects to help many people get back into work, or combat loneliness and find a purpose in their community. James has been voted GP of the Year in the prestigious General Practice Awards 2013 – Caring for vulnerable groups category (RCGP and MDU).

JHH congratulates James and very well deserved! See www.themdu.com/guidance-and-advice/journals/good-practice-october-2013/gp-enterprise-awards-2013
Sustainable medicine: the rebirth of wisdom and compassion in healthcare

John Kapp, BHMA member

This issue of JHH is mostly dedicated to the joint anniversary conference held in November at the University of Westminster. It celebrated 40 years of the SMN, and 30 years since the founding of the British Holistic Medical Association (BHMA). Our two organisations have worked closely together over the years.

The conference expressed concern about the survey findings published in Pulse magazine last year which showed that 43% of GPs were at ‘very high risk of burnout’, and 97% said that they did not think they were positively influencing other people’s lives or accomplishing much in their role. It is questionable whether those who are burned out are fit to heal others.

GPs are now responsible for £65 billion a year, (two thirds of the NHS budget) – an average of £220 per patient contact. So they could – at least in theory – decide on how this is to be spent. The conference – reflecting the BHMA’s mission of ‘physician heal thyself’ – heard about a number of ways in which GPs could use these resources to improve their own, and their patients’ health.

Dr Chris Irons, of the Compassionate Mind Foundation (www.compassionatemind.co.uk) has been using Dr Paul Gilbert’s compassion focused therapy (CFT) successfully, even with some psychotic patients. Describing how our mind/brain nervous system has evolved over millions of years, he spoke about the science of compassion, exploring the evolutionary and neurobiological perspectives.

CFT uses mindfulness meditation to cultivate our innate ability to place our attention where we choose, and to practise being in ‘compassionate mind’, rather than ‘threat mind’ – a state which damps down empathy and is inimical to compassion.

Dr Irons highlighted in particular that the target-driven culture of the NHS, by pushing its staff too much into ‘threat mind’ and ‘drive mind’ is in great danger of crowding out compassion.

Dr Alastair Dobbin spoke on optimism, resilience and compassion in the health service, what works and what doesn’t, and can we afford it? In 2002 he initiated the Foundation for Positive Mental Health (www.foundationforpositivementalhealth.com) to promote positive mental training – a method derived from a sports-focused peak performance programme. The course has also been useful to many GPs and other primary care staff, on the basis that ‘you can’t be compassionate to others unless you are compassionate to yourself’. Preliminary evaluations have shown it to be highly effective in alleviating depression.

Dr Penny Campling, consultant psychiatrist and author of the excellent book Intelligent Kindness spoke on ‘Reforming the culture of healthcare in the wake of the Francis inquiry’. She warned of the danger that a target-based approach to implementing his 290 recommendations would increase stress levels in staff already working in an increasingly industrialised NHS culture.

Instead she recommended NHS organisations to create work cultures that nurture compassion and kindness, so that staff can safely cultivate their ability to listen to patients and their relatives. This demands time, peer support and compassionate managers who encourages person-to-person relations to flourish. She put forward the example of monthly ‘Schwartz Rounds,’ an innovation now gaining ground in USA healthcare (and being piloted over here by The King’s Fund) which make time for staff in clinical teams to address the emotional impact of their work. (www.theschwartzcentre.org).

She also emphasised – as did Laura O’Neal in her Reith lectures – that public servants need to be freed up to serve the public.

Dr Margaret Hannah spoke on ‘Compassionate public health’ and why medicine must urgently find a radically new way forward. She highlighted that individuals and groups have a profound capacity for generating real learning, growth and healing. She gave examples of how new solutions being found through mindful conversations between health professionals and those they serve, and of healthcare teams and organisations that had succeeded in developing a supportive and reflective culture. In particular she highlighted work being done by NHS Scotland’s Fourth Wave and through the International Futures Forum.

Plenary discussion The conference concluded that the prognosis for the new NHS ought to be good, given that GPs now control (potentially) how the NHS spends the nation’s money. If they were to access the many positive resources discussed at this conference, might they not find new ways to boost their own and their patients’ resilience? Indeed the nation’s GPs now have the power to turn the present crisis into an opportunity.
Intelligent kindness: reforming the culture of healthcare in the wake of the Francis report

Penny Campling
Medical psychotherapist

I spent most of my NHS career working in a residential therapeutic community for young adults with severe mental health problems. The idea was that rather than focus on individual pathology, the focus should be the community as a whole managing disturbance and distress together. We believed that creating and sustaining a therapeutic environment provided everyone involved with a ‘living-learning’ experience and opportunity for change. Hierarchical relationships were minimised and everyone involved had a significant say in how things were done and played an important part in each other’s therapy.

I have to say it was the most exciting and challenging place to work and often extraordinarily moving. I learned a lot about relationships between people and the functioning of groups, about the destructive effects of anxiety and how psycho-social disturbance can get acted-out at so many different levels of an organisation, about the conditions that nurture kindness and compassion and what makes people feel safe and secure enough to reach out to each other. It seems to me that all of this is pertinent to the NHS and healthcare organisations more generally, yet has been largely absent from the conversation. pennycampling@btconnect.com

I’m going to talk about the healthcare culture and the seeming deficit of wisdom and compassion. The events at Mid Stafford and the Francis report that followed have held up a mirror to us all, albeit at an angle amplifying the perversions in the system, but nevertheless, a mirror that reflects dynamics we know to be real, dynamics that are part of our working lives and entrenched in our organisations.

I recently wrote a blog for the BMJ titled ‘The last thing the NHS needs is a compassion pill’. I had the picture in my mind of the NHS as an over-treated patient – you know, those patients with multiple system failure that get ever more treatment thrown at them in an increasingly desperate manner making it almost impossible to work out what’s going on. I have a sense of the NHS as being the victim of one initiative after another – usually well-meaning, often contradictory – and fear the latest may be a bureaucratic compassion project! In one week, I had bumped into someone who had been dragged away from a patient because the manager was concerned they had failed to complete the new compassion tool measurement form; I’d heard about someone who worked in HR who was moaning about how stressed he was because he was having to change everyone’s job description to include the word compassion; and I’d been asked by someone if I would devise some multiple choice questions to test for compassion!

Shifting a culture is not easy, involving as it does, many overlapping, interacting and complex systems. It is so easy to make things worse. The panic following the Francis report is understandable but needs to be resisted. I am reminded of the quote from HL Mencken:

For every complex problem there is an answer that is clear, simple, and wrong.
(Henry Louis Mencken 1880–1956).

The importance of language

In the recent Reith lectures (BBC Radio 4 November 2013) Grayson Perry talked about the art world and how too much irony can make sincerity difficult. He talked about having an allergy to terms like passionate, spiritual or authentic. Though he values these qualities, he talked about protecting them, keeping them inside himself because the words so easily lose their original meaning. So we need the right language but have to be careful how we protect it if we are to avoid corrupting concepts such as compassion.

Just before historian Tony Judt died in 2010, he wrote:

‘We need to rediscover a language of dissent. It can’t be an economic language, as part of the problem is that for too long we have talked about politics in an economic...
language, where everything has been about growth, efficiency, productivity and wealth, and not enough has been about the ideals around which we can gather and be motivated collectively, to resist injustice, inequality, cruelty or unethical behaviour. We have thrown away the language with which to do that, but until we rediscover that language, how can we work together?"

When I first read this, I was struggling with my role as clinical manager of a personality disorder service. I had a strong sense of running out of constructive options. I was very unhappy with how things were going – not just in mental health services but in the NHS generally. And I had a growing feeling that it wasn’t just about financial cuts and bureaucracy but about language and our inability to talk about what really matters. I was in danger of venting my rage into a book that would have been an indigestible read and might well have made me ill! Instead I got interested in the word kindness.

"...these acts of kindness, that can take no more than half a minute, can have a huge impact on the experience of being a patient"

I had noticed that kindness was the word often used by friends and relatives who had been on the receiving end of hospital treatment. Sometimes, they described their shock at the neglect and lack of kindness, but more often the stories were of small acts of kindness that seem to have coloured their experience. My dad talks about having had an awful time recovering from surgery and telling how a nurse took the trouble to comb his hair and settle him down. He tells the story as if this changed his whole experience, and everything started to get better after that.

People often talk about the person who cleaned their glasses, or made sure their hearing aids were in properly. It seems these acts of kindness, that can take no more than half a minute, can have a huge impact on the experience of being a patient.

Kindness has its roots in the Old English word *cynd* – meaning nature, family, lineage – *kin*. Kindness implies the recognition of being of the same nature as others – being of a *kind* – in kinship. It implies that people are motivated by that recognition to cooperate, to treat others as members of the family, to be generous and thoughtful. At the time of the Enlightenment, kindness was a core moral concept, fundamental to the political battles of the time (Phillips and Taylor 2009). More recently, it has been sentimentalised and somewhat denigrated. There is much to be said for rediscovering its subversive edge and using the concept to think creatively about modern culture – particularly the pressing problem of providing humane healthcare.

The words kindness and compassion overlap and importantly both define our relationship with the other. The feel of the words are very different, however, possibly because kindness has its roots in Anglo-saxon, whereas compassion is a Latin word (literally, *suffering with*). For me, kindness has a more earthy tone whereas compassion conveys more virtue. Whether or not we focus on kindness or compassion, it is important to connect the concepts with intelligence and wisdom, otherwise we are always in danger of misinterpreting others’ needs. A classic illustration of how compassion can miss its target is the relief of Bergen in 1945. Memoirs of the soldiers and medical team recount the mixture of disgust, pity and a passionate desire to stem the death toll from starvation that led individual soldiers to hand over their beef ration to starving inmates, only to find this caused them to die faster because they could not digest it or struggled with protein overload. To be effectively kind, we have to be informed and also open and curious about the ‘otherness’ of the other. It is an ongoing learning experience.

Michael Sandel, another Reith lecturer (BBC Radio 4 2009) reflects on how we have come to talk about virtues like kindness as if they are commodities and challenges the idea that they are a finite resource.

The notion that ethics, altruism and fellow-feeling are scarce resources, whose supply is fixed once and for all and depleted with use, this idea seems to me outlandish – outlandish but deeply influential. My aim in these lectures has been to call this idea into question. I’ve tried to suggest that the virtues of democratic life – community, solidarity, trust, civic friendship – these virtues are not like commodities that are depleted with use. They are rather like muscles that develop and grow stronger with exercise.

A virtuous circle

Kindness has an emotional, a cognitive and a behavioural component. It is about feelings and attitudes, but it is also about what we do with those feelings and attitudes – about action. It is a dynamic concept involving more than one person: something that happens between people. *Kindness begets kindness* as an older generation was fond of saying. An individual act of kindness causes ripples in the wider system. This diagram of a virtuous circle is an attempt to picture the potential for a focus on kindness to change the system at large.

Simply put, the more attentively kind staff are, the more their attunement to the patient increases; the more that increases, the more trust is generated; the more trust, the better the therapeutic alliance; the better the alliance, the better the outcomes. The result of all this is a reduction in anxiety, improved satisfaction (for staff and patient), less defensiveness and improved conditions for kindness. This system will flourish if individuals and the system as a whole are driven by a sense of kinship. This can be
expressed as simply as seeing oneself in the patient – or, as the Point of Care Foundation put it, ‘seeing the person in the patient’ and delivering the sort of care you would like for your family and friends. This sense of kinship will promote the feeling and expression of kindness which then directs attention and so on. Each stage in this cycle can be seen as a mutually reinforcing cycle in itself: for example, kindness breeds attentiveness which in turn reinforces kindness, attentiveness and attunement feed each other, a stronger therapeutic alliance does not just produce better outcomes but fosters trust which in turn strengthens the alliance. There is a body of evidence that supports this virtuous circle including published patient reports. Attachment theory (Holmes 1993) and advances in neuroscience indicate that the quality of early caregiving shapes the development of neurological systems in infants. This influences the capacity to regulate stress and self-soothing, both in infancy and in later life. Throughout life the experience of kindness continues to nourish our brains by triggering the release of endorphins and oxytocin – both closely associated with wellbeing and lowered anxiety, but, interestingly in the case of oxytocin, with a sense of connectedness. Although there appear to be no specific studies on healthcare outcomes where kindness itself is the defined focus of exploration, there are helpful findings in the field of mental health. Studies show that staff empathy, warmth and unconditional positive regard have a positive effect on patients’ recovery. In general health, a number of studies make a link between high anxiety levels and delayed post-operative healing (Cole-King and Harding 2001, Weinman et al 2008). Another study was able to show that patients give more useful information about their symptoms and concerns when staff show empathy and that this leads to greater diagnostic accuracy (Cooper 2008). Comparison of ‘compassionate care’ with ‘normal care’ in a group of frequent attenders at an accident and emergency department demonstrated that those consigned to ‘compassionate care’ had fewer repeat visits and were more satisfied with their care (Rendelmeier et al 1995).

The therapeutic alliance is particularly well researched within the field of psychotherapy, with 24 different scales developed to measure it and over 4,000 peer reviewed papers and dissertations written over the last 30 years. A consistent finding is that personal qualities of the therapist, such as empathy, warmth, openness etc are more strongly correlated with positive outcomes than the particular method or model of psychotherapy used. A good therapeutic alliance is the main predictor of good outcome.

The nature of the healthcare task

If we are serious about the culture of healthcare, we need to be clear about the conditions that will nourish this virtuous circle. We know from staff surveys that morale is low, that staff feel unsupported, undervalued, not listened to. We need staff at all levels of our organisation who are able to bear the patients in mind despite all the distractions, who understand what contribution they can make to improving the patients’ experience and who have a sufficient sense of agency to act on their initiative. All healthcare staff need to understand where they fit into the system and why, and how important they are. As another Reith lecturer, Onora O’Neill said (BBC Radio 4 2002) public servants need to be free to serve the public.

Throughout life the experience of kindness continues to nourish our brains

It’s important to understand and acknowledge just how difficult the healthcare task can be. It is easy to forget the appalling nature of some of the jobs carried out by NHS staff day in, day out – the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products. It takes energy and concentration to be in the right state of mind so as not to physically recoil and express disgust. It is common to say that this state of mind involves ‘professional detachment’, but it also takes courage and ‘human’ kindness. The detail in the Mid-Staffordshire inquiry reminds us of the shocking extremes of unkindness when failures of bodily functions are not managed sensitively and efficiently. For example, one woman told of finding her mother-in-law, a 96-year-old woman with dementia, in a cubicle in the Emergency Admissions Unit, having soiled herself.

We got there about 10 o’clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn’t got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and ... covered in faeces. It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot sides, so she had obviously been trying to lift herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time. It wasn’t new. (Francis 2010)

Both individuals and organisations have a tendency to organise in ways that minimise the conscious experience of anxiety. A famous study of nurses in the 1950s (Menzies Lyth 1959) sought to understand why nurses resigned from their profession in such high numbers. It showed that the stresses of nursing, and the intimate relationship it demanded with patients, made an impact on the organisation of care, leaving those closest to patients exposed to emotional pressures that most senior staff and managers were defended against. Menzies Lyth felt that the work of nursing – what she called the objective situation –arouses feelings and associated thoughts associated with the deepest and most primitive levels of
the mind because it involves physical and emotional contact with illness, pain, suffering and death (p47).

She proceeded to show how the organisation of the hospital can be seen as consciously and unconsciously structured round the evasion of this anxiety. The observations which drew her to these conclusions included a range of interacting phenomena. She identified the process of splitting up the nurse–patient relationship by breaking the workload into a list of tasks and dividing each nurse’s time between 30 patients. She observed depersonalisation and categorisation (eg referring to the patients as ‘the liver in bed 10’ rather than by name), and the detachment and denial of feelings. She noted the attempt to eliminate decisions by ritual task performance and to reduce the weight of responsibility in decision-making by checks and counter-checks. She found purposeful obscurity in the formal redistribution of responsibility, both idealisation and under-estimation of personal development possibilities, and avoidance of change. Importantly, she saw that the social defence system:

‘prevents the individual from realising to the full her capacity for concern, compassion and sympathy, and for action based on these feelings that would strengthen her belief in the good aspects of herself and her capacity to use them’ (p75).

Menzies Lyth proposed that the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety. In the intervening years, these ideas have been developed, looking at the goodness of fit between organisation structures on the one hand, and the emotional demands of healthcare work on the other. Sadly, although this work was first published in 1959, there is still very little understanding of the effects of anxiety on our healthcare organisations and the individuals who work within them. Unless this emotional labour is seen as integral to the healthcare task and proper measures put in place to help people understand and process it, there is little chance of the culture changing in a positive direction.

**Virtuous circles are vulnerable**

It is a sad fact that healthy cultures – virtuous circles, if you like – take years to build, take much effort to sustain but can be destroyed very easily. Vicious circles, on the other hand, are difficult to reverse. On a grand scale, they can be destroyed very easily. Vicious circles, on the other hand, are difficult to reverse. On a grand scale, they can be destroyed very easily. Typically, their attention is released from self-protection, and their culture – what Chance calls bedonic – appears to promote self-confidence, empathic co-operation, curiosity and reality-based intelligence. Chance observed a transient third state – the agonistic – that is characterised by individuals simply fighting things out for themselves, the violence consuming all important group resources. This agonistic mode did not promote overall group survival, and represented a collapse of culture.

Extrapolating from groups of primates, Chance hypothesised that human groups may become stuck in the agonic or hedonic mode or unconsciously move back and forth between them. Each mode predisposes individuals and groups to deploy their attention in distinct ways, so that they are either prevented from, or enabled, to employ their intelligence.

Chance looked at what happened in Gombe, Tanzania, in the early 1960s when Jane Goodall’s researchers tried to engage a happily hedonic group of chimps with plentiful (but not unlimited) supplies of bananas, so that they could be closely observed. He observed that they were tipped over into a murderous, competitive agonistic mode. It appeared that competition for bananas had provoked this change: it had distracted their attention, squeezing out the expression of reciprocity and mutual reward so essential to keeping tension down. Members of the community had moved from awareness to reactivity in the context of the competitive situation.

It appears that hedonic cultures are the most vulnerable to collapse. Agonic cultures – all hierarchy, subservience and knowing your place – are more protected against such dangers by their rigidity, hypervigilance to threat and their being used to managing high levels of tension. They are not, though, gentle, attentive or creative. The problem is that the gentle chimps who habitually focused their energy on nurturing kinship relationships were easily tipped into becoming envious, hateful and violently murderous as their kin became recast as enemy – just like humans.

**Perverse dynamics**

There is little doubt that the communalism and spirit of co-operation that provided the value base for implementing the NHS in the aftermath of the Second World War has been steadily encroached upon by individualism and consumerism in the intervening years. In her book, *The Perverse Organisation and Its Deadly Sins*, Susan Long describes a move in society from a culture of narcissism (Lasch 1979) to a culture of perversion (Long 2008). Perversion flourishes where instrumental relations have
dominance – in other words, where people are used as a means to an end, as tools and commodities rather than respected citizens. It is these relations that Long sees predominating increasingly in modern organisations. Her book researches large private corporations rather than the public sector but the corporatisation of the public sector means much of the thinking in her book is relevant to the modern health service.

Perversion is about seeking individual gain and pleasure at the expense of the common good, often to the extent of not recognising the existence of others or their rights. Perverse individuals do not see themselves as such and many of them appear to others as ‘kind’ – Harold Shipman being the most extreme example.

It is important to realise that Long’s emphasis is on perversity displayed by institutions, rather than by their leaders or members. There is no suggestion that individual NHS workers, as people, are any more perverse than workers in any other organisation. Nevertheless, in reality, an organisation and its members are entwined: the decisions and action of individuals are influenced by organisational culture, and, in turn, reinforce it, for good or ill. Perversion may seem a strong word to associate with the health service but it does shed light on frankly exploitative behavior and helps explain how many people in positions of trust end up abusing those positions and how people may be collectively perverse despite individual attempts to be otherwise.

There are a number of inter-linked reasons why the pull to perversion is strong at the present time. Industrialisation, marketisation and the close regulatory environment have had a huge impact on relationships between managers and clinicians, between purchasers and providers and between patients and staff. It is important to understand the political forces at work that make it harder to put patients at the centre of healthcare. How will historians make sense of the changes we are living through in the NHS? If we are serious about the importance of nurturing kindness and compassion in our healthcare environment, we need to engage with the forces pulling people at every level of our organisations in the opposite direction.

**Finding our way**

No one can prescribe or dictate for kindness and compassion. Cultures grow and emerge. They are cultivated over time rather than organised overnight. The list above suggests some of the things we might usefully address in this venture. It is my hope that articulating a clear picture of intelligent kindness illustrated by the virtuous circle described in this paper could provide a touchstone, strengthening relationships with colleagues and patients and counteracting the pressure to adopt instrumental attitudes to the work. The possibility emerges of a kinder culture developing as all aspects of the NHS –evidence, skill, new technologies, where money is spent, how people are managed – are scrutinized in terms of how they support this virtuous circle.


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The science of compassion: evolutionary, neurophysiological and psychological perspectives

Chris Irons  
Clinical psychologist

My earliest reflections on compassion emerged in my early teenage years during conversations with my grandfather, who moved to the UK from Jamaica after fighting in the Second World War. I vividly remember his stories of how cruel people could be in the face of the suffering and distress of immigrants, but also the great warmth, kindness and compassion that he had observed, to him and others, during the years following the war. As an adult, I have been lucky to work with Professor Paul Gilbert, and study compassion in more depth, both in terms of its definition, qualities and associations with other human experiences (e.g. shame, self-criticism and mental health problems), but also in an interpersonal, psychotherapeutic context. I feel excited about what the emerging ‘science of compassion’ can teach us about how to engage with our own, and others’, distress and suffering, and how we might find ways to alleviate this.

Introduction

A work colleague recently told me that they felt compassion was the latest ‘in vogue’ concept in the NHS, something that people had ‘jumped on like a bandwagon’, but was ultimately vacuous and meaningless, as ‘it’s just what all of us are trained to do’. Neither of these statements is true – but it is not an uncommon sentiment, and the fact that my colleague didn’t know they’re not true is more worrying. For over 2000 years, Buddhist psychologies have been highlighting the importance of understanding the complexities of compassion, and how we need to cultivate our minds for compassion. In the last 20 or 30 years or so, compassion has become an increasing focus of western scientific study. This research has revealed very important insights into the neurophysiology, hormonal and genetic basis for compassion, as well as its social and contextual facilitators, mediators and inhibitors (Gilbert 2009).

Compassion has also become a central focus of psychotherapy. Indeed, over 20 years ago, Gilbert (1989) raised the question of compassion as a therapeutic process. Compassion focused therapy (CFT) (Gilbert 2009; Gilbert and Irons 2005) subsequently emerged as a way of helping people with severe and enduring mental health problems, often associated with complex histories (trauma, neglect), and high levels of shame and self-criticism. These are individuals who commonly have experienced little compassion in their lives, and are often distrustful or fearful of it (Gilbert 2009).

Over the years, people have been applying CFT in a variety of populations, including in mental health (depression, anxiety, psychosis, eating disorder, personality disorder), health (traumatic brain injury, pain) and non-health sectors (e.g. schools). CFT roots itself in evolutionary science, neurobiology/physiology, and the psychological sciences (e.g. social and developmental psychology). These different areas of science have much to say about compassion. Although there is certainly a lot of research emerging in recent years showing a variety of benefits of cultivating compassion (which I will return to below), it is helpful to also consider compassion within philosophical, biological and evolutionary context, as this helps to highlight that rather than being a ‘fad’, compassion has ancient foundations, and cultivating compassion may have a variety of positive impacts upon our wellbeing.

The first step: compassion as a ‘reality check’

Before focusing on the benefits of cultivating compassion for ourselves, others and in healthcare more generally, it is useful to first consider the reasons why we might need to do this in the first place. Why do we even need compassion? From a CFT perspective, as with a number of philosophical traditions, compassion begins with a reality check about the nature of life, the reality of suffering, and how many of the difficulties we face in life are ‘not our fault’. Here, it is helpful to consider three key ideas relating to evolution, biology and our social circumstances:

The first reflection is that we are an emergent species, whose bodies and minds are the products of hundreds of millions of years of evolution. An
understanding of evolutionary processes may help us understand not only why we experience distress but also why compassion might be helpful for us as individuals and as a species. Evolution works on the process of conservation and adaptation, building upon what already exists and selecting traits and attributes (physical or mental) that confer some sort of benefit to the organism and/or group in the environment they inhabit. However, this process also results in some trade-offs, which are often less helpful. For example the human spine evolved from animals who lived on all fours, in which the spine is ‘horizontal’; however, at some stage in our past, a series of evolved adaptations led to increasingly upright stances, with the spine placed in a vertical position. While this conveyed a number of advantages – an increased line of sight to spot predators and freeing the hands to hold and carry things (our young, weapons, food) – it also created some serious trade-offs. For example, the cause of most days off sick from work in this country is back pain, and much of this can be understood by us having inherited a spine that was not designed (originally) to carry body-weight vertically. This of course is no one’s fault, but rather a result of evolutionary processes, but it can, and does, cause people a lot of physical and mental suffering.

The second reality check is that our lives are relatively short; on average in this country we live for between 28,000 and 30,000 days. Not only are our lives relatively short, but as we get older we are increasingly likely to experience suffering; our bodies begin to break down, we will suffer pain, illness and disease, and people we love will die. The reality here is that some of our suffering and distress come with the territory of being gene-built, biological creatures that age and ultimately die. Here again though, it is important to recognise that these are not of our choosing or manufacture. Some of our biological fate depends on a genetic lottery; that is, the genes that happened to come together, one set from our mothers, one from our fathers. If a different sperm than the one that fertilised our mother’s egg got there first, we would be a completely different person. Moreover, we do not choose who our parents are, nor which version of their genes (the specific sperm that fertilises the egg) we inherit. However, these will have a significant impact on the physical version of us in the world today. Sadly, while this process is completely outside of our control, our ‘intelligent’ thinking minds can cause us problems here, as we can form a sense of self based on a physical entity (body) that can be full of shame and self-blame for things that were completely outside of our control.

The third point is that while genes and biology are an important part of who we are, we cannot be reduced to ‘just’ genetically assembled organisms; in fact, there are only a relatively small number of single gene illness or diseases. Rather, much of who we are, including the distress we experience, is because we are socially constructed – that is, we are the product of the experiences we have had in life. The physical, environmental and social-relational contexts which we have experienced hugely influence our identity and version of ‘self’ or ‘I’ in the world. Importantly, just as we don’t choose our genes or biological nature, neither do we choose our social environments, but these have a significant impact on the mind that we go on to develop. I do not choose much of the social circumstances of my life – the type of personality my parents have (loving and sensitive, or neglectful and abusive), the type of country I’m born into (war-torn or peaceful; affluent or poverty stricken; Christian, Muslim or secular), the type of school I attend (successful or failing) nor the friends I have when I’m growing up. However, different versions of these will lead to very different versions of the ‘me’ that exists in the world today.

Nature via nurture

Of course, there are important interactions between the above points, and we know that phenotypes are highly plastic. (Belsky and Pluess 2009). Recent research has found that our genes express themselves in different ways depending on our environmental experiences. If I am raised by parents who are loving, sensitive and available, the genes in my frontal cortex will express themselves in a particular way that will give rise to a particular version of ‘me’. However, as we often say in CFT, imagine instead that I was kidnapped as a two-day-old baby and raised by parents who were part of a violent drug gang; parents who were neglectful, critical and abusive towards me, and I witnessed people doing terrible things to each other. Now the genes in my frontal cortex would express themselves in different ways, giving rise to a different version of ‘me’ in the world. Again, we do not choose either our genes or our early rearing experiences, but they will have a significant impact upon the version of us in the world, and the type of mind we see and relate to others and ourselves with. Our minds are designed for us, not by us, and are the phenotypic reflection of the complexity of our biological mind and a socially constructed ‘self’.

Understanding that so much of our suffering, our distress and our sense of self is not of our choosing, and therefore not our fault, is an important compassionate insight. This in itself can make profound change in our relationship with distress and suffering. But if our suffering in life is not our fault, then how do we begin to take responsibility for the difficulties we often face? Here it is important to try and separate fault and responsibility. For example, another common example in CFT would be: although it is not my fault if I inherit genes that make me more susceptible to lung cancer, if I smoke 40 cigarettes a day then it’s quite likely I’ll develop lung cancer, experience much pain and suffering, and probably, an early death. Although I cannot take responsibility for the genes I have inherited, an awareness of this can lead to taking responsibility (motivation, effort and distress tolerance) in finding ways to stop smoking.
Multi-mind – old and new brains

As we take further steps into understanding compassion, it is helpful to return to evolution. In particular, understanding the phylogenetic development of the human brain can help us to understand the different drives and competencies of our mind, and that our minds are actually quite ‘tricky’ and full of evolved glitches, and often get caught up in a variety of non-rational heuristics (Gilbert 1998). A useful heuristic when thinking about the human mind is that we have an old brain, that has a particular psychology relating to certain emotions (eg anger, anxiety, sadness), motivations (for basic survival, like food and shelter, but also for relationships and status) and behaviours (fight, flight, submission, freeze). We share these psychologies with many other animals.

However, approximately two million years ago, humans began to get smart. Our minds began to develop increasing cognitive abilities – a ‘new brain’ – which bestowed us with wonderful cognitive endowments, such as being able to imagine things that aren’t real, plan for things that haven’t happened yet, and run complex cognitive simulations in our minds (‘if I say “a” to her, then she will respond with “b”, and then I will tell her “c”’ and so on). However, as evolutionary process often does, this adaptation this also led to some significant trade-offs for our species, as our cognitive power can manipulate and distort old brain emotions and motives with some quite devastating consequences. For example, while our pet dogs may put on weight if they eat too much, they do not then get caught in thoughts like: ‘gosh, now I’ve put on weight, none of the local dogs will find me attractive anymore’. However, we can and do think like this (new brain), which can then subsequently drive old brain emotions (eg anxiety) and behaviour (avoidance). This of course is not our fault, but rather a ‘glitch of the mind’ that occurred partly as the result of humans becoming smart. While other animals also get angry and fight (old brain capacities), only humans’ intelligence and planning (new brain) can build nuclear bombs to do this. Moreover, as cognitive therapy has long pointed out, our patterns of thinking (new brain) can cause us much distress (old brain), and these types of cognitive-emotional loops are common in many mental health diagnoses.

There are a number of things we can do to help our minds to deal with these ‘loops’. One way is by practising and learning mindfulness. In CFT, mindfulness emerges from new brain capacities, that is, consciously focusing ones attention in the here-and-now in a particular way. Cultivating attention and mindfulness helps us to notice these ‘loops in the mind’ (new brain – old brain interactions), and then find ways to step outside of them by redirecting attention. In particular, key here is learning how to ‘slow’ and ‘stabilise’ the mind. Once we have developed the capacity to slow down and redirect attention, we can then focus on specifically cultivating compassionate motivation. In CFT, compassion sits as an ‘old brain’ capacity, as our ability for compassion arises from our capacity to care and nurture others, something that evolved with the emergence of mammals in the world, and is at least 120 million years old. Compassion operates as an organising motive for other faculties of our minds, bringing them into focus and co-ordination which, as we will return to later, appears to have a variety of benefits for our health and wellbeing.

Evolved emotion regulation systems

Motives evolved to help animals survive and seek out things that are important to them (eg food, shelter). Emotions help to guide our motivations and goals by responding in different ways to whether we are successful or thwarted, blocked or threatened in some way. In CFT, we suggest that our evolved emotions can be clustered into three different systems (Gilbert 2009), based upon a simplified version of neurobiological and physiological research (eg Dupue and Morrone-Strupinsky, 2005; LeDoux 1998; Panksepp 1998). These three emotion-regulation systems are designed to do different things, and are depicted in Figure 1.

The threat and self-protection system

This system evolved for detecting and reacting to physical threats. Once triggered, it gives bursts of feelings such as anxiety, anger and disgust, which urge our bodies into action to protect us from the threat (eg by fight, flight, freeze, submission). The threat system works off a ‘better safe than sorry’ heuristic, and is highly conditionable. When responding to a threat, this system is often associated with the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system activation in urging a response (eg fight-flight). However, a threat can also trigger a very different ‘shut down’ and immobilisation response, which is regulated by the unmyelinated dorsal vagus nerve (Porges 2007). These responses all help to co-ordinate the physiological, emotional and behavioural response to threat.

The drive-seeking system

This system is an appetitive and consummatory system; it evolved to give us pleasurable feelings which motivate and urge us towards certain things that are important for our (and others) survival and flourishing, and give us bursts of pleasurable feelings (reward) when we achieve the thing we were aiming for, thus making it more likely that we engage in that behaviour again. The drive system is underpinned by the hormone dopamine, and is therefore an activating, high-energy system.

The soothing-affiliative system

When animals aren’t threatened or seeking something, it is important for them to ‘rest and digest’. This system gives rise to a sense of calmness, contentment and peacefulness. There is often a sense of ‘slowing down’ with this system, and it is linked to activation of the
The mammalian caring and affiliation system evolved within early mammalian attachment relationships, and is associated with optimal functioning of the myelinated ventral vagal nerve, which has been found to be important in the evolution of the parasympathetic nervous system and subsequent regulation of the sympathetic nervous system (Porges 2007). Consequentially, the soothing-affiliative system can be triggered by affiliative relationships and is highly responsive to signals of care, kindness and safeness. Neurophysiologically, this system is associated with the neurotransmitter endorphin, and the neuropeptide oxytocin. Research has highlighted that oxytocin and its close relation, vasopressin, have important roles upon bonding of parent and infant, and the degree someone is trusting and caring, and have a calming physiological effect (Insel 2010).

**Mammalian caring and affiliation**

The evolution of mammals brought new psychologies to the world. Of all species, we are in most need of affiliative relationships (Cacioppo and Patrick, 2008), and it turns out that caring and affiliative relationships have a significant regulating effect upon our physiological and psychological systems. Compared with reptiles, mammals provide a significant amount of investment – protection, care and nurturance – to their offspring. This is important, as it means that parents need to be orientated to their offspring, to be motivated to care, to notice and respond appropriately to signals of distress. Recent research has shown that the physiological systems of mothers and fathers – such as their level of oxytocin – change during affectionate contact with their infant, and in turn, greater affectionate touch and play stimulates higher levels of oxytocin in infants (see Feldman 2012 for a review). Crucially, the infant is also orientated to remain in proximate contact with the mother, and to receive care and nurture (eg food and warmth, but also soothing when distressed). The quality of this relationship in early life has a significant impact on a whole range of processes, including the maturation of biological and neurophysiological systems, activation and expression of genes, and functioning of psychological competencies (Gerhardt 2004; Cozolino 2007; Belsky and Penney 2009).

John Bowlby, who developed attachment theory in the 1960s and 1970s, pointed out that the caring other provides an infant with two major sources of developmental help – a secure base and a safe haven. When we talk about soothing and the way individuals calm down, we are often referring to safe haven function – that is, the ability to turn towards sources of comfort for support and calming. However, compassion also provides for a secure base function, which is to develop the confidence to go out and explore and face the challenges of the world. So consider that you have some difficult things to do in your life. Maybe you have to go and have some tests for a potentially serious illness, or you have to go for an interview, or you are going through a divorce. Now imagine that you have a friend. How would you like your friend to be? How can they function best for you in these contexts? Very clearly they must do (at least) two things. The first is to support you so that you can begin to feel soothed to some degree by their kindness. But the second is to encourage you to do what you need to do – that is (for example) to go to the hospital, or to the interview, or find a good lawyer. What your friend would not do is to suggest you avoid those things because they’re painful, frightening or difficult – they would not say to you ‘well the best way to help yourself is to sit at home and accept things as they are’. Compassion is about descending into suffering, and finding the strength and courage to face up to what we need to face up to. So soothing is part of compassion, but often behavioural action is needed.

**Compassion emerges out of caring**

Our evolved capacity to care and nurture, adapted within the attachment system, originally functioned as a way of maximising survival and fitness of offspring. As Cozolino (2007) puts it, ‘We are not the survival of the fittest. We are the survival of the nurtured’. However, we also know that for at least 1 million years, humans have also been caring for each other, not just for infants. Fossil records indicate that our ancestors, even in old age with serious illness or bone fractures that would incapacitate and lead to death, survived these events to live for years longer. This is only possible if other people in the group cared for them. Here, we see the generalisation of care and nurturance for infants to adults. The fossil records show
that our ability to be orientated to others, to notice their suffering and do something about it, has been a feature of our species for a very long time.

Research has also shown that affiliative, caring relationships are not just physiologically regulating for infants, but also have a significant impact upon the regulation of genetic, neurophysiological, and psychological processes throughout life (Cacioppo abd Patrick 2008; Feldman 2012). As in early life, when we turn to the warmth, reassurance and love of our caregivers when we’re distressed, when distressed as adults the care and support of others helps us to feel better – to feel calmed and reassured. In this, there are certain qualities of other people that are generally seen as helpful, such as caring, empathy and support. Here in adulthood, engaging in affiliative relationships (soothing-affiliative system activation) helps to regulate threat system activation.

Out of this capacity for extended care emerges compassion. A common definition of compassion is: ‘A sensitivity to the suffering of self and others, with a deep commitment to try to alleviate and prevent it’. In CFT, we refer to this definition as containing two psychologies of compassion (Gilbert 2009). The first involves being sensitive and open to suffering (and its causes), to move towards and be willing to engage with it. There are a number of different qualities that contribute to the first psychology of compassion, including motivation to be caring, sensitivity to distress, sympathy, distress tolerance, empathy and non-judgement. In comparison, the second psychology of compassion involves the desire and attempts to alleviate suffering; to be motivated to reduce suffering and prevent it from returning. Here, there are a variety of ways in which we can practice and develop skills (for example, in the way we think, feel, behave and focus our attention) that help to cultivate qualities of the first psychology of compassion, and through doing so we begin to find ways to alleviate distress.

Compassion and wellbeing

While the above provides an outline of the evolutionary, biological and neurophysiological background to compassion, it is useful for us to consider why compassion matters. What, if any, benefits does compassion confer? Well, there is now an emerging science of compassion, spanning diverse areas of investigation including biology, neurophysiology, developmental psychology, social psychology, affective neuroscience and psychotherapy. A variety of cross-sectional studies have highlighted that those people with higher levels of self-compassion are more likely to score lower on measures of depression and anxiety symptomology, as well as report lower levels of shame, self-criticism and rumination (Ferreira, Pinto-Gouveia and Duarte 2013; Krieger, Altenstein, Baeftig, Doerig and Holforth 2013; MacBeth and Gumley 2013).

However, just like your physical fitness, with practice our capacity for compassion can also be cultivated over time. Studies have found that when people practise compassion-based exercises, this is associated with increased self-report levels of compassion (Neff and Germer 2013), along with a variety of neurophysiological and neurobiological changes, as well as improved immunological response (Lutz et al 2008; Pace et al 2009). Moreover, our work on CFT, with people with a variety of mental health problems, has found that training people to develop their compassionate skills – for others and themselves – can be helpful in a variety of diagnoses, including depression, eating disorder, schizophrenia and personality disorder (Laithwaite et al 2009; Gilbert and Proctor 2006; Lucre and Corten 2012; Gale et al 2012).

But practising compassion does not just lead to a sense of inner calm and happiness. As the Dalai Lama has pointed out, compassion needs to be associated with action, and for many, compassion is associated with motivation and desire to try to alleviate suffering in others. Interestingly, studies are now supporting this. For example, Condon et al (2013) found that after a short period of time practising either mindfulness or compassion exercises, participants were five times as likely to notice and try and respond helpfully when confronted with the suffering of another person, compared with a group of people who hadn’t spent time practising mindfulness or compassion. Other studies have shown that compassion also helps us to engage in things that we find difficult. In experimental inductions, Breines and Chen (2012) found that participants in a self-compassion induction, compared with those who had self-esteem induction, had a significantly greater motivation to make amends for a moral transgression, spend more time studying for a difficult test following an initial failure, and greater motivation to change a perceived weakness.

Conclusion

The origins of compassion have deep roots in our evolutionary history, and in particular the evolution of attachment behaviour linked to care, nurturance and affiliation. There is a growing research field looking at the science of compassion, and in particular, its associated neurophysiology, its link to health and wellbeing, and how it may be taught and used as a way to treat psychological distress. Rather than a passing ‘fad’, or something ‘we all just do’, research is highlighting the nuanced, complex nature of compassion, its link to early attachment experiences, and just how difficult it is for some of us to experience (eg.Gilbert et al 2011). Approaches like CFT are developing interventions that are focused on helping individuals and organisations to cultivate compassion, and future research will focus on how this more be done in increasingly effective ways.


Gilbert P (2009). *Evolutionary psychopathology: Why isn’t the mind better designed than it is?* British Journal of Medical Psychology 71 pp 553–575


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Optimism, resilience and compassion in the health service: What works and what doesn’t, and can we afford it?

Alastair Dobbin

I work for a mental health charity in Scotland that helps build mental resilience by taking an approach of building access to positive emotions. I learned hypnotherapy 25 years ago, and for many years I ran an NHS clinic for mental health referrals from fellow GPs. I was impressed at how very simple tools such as self hypnosis could have a big impact on patients’ problems. I did research with Edinburgh University into the treatment of mental health disorders, depression, burnout and psychosomatic disorders (irritable bowel) in a primary care setting. Based on my research I have developed a guided self-help programme called Positive Mental Training for use by GPs and other health professionals in the treatment of emotional distress.

At the Foundation for Positive Mental Health we seek to bring about recovery by building mental resilience. It’s recovery I’m interested in. Like any GP I have seen many people on the edge of despair. A GP who doesn’t know how to help such people is wasting a huge opportunity to turn them around. I wanted to design a system which would enable a GP with ten minutes for their patient, to engage with them and turn them around from despair, as those in despair already have all the conditions in place to change, to transform. GPs have very little time to do therapy in their surgery but you can direct a patient to resources which will help, and if you understand the process of recovery you can transmit this to the patient and increase their expectation of recovery. There is increasing evidence that the key process in recovery from distress is the ability to see yourself recovering. But if you are immersed in negative emotions you cannot imagine your despair changing; positive emotions allow you to see a distress-free future.

When I first used this programme, I didn’t know if it would work. I gave it to some of my patients, and to my surprise some of them came back transformed. Subsequently, at a time when I was under a lot of stress myself, I tried it too. The patients had mirrored their recovery back to me, then I used the programme and now I mirror it back to other GPs, I call this two-way process therapeutic mirroring. So I speak from experience of 30 years in full-time general practice of witnessing recovery from distress through positive emotions, and I know it can enable us to fight burnout and hence increase compassion.

Compassion and burnout

‘You can search throughout the entire universe for someone who is more deserving of your love and affection than you are yourself, and that person is not to be found anywhere. You yourself, as much as anybody in the entire universe deserve your love and affection.’

Buddha

I’m going to talk about compassion, having done some recent research with McGill University in Montreal on positive emotions which I’ll come back to later. You cannot be compassionate to each other if you are not compassionate to yourself. And we who work on the front line in the health service do quite desperately need more resilience and compassion. A survey in Pulse this year looking at the level of burnout in GPs measured the three aspects of the Maslach Burnout scale; exhaustion, depersonalisation and personal efficacy and found that of the 2,200 respondents over 70% had high levels of exhaustion, over 40% had high levels of depersonalisation, and 97% rated their personal accomplishment in the job as very low (www.pulsetoday.co.uk/home/battling-burnout/revealed-half-of-gps-at-high-risk-of-burnout/20003157.article). The depersonalisation aspect of burnout measures your ability to have empathy with your patients, and the high levels represent a tragedy for doctors and for patients and goes some way to explaining the current crisis of compassion in the health service.
I believe that patients and GPs can therapeutically mirror a sense of recovery to each other. But you can’t be compassionate if you feel in a bad way yourself, because then you will be in fight or flight mode. And in this threat mode the compassionate mind simply won’t work. As a GP you can’t generate compassion if you’re sitting there feeling miserable or totally overloaded. But I am afraid that’s what many GPs are doing. From this perspective if you can’t access positive emotions, you can’t be compassionate to people. So if you are under stress, and have lost your resilience, the first step (whether you are a doctor or a patient the same applies) must be to access a positive representation of yourself. Our research showed that in many cases this is blocked by a non-compassionate feeling towards oneself.

Positive emotions are experienced in the body, indeed all emotions are experienced in the body and are inextricably linked with the body. If you are unable to smile because you hold a pencil in your mouth you experience less amusement. This means you have to work with the body; not just the mind in isolation. Those in severe distress in addition to talking therapy will need to work with breathing and physical relaxation.

**Mirroring and empathy**

When you see someone performing an action, motor neurons in your own brain mirror the action in your own body, as if you were doing it yourself. This unconscious effect can be measured in the muscles in the body. A simple example: when you see a child struggling with their shoelaces your fingers start fiddling in sympathy ‘itchin to help’. This is a mirroring effect. Mirroring is a very important and fundamental part of human interaction. There are cells in the pre-motor cortex that respond to the sight of action and even the sound of action. If you hear footsteps, your legs start ever so subtly to move in the same rhythm. You can also deduct the emotions and intentions of the walker – confident, hesitant, hurried etc.

‘Theory of mind’ is a term for a human quality that gives us some sense of what someone else is thinking and feeling, mirror cells explain this ability. In evolutionary terms being able to predict other people’s intentions, the outcome of an interaction and what we feel about it obviously improves our own and our species’ chances of survival. It works a bit like this: for instance, I mirror in my mind how it would feel if I said to you ‘I think you’re very fat’. Before I blurt it out I’m likely to feel what its effect on you is going to be, and internally to model your emotional response based on how I would feel if you said it to me. In my mind I play the whole interaction and feed it back to myself. In effect I am mirroring you and seeing how it feels before I say it. Damasio talks about this in his book *The Feeling of What Happens* (Damasio 2000).

While you are talking to a patient all sorts of signals are letting them know whether you are really engaged with what they are saying: tone of voice going up and down, breathing more slowly (more or less in step with theirs), and your face will be reacting more. There could be postural mirroring too, and you might be smiling more, and more genuinely. All this is a manifestation of what Steven Porges calls the ‘social engagement system’; his polyvagal theory explains how it evolved and what the parasympathetic nervous system has to do with activating it (Porges 2007). The point is that this interactive effect is both psycho- and physiological, your patients cannot absorb what you are saying if you are not able to engage this system when you are talking to them. The TDCRP study in the US showed that the most important factor predicting recovery in any therapy is the level of warmth shown by the therapist, and the expectation of recovery of the patient, and this effect has been shown in many studies (Rutherford et al 2010).

**Emotions: brain or body?**

William James’ view of emotions was that they are primarily bodily states (autonomic and behavioural) which ensure survival and maximise opportunities, and the feeling is due to conscious perception of the behaviour. The classic example is of a man out for a walk who thinks he has seen a snake on the path ahead, as demonstrated in figure 1.

The perception goes to his visual thalamus and from there it sets off two pathways: a slow one (B) goes to the conscious recognition part of the brain that makes you think ‘hey there’s a snake, they’re dangerous I’d better watch out’. But the fast track to your amygdala (A) bypasses the cortex, triggering – even before the slow-track conscious awareness of the threat – a flight–fight–freeze response. A split (potentially lifesaving) second before the conscious recognition and the thought, the

**Figure 1:** The body–mind loop (based on Ledoux 1996)
whole body freezes, and blood pressure and heart rate shoot up readying the body for action, and that is what makes us perceive the danger and saves us.

This all-important fear system is crucial to survival. And even if the pathway to the cortex (B) is cut (which was done experimentally by Ledoux) an animal confronted with a predator will still react with fear, while if A is cut the animal does not react. So in threat situations, bodily threat responses and feelings of fear kick in just before the snake is consciously seen. This also explains what happens in the all too familiar situation where we are walking down the street on a windy day, and a piece of paper blows in front of us low down which looks like a rat running in front of us. Immediately the heart is racing, but then just after your reflex-like startle reaction, you realise it’s just a piece of paper blowing in the wind, but the conscious mind cannot overrule the fear, and it takes time to calm down after.

So there can be situations where the body is reacting as if there is a threat because the amygdala is signalling THREAT! yet the conscious part of the cortex doesn’t know why. One example would be somebody who was abused when he was five in a room painted purple feeling uneasy in a room with purple walls. He doesn’t know why he doesn’t like it (often memory circuits are ineffective before the age of seven), but his body remembers (Rothschild 2000) and feeds back messages to watch out for danger and he becomes withdrawn and hypervigilant and does not interact effectively with others, his social engagement system is overwhelmed by the oppositional inhibition of his sympathetic nervous system.

Typically if an anxious or angry body causes the conscious brain to feel that something is wrong, the conscious mind will seek out a cause for the feeling of threat. For example, a man seeking a cause for this background emotion is unaware of the source and looks around for an explanation which he tends to misattribute to the nearest thing, and so may end up blaming his wife for not being nice to him. This kind of misattribution and associated hypervigilance is very common in depression and anxiety – it’s called a negative cognitive bias, or just plain catastrophic thinking. The term for this kind of thinking is ruminative; thoughts that go round and round in your head: you wake up anxious in the night thinking ‘I shouldn’t have talked to my partner that way’ but after a while you think ‘this is crazy, I shouldn’t be worrying, I have work in the morning’. So you decide to put it out your mind, but then you start worrying about the children not doing well at school, or money problems. The body is telling the mind that something is wrong, but because there is no conscious recognition of what it is the mind searches around for reasons, and finds problems that really have no relevance to how they are feeling. To break this cycle we need to cultivate ways of relaxing the body – the mind will follow.

So the bodily anxiety keeps feeding back up into the brainstem and this tells the thalamus and other brainstem structures to look out for the source of danger – hyper-vigilance. This alerts the amygdala to ramp up even more; this increases the effect of the fear on the body so the anxiety and rumination go round and round in circles (as in Figure 1) as the anxious mind alerts the already anxious body, a vicious cycle. Under these conditions it is easy to misinterpret ambiguous communications in other people’s conversation, or in written communications; the subject develops a negative cognitive bias, becomes a catastrophiser, basically expecting things to go wrong. So it is very useful and important to calm the body and to focus on inducing instead an up-welling of positive emotions.

**Positive and negative messages from the body: oppositional inhibition**

There are two categories of sensory pathways up the spinal column. One carries messages to the somatosensory cortex about fine touch and proprioception; this is called exteroception. The other pathway comes from the internal visceral organs and goes to the insular cortex, to give feedback from stomach and heart and intestines; this is called interoception. It used to be thought that the contralateral dorsal columns that carry temperature pain and crude touch were part of the exteroceptive system terminating in the somatosensory cortex. However research over the past 20 years has shown that these modalities are part of the interoceptive system, and terminate in the insular cortex along with many other modalities ascending in the contralateral columns, chemoreceptors (lactate, histamine) vascular dilatation receptors, and others. These all have a direct effect on the emotional balance of the body, in effect temperature pain and ‘crude touch’ (more accurately gentle touch as for instance in co-specific massage or grooming) which are now recognised as interoceptive, are sensations but are also emotions (pain of course is a negative emotion – gentle touch a positive emotion) because they result in delineated patterns of behaviour – pain for instance causes healing behaviours such as protective withdrawal, gentle touch causes approach and a relaxation response. The insular cortices (left and right) is where all this potentially emotion-generating feedback from the body gets integrated (Zautra et al 2010, Craig 2005) see figure 2.

All the positive sensations/emotions end up activating the left insula (positive sensations from the right body cross to the left insula), the negative sensations/emotions from the left body cross over to activate the right insula. On MRI scans activity in the left insula is associated with parasympathetic activity, and activity in the right is associated with sympathetic (fight or flight) activity. The most important part of this left/right balance in the insula is called oppositional inhibition; if the activity in the left insula increases, this automatically inhibits the activity in the right insula and vice versa. Finally, as shown in Figure 2, the verbal auditory and social information is all integrated in the left and right insula in the same way to
produce a global balance of threat and opportunity which is then expressed in a dominance of either the sympathetic (withdrawal) or parasympathetic (approach/engagement) systems. In a healthy individual there is a continuous balancing of threat and opportunity.

In the past, psychotherapy has tended to focus on clients’ perceived deficiencies, negative experiences and bad feelings and tried to ‘diminish the negative’ impact. We say, ‘you think you’re a failure, tell me why’. But really is that going to help? This new evidence of the oppositional inhibition in the left/right insula allows a new model of emotional balance, with new ways of promoting recovery; by boosting positive sensations and emotions we can diminish negative emotions. The major advantage of this is that positive emotions in addition to diminishing negative completely change the way our brains work; it floods the cortex with dopamine enabling problem-solving, increased working memory, increased flexibility, increased generosity to self and others, increase empathy and increased social engagement. Gentle touch, or calm breathing (which also beneficially increases CO2) all boost activity in the left insula. Fortunately as practitioners we have permission to offer patients the kind of touch that can induce positive emotion: even taking someone’s pulse – always providing that the clinician is calm and engaged – can do this. Also, in this model we can see how, for instance, hearing someone praise you in a genuine engaged way will diminish pain and anxiety, as in the same way gentle rubbing and slow breathing and smiling at someone will. So we can give people who are stressed positive visualisations – relaxing on a warm beach etc, or a positive visualisation of themselves coping in a future situation. These mind–body approaches present some significant opportunities for future mental and internal medicine: positive emotions reduce levels of inflammatory markers in the body, so a positive outlook reduces stroke and cardiovascular problems (Brouwers et al 2013): optimists with a positive view of aging live seven years longer (Levy 2003).

Social engagement and affiliation

The vagus nerve doesn’t just innervate the heart and the gut, it branches off to brainstem nuclei that innervate various sets of muscles around the head face and neck as well. Signals from these nuclei influence your facial expressions; the more active the vagus the more activity there is in these nuclei and the more movement of a social engagement nature there is in your facial muscles making others give you more positive feedback. The vagus of course also innervates the laryngeal muscles – the greater the activity in the vagus the more interesting your voice becomes with greater musicality and tonal range, and the stapedius muscle acting on the ossicles attune...
Two kinds of thinking

Two kinds of thinking

You need to take two categories of thinking into account: the ruminative and the experiential. We have already described ruminative thinking at night. Ruminations are absorbed in your emotions which is great when you feel good but counterproductive under stress. Your body makes them feel worse. This is called the upward counterfactual effect. Experiential thinking is mindful thinking, stepping back from your emotions. There are a number of ways to facilitate thinking like this: meditation, where you stand back from your thoughts, autogenic training, hypnotic, or even, as we found out, just closing your eyes and visualising under conditions of attentional distraction. Resilience represents the ability to switch your processing mode from rumination to experiential thinking, and the exercises in positive mental training are designed to facilitate this, which allows access to positive emotions, overcoming the upward counterfactual effect.

With McGill University we have been researching into something called guided visualisation of positive reappraisal, which is another way of putting people into a state of experiential thinking to overcome the upward counterractual thinking which would normally block their ability to see positives. We took a cohort of students and measured their depression level then we asked them to recall an event that was difficult for them (self-defining – negative) from the past. Some days later we called them in, measured their level of positive emotions, got them to recall the negative memory and assigned them to listen either to an audio recording of guided visualised positive reappraisal which is part of the positive mental training programme and included phrases such as ‘you will grow as a result of difficulties’, ‘you will find you can never fail’ ‘there’s something positive to be found in everything’ or to a guided relaxation track. Depression is due to a lack of positive emotions and we found that the reappraisal raised the level of positive emotions in the depressed students to the same level as that of the non-depressed while the relaxation had no effect. We had enabled a new perspective on the past event in which rather than feeling traumatised and damaged by the event with a negative view of themselves, they were able to see the positive aspects of the situation, stop blaming themselves for what went wrong, see the bigger picture. We feel that a failure of positive reappraisal is one of the key deficits in distress and depression (Dobbin et al 2014).

Positive mental training

We have developed a self-care method called positive mental training. Patients watch a DVD introduction, then listen to a series of 12 x 18 minute audio tracks, moving on to a new one each week. The first four are relaxation, breathing, setting up a trigger, learning to visualise, then there are cognitive exercises including positive future visualisation and desensitisation. We have demonstrated useful change after the first four weeks. So patients take the pack away and they listen at home once a day, 18 minutes; no need to read. Getting all this across fits into

It seems that without positive emotions you will be far less resilient

Two kinds of thinking

Two kinds of thinking

Therefore when tackling the upward counterfactual effect we need to take two categories of thinking into account: you hearing more acutely to the human voice. The vagus nerve also makes your breathing and your heart slow down. The vagal system activates a whole calming and socialising system designed to affiliate you to others: to first try to befriend others before resorting to flight and fight.

If the left insular is activated (by positive messages from the brain and body), all these socialising signals and tunings-in will kick in. This makes you more likely to engage with people, which in turn increases this positive cycle. It inhibits the right insula switching off the effect of pain and distress and negative statements from those around you criticising you, (which all increase activity in the right insula) you get into an upward spiral of positive emotions.

But if the right insular is overactive (because of negative signals from the brain and body), this will increase the effects of the sympathetic nervous system, inhibit the left insula and reduce the vagal input into the social engagement system. With less parasympathetic braking on the sympathetic system’s influence, voice and expression put out signals of threat – fight, flight or social withdrawal. Obviously a negative spiral will result: unsatisfying social input, negative emotions, more off-putting signals, social disengagement etc.

Barbara Frederickson worked with people after 9/11 and found that those who were more resilient were those most able to access positive emotions, and that this boosted their resources for dealing with the stress and trauma. It seems that without positive emotions you will be far less resilient. Recently she has shown that if you feel more positive you will interact more with others and your autonomic nervous system will work differently (Kok et al 2013); that if you have positive emotions you will broaden and boost your ability to cope with others and with stress.

Our research supports this idea.

So how are we to increase positive emotions? I am very interested in the notion of reappraisal. The Buddhists call it transformation. It means finding something positive in negative events that have happened in the past. But research shows that if you remind someone who is depressed of all the reasons they should be cheerful, they compare this with their current state of misery and this makes them feel worse. This is called the upward counterfactual effect, but it can be overcome by changing your thinking style, the way you process your thoughts.

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a ten minute appointment. In our workshops we have a ‘three minute challenge’ in which we get doctors to model their difficult patients and we model the doctor and show how one could engage them with the programme in three minutes. Patients are very ready to accept advice from a primary care professional about the mind and body interaction, GPs are expected to know about the body, and it seems entirely logical to say ‘when your body is tense it makes your mind feel tense, makes you jumpy and edgy. By relaxing your body you will relax your mind’.

It all started with a sports programme developed by a sports psychologist for Swedish Olympic athletes designed to help them win gold medals. Olympic athletes have to be very good indeed at bouncing back, seeing the positives in a losing performance (‘It was great to perform with such talented opponents, I learned a lot and will be better because of this’ rather than ‘that was terrible I am obviously just no good at this’) and the originator of the programme sought to inculcate the thinking of the winners into all athletes and used a programme which positive mental training is based on. So in 2002 I went to Sweden, and shadowed the originator for a couple of months to understand how the programme was used, then came back and started using it with my depressed and distressed patients and found it was very effective at treating depression. We did a study with Edinburgh University in primary care using GP referrals for depression which confirmed this beneficial effect. The origin in sport makes the programme non-stigmatising. Subsequently we did a study in NHS services looking at patients referred for mental health problems to the occupational medicine department which showed excellent outcomes with burnout using positive mental training. Two years ago we did a workshop with 40 health professionals in Wales and measured their wellbeing prior to this using the Warwick Edinburgh Mental Wellbeing Scale, and found that doctors in particular initially had very low wellbeing, but six months after attending the positive mental training workshop they were back to normal. Then in 2011 we researched into depressive thinking with McGill University, Montreal, and found that a 10-minute audio track using a positive reappraisal recording as described above rapidly raised the level of positive emotions in depressed students. We also did a study at Kings College looking at cost effectiveness. The cost-efficacy of positive mental training was particularly large in patients with a severe depression at baseline who actually ended up with a better quality of life than non-depressed patients, a true transformation. All these papers are on www.foundationforpositivementalhealth.com/papers.

This is not face-to-face therapy or drug therapy, so if someone wants those, I wouldn’t suggest this approach. Nor is it helpful for bipolar disorder or schizophrenia. Of the estimated 70,000 people who have used positive mental training no-one has told us that they have been flooded with negative emotions. Occasionally though somebody will start to feel uneasy when they start to relax; in this case they are not ready to deal with their past memories. As with any form of therapy it can never be right to take someone into territory where they don’t want to go. But in our experience if a person isn’t ready they simply turn the CD off and don’t carry on with the programmes.

The course for professionals who want to understand these principles of recovery and start using positive mental training has been RCGP accredited. Since 2006 we estimate that 70,000 patients (judging by pack-sales and downloads) have been treated across the UK, mostly through GPs, but also nurses, CPNs, psychiatrists and mental health workers. It can also help GPs themselves with their own burnout – exhaustion, cynicism, depersonalisation – and loss of personal effectiveness.

NHS staff do need to have their positive emotions encouraged. But our government doesn’t do that, telling us instead that we need better governance and management systems. Yet as the population gets older and sicker it seems the NHS is destined to have relatively fewer resources. So no wonder doctors are feeling burned out and depressed! When did I last hear a politician or a manager say ‘most health service staff work really hard day in and day out in really difficult circumstances’? Though we don’t know how many of the GPs on our courses have used it, probably quite a lot have: in an anonymous online survey 9 out of 11 GPs were using it themselves. We also know that many (in follow up 50%) of the health service staff attending our one-day training courses use positive mental training for their own benefit. We are going to be developing an online version soon.

Dobbin A, Ross S, Philippe F. Re-appraisal of negative self-defining memories: the relationship to positive affect and specific memories in high and low levels of depressed mood. Under review for Memory.
Compassion in public health

Margaret Hannah
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Fellow, International Futures Forum

I’m a consultant in public health. When I got into public health medicine I found the step up to consultant from training was a big one: after six months I couldn’t understand why I was feeling so stressed. So I started to meditate, and I found the positive emotions elicited when I entered that calm space in my mind could help me tolerate and navigate the stresses and strains of being a senior doctor in our health service.

Introduction

Five years into my job as a consultant in public health I hit something of a wall. That’s not so unusual at consultant level, but my wall was about my practice itself. I though I had been trained to do something that would help the health of the population, but despite five years in post I didn’t seem to be making much difference. I’d been generating a lot of paper and reports about what we needed to do, to try to get services to realign towards priorities, but then I would look out of the window at my community – villages around Fife which used to have a lot of mining and industry, but don’t have any now. In the traditional public health sense they are very deprived places (though not in other ways that I’ll come to later). It was a very big wake-up call to face my ineffectiveness, but I didn’t want to carry on working like this for the next 20 years.

And so I started exploring other ways that public health might work. I wasn’t alone in that journey, and I want to acknowledge all the other people who’ve been influencing the way I think and work today. Firstly the International Futures Forum and Graham Leicester, who is my husband and a fairly influential person in my life(!), and other people working with me on what we have called the Fifth Wave of Public Health, Phil Hanlon, David Reilly in Glasgow, my colleagues in NHS Fife and people I’ve worked with in Ayrshire and Arran and at Robert Gordon University in Aberdeen.

The crisis and a thinking framework

Medicine obviously can’t go on like this, so where do we go next? This isn’t just a challenge for health systems, it’s probably so in every system we can think of today. We’ve reached the end of the road, we’re at the top right-hand corner of the exponential graph – so where will we go off the graph? Let me give you a bit of insight into thinking about this using the Three Horizons Framework.

Three Horizons (H1, H2 and H3) helps us think about our current situation while taking into account our aspirations for the future, helping us to navigate from one to the other. The diagram shows time along the bottom and the viability of our system along the other axis. In our current systems we are seeing increasing signs of synchronous failures that are putting great strain on the system as a whole (H1). Of course we keep trying to fix them, to keep this system going, to keep it as it is. However, there are some radically new ideas coming into the frame (H3) which are actually a much better fit for the emerging environment. And of course, because this is a cyclical process, at some point in the future they will become the new first horizon.
When you start to innovate (H2), spending time trying to fix this first horizon can become quite tiring if it’s already in failure mode. And in reality we’re already experiencing the law of diminishing returns and seeing its impact on expenditure. So we keep trying all sorts of new moves and targets and guidelines, but really they are not going to solve the big problems. Currently most innovations are directed to keeping H1 going. What we should be doing is innovating in ways that encourage the emergence of the third horizon while being careful not to throw the baby out with the bathwater. There are many good things in the current system which we will want to keep in the future.

In Fife, we have been asking people about their aspirations for the new system (H3). It can be hard to get that conversation going if you haven’t already prepared the ground a bit, but when people are relaxed we have found we can ask them what kind of health system they would like to be working in. Then you start hearing words like compassion and love, life, healing, recovery.

With Three Horizons thinking, all three horizons are present all the time; one dominates and the others are subordinate. In other words, somewhere in the world there are examples of our aspirational future already present even if they are small scale and on the margins of the existing system. So we asked our staff whether they had heard of any examples of healthcare where people were empowered and working in a relational way and had found pathways to recovery; somewhere that’s all about wellness and culture and values? That’s how in 2009 we heard about Southcentral Foundation in Alaska, and in 2010 we got a team over to tell us more.

Alaska’s indigenous people were there long before the United States of America was founded. Of course they were very much treated like other native people, and moved off their land. Russians took over Alaska first and brought many of advantages of our western culture: infections the locals hadn’t been exposed to before, alcohol they hadn’t tried before, and guns. So their culture was under attack. The Americans weren’t any better after they bought Alaska from Russia. For many years, it was the place where the US intelligence service listened in to Russia. As Sarah Palin told us, you can see Russia from her back garden.

Native culture was ripped to shreds by acute exposure to a very different culture. The Alaskans’ process of recovery has not just been about the health system but about them as a people and being true to their values. The federal government in the US had been funding their health and education systems, much like the NHS is funded by central government in the UK. But the locals negotiated to take over more and more of it. In fact over 25 years Alaskan Natives have taken many of their services back to their ownership. In particular South Central Foundation now owns and runs its whole healthcare system.

What has South Central Foundation done? Huge things. The buildings are reflective of an intentional design, traditional materials, a little herb garden, traditional healers alongside western medics. A consulting room is called a talking room, because 80% of your consultation is talking. Both seats are equal in size – you couldn’t tell who’s the doctor and who’s the patient, that’s intentional and the technology is kept to a minimum in that room so that nothing gets in the way of the conversation. The whole place is built on quality conversation – they don’t have many meetings but they have conversations all the time.

We were very inspired by that and came back determined to work this way with our own teams. The Alaskans taught us we had to shift the balance from control to participation. Most of the time if you’re very sick or unconscious or in great pain you’re not going to worry too much about the quality of relationship you have with your doctor, you just want to feel better. But 80% of our work now is low acuity, chronic, complex, difficult to treat and does not need the system to be controlling. It needs you to be in charge and making the decisions. But if there’s no one-size-fits-all answer to problems then we are going to have to find ways of co-working towards unique solutions for each person’s chronic health care problems.

Penny’s talk touched on the gift relationship, and the gift economy (see page 5). In healthcare I would say we can worry about money on the margins, but as soon as money gets to the foreground it starts to corrupt the process. Somehow we must keep it on the margins and nurture as much co-creative activity as possible. In that regard I don’t see my community as deprived anymore.
I’m the deprived one in not seeing that before. We’re realising that our local people already have many of the solutions themselves. So now I see my job in public health as being about helping them do more of that.

Why we need stories

So moving on to a couple of stories. Claire is an occupational therapist who’s been working on a project with me for three years now. She tells a story of working with a woman with Parkinson’s disease referred from a GP because she’s not managing mobility-wise and she’s really going downhill. Claire arrives at the house and the woman doesn’t want to engage. She is not interested, and it’s really hard for Claire to even get her foot across the threshold. She thinks ‘I recognise that painting on the wall’ – there was something on the wall that reminded her of when her kids were little. So she was able to connect with the woman by talking about her own kids and her own life, and to ask her what was interesting in her life. It turned out she’d been a great knitter. This was nothing to do with Parkinson’s, but it turned out she’d like to do knitting again. So she got a pattern for sweaters for dolls and started knitting. Then Claire said ‘what else do you like to do?’ ‘I like to bake.’ ‘I like to bake too, do you have any recipes?’ ‘Yes, I’ve got great recipes.’ Claire says ‘I’ll take those back to the hospital and we’ll bake them with the other clients’. Soon this woman is starting to be part of a network of people. And when Claire goes back and says ‘how are you doing?’ she says ‘Yeah I’m doing quite well, my friends say I’m walking taller and my husband thinks I’m less of a burden’. So she’s getting out more, though she was socio-phobic at the start of all this. Claire is from Ireland so she could talk for hours about all of this, though she was socio-phobic at the start of all this. Claire says this is how she does; that she can make a difference. She’s now the clinical lead of the project, and we’re really glad about that.

Evelyn is an assistant occupational therapist. She brought us the first case we did for this project: a woman who was a former head teacher of a primary school, who had poor eyesight, mobility and mood. She’d been in hospital and was back home and isolated. She didn’t like the sandwiches she had each day from Meals on Wheels, so Evelyn asked her what she would like, and she said ‘I’d love to go to Sainsbury’s’. So Evelyn worked with a local community transport person to get her round Sainsbury’s, which had had a new extension since she’d been three years ago, and the woman had a ball going up and down the aisles. Evelyn was so humbled by how the woman felt – she had described the experience as making her feel human again. I can’t tell you how hard it is to get to this point. That one story kept us going for six months, but we knew we were on to something. Claire says this is how she works now; and the teams say the same. They’re changing the conversations they have with old folk and finding unique solutions. So we’re growing in that direction.

The Kitbag

I want to talk about the Kitbag because it combines a number of psychotherapeutic insights with a community-centric design. It’s a conversation-making, storytelling tool, which includes elements of mindfulness, relationship practice, and creativity. We had to work with all sorts of designers to get it right.

The Kitbag provides a set of resources to encourage reflection, calm states of mind, creativity, self-help, dialogue, hope and a higher purpose in life. It contains three sets of cards. The first set called Presence provides mindfulness practices. The second set called Hope contains short quotes from people’s experiences of going through hard times. The third set called Transform provides simple exercises to work through during the course of everyday life to support personal growth. In addition, Kitbag contains a talking stick and egg timers to enable people to have balanced and respectful conversations, two small bottles of oil for calming and soothing, a colour chart, a CD with short musical tracks to explore feelings, and a set of beads for relieving stress.

Within the NHS, chaplains have been using the Kitbag to support families and staff during stressful times. It is being used in mental health teams to provide opportunities to share stories and unburden from the emotional demands of their work.

Dr Oz (the one on the Oprah Winfrey show) gave us a kind of parable based on how the heart works. The heart muscle has to be oxygenated before it can generate the power to circulate blood round the body. Dr Oz (who previously worked as a heart surgeon) pointed out that the coronary arteries come straight from the lungs, and that only during diastole when the heart is relaxed and before it contracts, can the heart muscle be fed its blood supply. Of course! How else could it work? Here’s the parallel: we are very clear that our staff have to be able to nourish themselves and do self-care if they’re going to be able to practice in tough times. And these are tough times. Remember what the airline safety videos tell us? In the event of an emergency put your own oxygen mask on first, before you try to help anyone else. So we created a mini-version of the Kitbag which simply contains Presence Cards and a one-minute egg timer has been distributed to over 300 NHS staff in Scotland for personal use.

We encourage our staff to take one minute of calmness before seeing a client. Not always possible, but we encourage it. And have you got a minute to really listen to the patient? It’s surprising what can be expressed in that short space of time. So that’s what the Kitbag’s presence cards are about. And the talking stick was inspired by the Alaskan tradition: in their meeting-circles only the person holding the stick gets to speak.
Wisdom and compassion: At the heart of Penny Brohn Cancer Care

Michael Connors
Acting CEO, Penny Brohn Cancer Care

This article reflects on my experience of working with clients using the Penny Brohn Whole Person Approach and its application to working with people affected by cancer. Compassion and wisdom are core aspects of the support at the very ‘heart’ of the work of Penny Brohn. In my opinion, this helps people find a way towards self-awareness, self-compassion, personal wisdom and greater resilience, and a way of living as well as they can with the often life-changing impacts of cancer.

Introduction

Compassion is rooted in the Latin verb *pati* meaning to suffer and the Latin com meaning to be with. In this paper, I define compassion as ‘empathic understanding and presence with suffering’.

This suffering can occur across all the interconnected parts that make us a whole person: the physical, the mental, the emotional and the spiritual/existential aspects of being human. I will explore how the whole person approach that Penny Brohn holds at the core of its services is the most compassionate approach to adopt with our clients’ suffering as this allows for all major concerns. This approach is offered with an ‘open heart’ – an attitude where the person’s individual experience is honored and their inner sense of themselves acknowledged and supported.

Wisdom is often associated with the intellect or insight; with ‘knowing’ or ‘seeing’ or in some way applying knowledge. However, there are also ways of understanding wisdom in terms of the body and of deep emotion. Definitions of wisdom can also be categorised as human or divine. And there are many views of what wisdom means in religious, spiritual and philosophical terms.

But for the purposes of my reflections in this article, I will define wisdom as ‘seeing, knowing and bringing into action that which brings us into human growth and development’. In a holistic context and in order to grow as a human being, we must therefore access many kinds of wisdom: mental/intellectual, feeling/emotional, the body and physical senses and the spiritual/existential dimension. The deep attention to ourselves that this calls for can be fostered by diverse practices that encourage attention: mindfulness, body work, psychotherapy, nature connection as examples. All are core aspects of our services at Penny Brohn Cancer Care. I will explore how this applies in practice towards the end of this article to illustrate how compassion and wisdom are at the heart of the unfolding capacity for moving towards holistic wellness.

Although being affected by cancer or any serious or life-threatening illness heralds a time of deep crisis, suffering and confusion for many people, it can also become a conscious life journey to be navigated; even a life changing experience to be integrated.

When Penny Brohn was diagnosed with breast cancer, her life changed, and she spent the rest of her days dedicated to the alleviation of the distress a cancer diagnosis puts people through. Realising that the holistic needs of people were not being met, she committed herself to developing the sorts of services she felt were necessary.
needed to address this deficiency. The approach as it developed always held in view the person as being a ‘whole, greater than the sum of their parts’. Therefore, addressing the true impact of cancer required psychological, emotional, physical and spiritual/existential challenges to all be considered in order that development and growth in these areas could be supported and encouraged.

The services that have now developed from this approach at the centre include residential courses at our 26-bedroom national centre near Bristol. These services range from single day to five-day programmes. We also have a number of non-residential courses, such as weekly exercise and mindfulness drop-in groups in and other self-help courses focusing on specific support or techniques that help a person to live well.

The holistic impact of cancer

Over the 34 years that the centre has been helping people we have developed a range of interventions and ways of offering support. Our courses explore the impact of the cancer and treatment and provide support, guidance and self-help tools to help alleviate some of these. Where required we can offer one-to-one interventions and support as well.

There is a model (below) that we use to help people explore the impact cancer has on them. The client will be able to look at each section and assess the current and ongoing impacts in each area.

A tool to help begin assessing the impact of cancer

```
Impact on whole person
   Person
   Relationships
   Purpose and meaning
   Spiritual/finances/welfare
   Psychological
   Emotions
   Physical
```

The impact we find varies from person to person in a unique mix. For instance when we look at purpose and meaning it may be that for one client this is an area of very deep impact, while for another this aspect seems to have very little impact at this time. The clients measure their concerns so that their highest concerns can be seen more easily.

The suffering that people experience is of course unique to each person – an individual complex mix of all these practical, psychological, physical, emotional and spiritual/existential concerns. The tool supports systematic self-reflection, and it is a process that I believe encourages a client’s self-compassion and opens the person to begin further self-exploration that may lead them to find their emerging holistic wisdom.

I believe the understanding, knowledge and experience we have gathered over many years, and which we hold together at Penny Brohn helps sustain our capacity for compassion. It has also informed the model of whole person support we use in our approach. This model is called the Penny Brohn Whole Person Approach (PBWPA).

The Penny Brohn whole person approach

Within the PBWPA we have created a range of key interventions and support. They include exercise and nutrition information, psychological and emotional support (both in facilitated groups and/or one-to-one counselling/psychotherapy) stress reduction through mindfulness, meditation and visualisation practices, and reflection on purpose, meaning and transformational change.

The journey with cancer

Each person’s journey with cancer is also a unique experience. But on that journey there are certain key points where the impact may feel greater.

• For some cancer is a single episode. The person experiences diagnosis, treatment, a post-treatment phase, and then lives without recurrence.
• For many others there is a recurrence. The person experiences a recurrence with further treatment, then lives on with or beyond cancer
• For others the recurrence or ongoing recurrences is/are ‘incurable’. Palliative treatment might then be given, and the person continues living with cancer in what is often termed the palliative stage.

As advocates for the whole person approach, we aim to accompany people on their journey, not just for short interventions, but to offer ongoing support. This long-term contact has become a core element of our service. An openness to following a person’s individual, unique story of concerns calls for a deeply compassionate
process. By not dismissing, denying or glossing over the impact, we hope that all who work at Penny Brohn create opportunities for people to fully engage with their experience, and so find the deep emerging wisdom needed to live as well as they can.

The team at PBCC offers time, space, acceptance and care. Together with the client we hold a deep understanding of the challenges faced during the journey with cancer. Between us we are able to offer relevant information, valuable tools and the kind of support that can help those who come to PBCC to navigate their journey.

One of our main aims is to accept a person’s experience empathically and through this allow that person to find their own sense of self compassion. Beside this we also encourage our clients’ to trust their own inner wisdom in the expectation that it will guide them on their journey.

At PBCC compassion and openness to personal wisdom are core values. And I believe they are necessary attitudes for those who aim to help someone live as well as they can with the complex impacts of living with cancer.

While always holding the needs of the whole person at the centre of our services we also acknowledge that when a person is affected by cancer it impacts not only on their own experience but also affects their relationships and their family, friends, loved ones, work colleagues and others.

‘Without suffering, you cannot grow. You cannot realise peace. An organic gardener needs garbage to transform into compost for her roses. We may need suffering to transform into insight, insight into non-duality, insight that leads to compassion.’ Thich Nhat Hanh

I have found this attention to the mind and deep emotions and to the body and the existential/soul/spirit aspects of being human allows the development of clear and integrated wisdom. Compassionate opening to the human heart makes space for shared understandings of what going through the complex challenges of the cancer journey can mean. In exploring this experience with others on similar paths, deep wisdom may be shared and learned from one to another. In my experience at Penny Brohn this openness to the depths of our human experience has facilitated the deepest questions of purpose and meaning and realms of spiritual understanding. Through engagement with these deeper places filled with meaning, purpose, soul and spirit, compassion and wisdom have arisen powerfully for the participants.

As each person is unique the changes offered by this wisdom and compassion will be individual and proportionate to them. Having faced the deep realities of cancer’s impact, the task of embodying this wisdom and living as well as one can must follow. Hence the change and transformation needed to move further into self-care.

We realise it is increasingly important that we find ways of ‘measuring’ impact and self-care effectively. Having carefully monitored so many clients’ concerns and wellbeing over time we do know that the impact of what we are doing at the centre has a broad range and depth. And we know too that we are making a significant difference to many people’s lives. Some very interesting and important impact measures which have emerged from a recent evaluation will inform our services well into the future.

**Self-compassion: caring for the carers**

Struggles with ‘burnout’ are a growing concern across the health and social care sectors. How best to look after ourselves as care-givers and offer ourselves self-compassion? These are questions of intense interest and importance at this time. I know myself that at the core of offering a space of care there lies a deep need to offer care and compassion to myself, and to acquire a wise knowing of the limits of my professional capacity to meet what sometimes can feel like an infinite need. I know there is a temptation to try and be ‘super human’, but also that such ambition is of course unsustainable. A healthy balance has to be struck between maintaining necessary standards of care quality and safety, while always preserving a place for the care-giver to be supported and to support themselves in their care-giving.

*When genuine compassion and wisdom come together, we honor, love, praise and include both ourselves and others. Instead of holding the ideal that we should be able to give endlessly with compassion for all beings “except me,” we find compassion for all beings including ourselves. The separation of self and others melts away. Then, like the sun rising, the strength of generosity and compassion will grow in our practice and we will discover it to be our true nature. (Kornfield, A Path with Heart, 1993)*

I believe the services we offer at Penny Brohn are deeply compassionate and encouraging of wisdom. Adopting a whole person approach can encompass the concerns and impacts experienced by clients and bring a compassionate understanding to this. I also hold that the adoption of a whole person approach is more likely to enable the client to find the necessary wisdom to bring about positive change and live as well as they may with the impacts of cancer.

For further information see our website www.pennybrohncancercare.org and to view our recent service evaluation report visit www.pennybrohncancercare.org/livingwell-fullreport

Penny Brohn Cancer Care has produced a range of Information Standard Accredited information sheets which are available at www.pennybrohncancercare.org information-sheets
Words and numbers: Servants or masters?

Caveats for holistic healthcare • Part I

David Zigmond

In my 45 years’ work as an NHS doctor I have witnessed undoubted yet paradoxical progress: the biomechanical has become massively more efficient, but often this has been at the expense of its human matrix – our personal connections and understandings. Computers have enabled information collation to an unprecedented degree. In the last two decades our healthcare has thus become dominated by a drive to turn all experiences and events into objective measurement, data and standardised, restricted language. This push to homogeneity and hegemony produces enormous, though unintended, consequences. This is the first of two articles profiling what I encounter.

Summary

Holism’s fuller engagement with realities is an aspiration and ideal. It can never be complete, and in practice there are many obstructions. These range from our use of language to our highly managed and industrialised culture. How does this happen? What are the consequences? This is the first of two articles. The second will be published in the next issue.

Prologue: caveats for holistic healthcare

Holism (and its lack) may be easier to recognise than define. It is more readily communicated and perceived by stories, rather than data or abstract formulations. This presents problems: holistic mindsets are now becoming harder to access and maintain, for our culture is now one that increasingly conceives and conveys in packages: food, fuel, news, entertainment, even thought are all likely to be coded, metered, monitored, measured or packed. This causes fewer problems when our encounters are with inanimate or less complex life forms: the production and distribution of eggs or detergents cause fewer ethical and social conundrums than the industrialisation of complex welfare activities (though even our simpler activities eventually confront us with wider ecological – ultimately Gaian – consequences).

We thus have an insoluble handicap. It is always easier to think in parts than wholes: language, analytical thinking, our micro and macro economies … all tend to fragment our perceptions and activities: ‘this is this, and that is that’. In contrast, holism’s tenet of infinite and often hidden interconnectedness tends to erase boundaries and conflate territories: ‘this is that as well as this’. Such thinking largely eludes schemes, packaging, academia, economic analyses. Our use of language, too, struggles to convey any sense of holism without serious loss or distortion.

The following two articles present a collage of notions illustrating, very partially, the extent of our difficulties and task. The notions themselves are presented without usual conventions of academic thoroughness or cohesion. The first article presents the skeleton of the view: the second provides further illustrations and variations. Overall, they represent some unsystematised, though summative, personal reflections from one practitioner’s decades of working in human healthcare – a chimeric and often paradoxical world. Philosophical contention is ever-present. We are accelerating our mandates for factory-like language and procedures to service increasingly complex healthcare: human nature and predicaments remain considerably more ambiguous.
I’ve got a measurement – it must be a fact

The rise of data and the curse of scientism

‘Nothing vast enters the lives of mortals without a curse’ Sophocles
(c. 496-405 BC)

There was life and technical success before computers, yet these are rapidly becoming harder to understand. Some examples: the manufacture of antibiotics, the D-day landings, man on the moon, Concorde – all of these were achieved with minuscule or no computer power – things we could not manage now in our ‘progress’. We have become empowered but deskilled: in healthcare, as we shall see, these subtle discrepancies lead to grievous losses.

Before the widespread use of computers, the harvesting and collation of measurements – data – was manual, labour-intensive and therefore slow. It thus required much deliberation and discrimination and – relative to today – its volume was tiny and consequently much more manageable.

The electronic unshackling of these activities has freed them from the constraints of our individual capacities for engagement, assimilation or understanding: data has multiplied exponentially and is now pumped and piped at us like gas or water – public commodities.

Measurement, the blood brother of data, has thus been conferred pre-eminent status in many humanly complex activities. Numbers are the most easily digested ‘food’ for computers, and computers are now essential to the functioning of any public service. Existence of people and their activities must be continually monitored and broadcast in a form that can ensure their organisational recognition, management and survival. The virtual world now defines and commands the real: measure or perish. Once started, this is difficult to slow or stop.

So, our institutions are now electronically held together by computers, computers need data, data needs statistics, statistics need measurements; ergo: measurement becomes the basic language and activity.

What does this mandatory measurement mean for healthcare? The consequences vary greatly with the type of activity. Sometimes the effect is facilitating and benign. For example, with activities that can be easily and directly measured, standardised and proceduralised: here the measurement culture can be applied with relative ease and evident benefit. Laboratory services, vaccinations and cataract extractions all serve as common examples. All have in common a clear, circumscribed physical basis, little variation in technique or human response and a high completion/success rate. In short, they can be easily humanly ‘mechanised’.

But much of healthcare does not offer this kind of simplicity for measurement, and then the effects often depart widely from the benign and facilitative. Measurements are at their most competent with physical objects or phenomena: a bloodcount is far less problematic or contentious than a mood-rating scale. This is because attempts to assess, measure and code other people’s experiences must be derived from something else: self-reports or other people’s perception being the commonest. All are subject to massive contention, contamination and compromise. What does this mean? Here are some personalised examples. (The doctors, patients and situations throughout this article are real but anonymised. The examples of doctors’ encounters will be relevant now to many other types of healthcare professionals, especially those working for the NHS or large corporations).

- Ms B is in dispute with the Department for Work and Pensions (DWP) over her Disability Living Allowance. Ms B claims severe symptoms and invalidity from depression, but her invalidity seems invalid to the DWP assessor: he asks the GP Dr F, for his opinion. Dr F in a complex but rapid judgement, agrees with the assessor. This ‘objective’ assessment is stymied by Ms B’s continually high self-reported, but quantified, depression scores. ‘Something’s wrong’ they all say in different ways. ‘Only the wearer knows where the shoe pinches’ says an old adage, but when is this untrue? Who decides? How?

- Kenny is 62-years-old, a single, lonely man, appeasing and self-deprecating in his manner. Harsh and neglectful parenting left him with impoverished self-esteem. A working lifetime as a road worker has crippled his lower body with degenerative arthritis. He left school at 14: his intelligence exceeds his words. After several years of courteous wariness he is, with Dr F’s gentle encouragement, beginning to talk of his burden of fear, loneliness, shame and longing. The ancient story behind it is poignant and powerful. Kenny has great faith in Dr F, but continues anguished in his small and crumbling world. Dr F asks for help from NHS psychological services, to help Kenny occupy his limited life more positively. Kenny returns to Dr F a fortnight later, fearful, tearful and trembling. He nervously indicates the immediate cause of his distress: a tightly stuffed, freshly opened envelope. It is from the psychology services. Dr F surveys several detailed questionnaires: ‘the service’, a complaints procedure and instructions for the service user. No one has spoken to him. In his frightened and faltering language Kenny conveys to Dr F his sense of bewildered humiliation and object inadequacy: ‘I don’t understand all this, doctor … I just can’t do it … I just want to talk to someone – like I do with you, doctor.’
The doctor remembers many years ago reading of Heisenberg, an early 20th century physicist. Heisenberg found that it was impossible to plot simultaneously the velocity and locus of an electron without changing these in an indeterminate way: the observation changed the reality. Dr F as a young man could not identify how this was relevant to his meagre knowledge of physics. Many years later he is seeing clearly how personal observation – when formulaic and non-bespoke – can adversely affect people, he knows well.

Philip is 86 and Dr F is visiting him at home, the week after his discharge from hospital. He had taken a first-ever overdose of his medication to end his life. An earlier than expected visit from his carer had found him collapsed and vomiting.

Philip now looks tired and Dr F again senses immense melancholia beneath the mask of rigid discipline, of understatement. The doctor knows some of Philip’s recent trials and sorrow: his wife’s grieving and fatal malignant illness, followed rapidly by the sudden death of his beloved son, their only child. And then the increasing impoverishment of his own Parkinson’s Disease, a gathering bass note.

Dr F had premonitioned Philip’s trapped but mute anguish and its possible tragic fruition, and had asked for help from his mental health services. Their (non) engagement proceeded by asking Philip to fill in detailed mood and anxiety questionnaires. These indicated mild, stable disturbance – measurements meriting merely a brief psychological care package from a low intensity (skills?) worker, and a routine, templated report of all this, electronically conveyed to Dr F.

Dr F’s perception is discrepant. He shares his unease with Philip, whose intelligence and insight survive his ravages of grief: I don’t like to tell anyone my troubles, doctor … I wasn’t brought up like that. I have my pride, you know … It’s different with you. I’ve known you years, and I don’t have to say much, for you to understand. But answer all those questions for a stranger? No.’

Dr F thinks of Philip’s formative years: a barser, crueler, braver world of much greater trials, losses and endurance; a black-and-white world where contained and stoic fortitude was a social essential. Dr F understands this with few words, and Philip understands that he understands. But a questionnaire?

Yet Dr F now inhabits a professional world in thrall to designated experts who are keen to quickly code and quantify the distress of Philip and Kenny, as well as Dr F’s ministrations, and then to instruct them all. Dr F’s understanding can seem piecemeal, slow and never finished: features of the inter-subjective, one-person-and-situation-at-a-time.

By contrast the questionnaire has slick allure: its ‘objectivity’ may be specious, but it is quantifiable and can be given to all – a demotic science. Dr F is thinking of the distinction between the scientific and the scientific: which is which? He is thinking, too, beyond his own professional end: who then will be speaking to the Philips of the world, and what kind of conversations will they be?

* * * * *

I’ve got a word – it must be real
The trap of reification

‘In the Beginning was the Word’ – John, 1.1

Language does far more than merely ‘communicate’: words first contain, then command and control our experience, and then our influence of others. The implications of this for healthcare are subtle, powerful and rarely discussed. A brief linguistic analysis will help us understand these.

All words are there to package and convey a description of, or notion about, human experience. All ultimately come from our perceptions, then our constructions. The basic components of language are: adjectives, describing qualities of experience (what something is like); verbs, describing activity producing change (what something does); and nouns, which attempt to capture a more static state, a ‘something’, from which these other two emanate (what something ‘is’). For example, I describe a small vertical platform supported by four vertical supporting posts: someone comes and sits on it – it is a ‘chair’. Generally, we think such ‘real’ things endure and we attribute them by nouns: adjectives and verbs are more the flux of experience.

In our usual waking life this may present few problems, with nouns seamlessly providing apposite bridges and anchors for the rest of our sense-experience, and those of others. But potential dislocation is ever-present.

An example: I am at a friend’s table, eating an unfamiliar dish. I do not recognise the texture or flavour of the meat, although I enjoy both. I enquire what ‘it’ is.

1 I am told: ‘It is lamb’. I am mellow with appreciation for my sensations, my friend and the cosmos.

2 I am told: ‘It is Alginon, my ginger cat. She was very old and was dying anyway’. What is in my mouth now triggers an explosion of nausea and retching. I jump up with disgust and mistrust. My friend and the cosmos turned malign.

The ‘actual’ experience is transformed by the idea of the ‘real’ source-object (lamb v cat). This noun now determines my subsequent experience and action: the adjectives (pleasure or revulsion) and the verbs (sitting and eating v jumping up and retching). All this happens despite my never seeing the putative lamb or cat: they are abstractions rendered powerfully ‘real’ by the noun. Such is the power and gravitational force of nouns.

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Nouns work with greatest clarity and efficiency when applied to physical objects: the words ‘table’ or ‘television’ rarely cause problems except to a foreigner, a lawyer or certain kinds of academic. We generally accept these object-nouns as ‘real’. Elsewhere the use of nouns is more problematic and more interesting: God, democracy or love may sound like (sacred) ‘things’, yet are essentially variegated ideas. Innumerable stories from world or domestic histories show how little clarity and consensus the nouns manage here, yet how real they are to their believers.

There are striking analogies in healthcare. One working definition of medical diagnosis is the organisation, then transformation, of adjectives (a) and verbs (v) into professionally conferred nouns (n) which then determine explanation, therapeutic action and prediction for others. With affections that are predominantly physical – ‘structural pathology’ or disease – we can call this type of noun a ‘substantial diagnosis’. Here is a simple example.

- **Tommy is six. Last night be became listless (a), pushed away (v) his favourite supper; complained of soreness (a) in his throat and abdomen and then started to shiver and vomit (v). Dr Y is now with Tommy and his mother. His job is to find and then confer the right organising noun, or diagnosis. When he sees Tommy’s much enlarged, reddened tonsils, flecked with creamy pus, he has the precise constellated noun: ‘acute pustular tonsillitis’, though he thinks ‘tonsillitis’ sufficient for his verbal communications. The formulation and conveyance of this word are beneficial for all: Dr Y knows what to do and what to expect, Tommy will almost certainly get better, Mother is comforted by this and the containing, reassuring clarity of this noun – the substantial diagnosis. For all, this process is helpful and uncontentious: the doctor’s knowing and naming the ‘thing’ of tonsillitis is a co-operative and shared blessing. Importantly, Dr Y’s diagnosis also relieves the sufferers from having to search for their own explanation, meaning of, or influence on, events.**

In other areas of healthcare this hegemonic use of nouns runs into many more difficulties. This is particularly so where the doctor is dealing with bodily dysfunction (functional dis-ease) in the absence of the evident structural changes of bodily disease. Equal difficulties are encountered with disorders of behaviour, appetite, mood or impulse (BAMI): the core of psychiatry and clinical psychology. The results here are more mixed: our medical-noun type diagnosis may sometimes bring evident clarity and relief to these physically non-fixated forms of distress, but often it will not. Then the professionally conferred noun – the diagnosis – is conveyed, but the benefits do not follow. In these situations the diagnosis may be ‘correct’, but clarification, relief or prediction remain poor. The doctor has – by convention – done their job, but none of the participants are gratified. We can call this a ‘nominal diagnosis’. Here are two examples:

- **K, a tense, conscientious, sensitive woman of 26 has seen several doctors over several years with benign abdominal and bowel symptoms. All have agreed she has Irritable Bowel Syndrome (IBS) and prescribed the usual medications, always with little or transient effect. Dr T realises that a wider vocabulary is needed to differently understand and influence her complaints. In his endeavour to do this, he learns a lot about her unhappy childhood home and how this has led to her guarded perfectionism and her painful ambivalence about close relationships. The long-term effects of this widened dialogue and vocabulary were slowly gratifying for both K and her doctor. Here the conventional noun-diagnosis of IBS was relatively ineffective and – probably – obscuring or obstructing more helpful personal understanding: it thus proved to be a nominal diagnosis only. The idiomorphic understanding she developed with Dr T proved much more helpful.**

- **Maggie, 55 years, has collected a variety of diagnoses from her many years of faltering contact with psychiatrists and psychologists: generalised anxiety disorder, agoraphobia, panics, emotionally unstable personality disorder with cyclothymia, recurrent depressive disorder, bipolar affective disorder. All are documented in the usual formalised language of designatory healthcare which then rhetorically confine and define Maggie by nominal diagnoses. These conferred nouns may superficially appear to offer real therapeutic understanding, leverage and prediction, but actually do not. None have offered Dr V greater personal understanding of Maggie. Dr V decides to create a larger and different kind of space for Maggie to talk. This dramatically changes not only Dr V’s view and understanding of Maggie, but also Maggie’s behaviour: her symptoms become much quietened. How does this happen? Dr V wants to know Maggie’s story, not for a Management Plan, but so that he can better understand. Her story has obscurely disturbed her for decades and it will disturb Dr V now. Twenty-five years ago she was married – happily she thought – with three children. She experienced her husband as kind, attractive and funny, but a bit feckless: he drank a lot. She suddenly has unmistakable evidence of his alcoholicly hazed, repeated sexual contact with their ten-year-old daughter, Amanda. In a volcanic eruption of mixed and primitive feelings, her marriage and family are destroyed. Years later the ruined landscape of her life is still littered with explosives. She tells Dr V of a current torment: Amanda – now a tough, cynical, sexually alluring, drug-abusing, spiky 34-year-old single mother – has restored affectionate contact...**
with her father and his second wife, and takes her children to see them. Maggie’s feelings towards her daughter are raw, kaleidoscopic and irresolvable: ‘My mind goes crazy with it, doctor … She was only ten: I should have known, should have protected her: but she knew, and she knew that I didn’t know … She was a child, but was – I didn’t know then – a serious sexual rival. Now she is stronger and healthier than me, and has more of a family – mine is destroyed. I love her as a mother, but hate her for what she did, what she does, what they have all done: but can I blame her? … Has she triumphed over me? I feel crazy and terrible for having just said all that, doctor, yet it’s such a relief that I can say these things and that you can understand …’

Dr V has a bespoke and ongoing dialogue with Maggie about her tragic story and her responses to it. Her distress often exceeds her capacity for words, yet words and ideas are what they exchange and they are many: guilt, shame, loss, rage, hate, love, contrition, resentment, despair, despondency, alienation, disconnection, blame, humiliation, revenge, sorrow, defeat … All touch on part of Maggie’s poisoned cauldron, but only part, and only transiently. Maggie now talks less of her symptoms and Dr V does not much offer his vocabulary of diagnoses or treatments. As their language has changed, so has the nature of their exchange, and then the pattern of Maggie’s distress. Maggie, so long burdened and defined by her multi-diagnoses, is now freer to suffer with her unique and humanly-understood tragedy. Dr V, too, though distressed by her story, is also touched and, paradoxically, nourished by such candid and courageous contact – the staple of compassion.

Others have asked: what is ‘really’ wrong with Maggie? Is there a word: is it ‘depression’? What is the ‘correct treatment’?

* * *

‘Language is, by its very nature a communal thing: that is, it expresses never the exact thing, but a compromise – that which is common to you, me and everybody.’ Thomas Ernest Hulme (1923), Romanticism and Classical Speculations

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This article continues in Part II: If you want good personal healthcare see a vet, in the next issue of JHH.

Notes

Detailed questionnaires are now being vaunted and procedurised throughout most NHS psychology and counselling services. This is explained by authorities as making the services more scientifically efficient. This is contentious, at least. In this author’s view it leads to specious science, dehumanisation, and a healthcare cult of scientism. The obstructive and destructive effect of these is extensive and subtle. See my articles How to Help Harry (Zigmond 2012) and Sense and Sensibility (Zigmond 2011a) Both available online at www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.htm

Interested? Many articles exploring similar themes are available via David Zigmond’s home page on www.marco-learningsystems.com

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This pack can help you decide what to do when low back pain is a problem. The CD explains about back pain, and guides you through useful exercises for flexibility, strengthening and relaxation.

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To order any of these products go to www.bhma.org/pages/books-cds.php
I was recently fascinated by a medical article about advances in eye surgery. I have no special interest in either eye disease or surgery, or highly technical medicine, but the fact is I was intrigued by what has become possible. The article concerned treatment for vitreous haemorrhage – bleeding into the centre of the eye often leading to permanent loss of vision. Treatment options include krypton laser to coagulate abnormal blood vessels, injections into the eye of hyaluronidase (to dissolve blood clots) or anti-VEGF agents (inhibitors of vascular endothelial growth factor such as the monoclonal antibody named bevacizumab – Avantis). When the blood does not disperse naturally, it can often be surgically removed by vitrectomy with sometimes good results.

The many years of advanced laboratory research and technological development leading to these treatments is an astonishing monument to human achievement. Considering this, the estimated NHS cost of £3,600 for injections and subsequent vitrectomy for threatened sight in one eye seems very reasonable.

About 17 years ago I studied for a year with a professor of ethics in medicine. I remember asking him a question about science and morality. Between the 1950s and the 1990s he and I had both lived through a period of astonishing scientific and technological development. I wanted to know how it is that science manages to build on knowledge from each generation to the next, whereas in moral philosophy we are still struggling to apply the lessons of Homer, Euripides and Plato. I don’t remember the professor’s answer which I probably didn’t understand, but the question still nags at me. This is presumably why I was so intrigued by that article on eye surgery. The fact is that the epidemic of type 2 diabetes (and hence of its complications) is caused by obesity and this is a socially determined condition – a matter of choice.

Since 1981 when I first arrived in the town where I would practise as a GP for the next 30 years the high street was packed with shops, including a wide selection of fresh food retailers, and only one café. Like many other towns the high street is now dominated by fast food shops, cafés and restaurants. There is temptation every few metres. Of course, the shopkeepers are trying to make a living like the rest of us. They provide what people want. So what has changed? The answer is income inequality. Between 1979 and 1991 income inequality rose by 50% in the UK and 40% in the USA and has remained much the same since then. This approximately corresponded to the premierships of Margaret Thatcher, Ronald Reagan and George Bush Snr. These were unprecedented levels of inequality. Most other developed countries had smaller increases, especially Scandinavia and Japan. They have correspondingly lower levels of obesity and diabetes, and of many other health and social problems. The mediator between inequality and illness/social fracture is thought to be status anxiety working through consumerism. Francis Bacon (1561–1626) put it rather well: Money is like muck, not good except it be spread. (For more on inequality, see the review of The Spirit Level in this issue.)

So what is the answer to the question I put to the professor? Why does scientific knowledge accumulate to build the edifice of medical technology, while moral philosophy fails to guide our social arrangements? Perhaps the answer is that science is based on theories that have boundaries – bits of reality parcelled up so they can be piled up into a monument to our cleverness. Morality on the other hand is fundamentally about relationships – the space in-between – the glue. It’s the building or the monument or the edifice that the next generation sees and pays big money for, not the mortar. But without the mortar to ‘glue’ it together the building falls down.

...and we all fall down!

William House
Retired GP; Chair of the BIMA
The spirit level – why equality is better for everyone

Richard Wilkinson and Kate Pickett
Penguin, 2010 (revised edition with postscript)

In wealthy countries, the damage done by being poor is not so much about how little the poor have, but rather how much less the poor have compared with the rich. This is the stark message of this book. To many readers it may be new, even startling, but the evidence is now clear and compelling in this powerful and eloquent book – the first on this subject to reach a wide global readership.

Through many years of painstaking research they have accomplished this task. But is knowledge enough to enable change? The politicians know about this book and its message (gainayers are a dwindling minority), but they dare not make it a political issue. The fragile UK economy is too dependent on consumer spending – it needs the population to be in status anxiety to persuade us to spend more than we can afford. But of course the resulting debt, inequality and consequent health and social problems damage us and the economy. We are stuck in a vicious cycle. The authors state: ‘Political will is dependent on the development of a vision of a better society which is both achievable and inspiring’ (p271) This is true, but we cannot expect it from the politicians: it must come from the people.

This book is a landmark publication. It should be read by anyone concerned with health, society or economics. It is now up to us, the readers, to make the change happen. The BHMA supports The Equality Trust (www.equalitytrust.org.uk) which exists to raise awareness and promote action on inequality. It has nearly 10,000 followers on Twitter (@equalitytrust). If you care about this issue, please support the Trust in whatever way you can. The website provides options.

William House

Thomas Aquinas – a portrait

Denys Turner
Yale University Press, 2013

What on earth is a book on the mediaeval Catholic theologian Thomas Aquinas (1225–1274) doing in these holistic pages? That question wouldn’t arise so easily, would it, if he were a Buddhist sage or a Sufi philosopher?

But Thomas is arguably the most important of Christian theologians, bridging the classical philosophy of Augustine and Aristotle into modernity.

So put aside any understandable suspicion of Vatican politics, cover-ups, crusades, inquisitions and institutional dysfunctions. And remember the redemptive aspects of Christendom. This is especially relevant to those of us who are interested in integrative healthcare, because the roots of medicine, particularly western medicine, are precisely to be found in religious communities, monasteries, convents, abbeys and colleges of education. Let your mind visualise the herb gardens and cloisters. Remember that historically all European universities were religious communities. Recall that the arts of healing were nurtured in these religious settings.

There is comfort to be found in reviewing these deeper roots. They provide hope that in the lengthy winding paths of historical development, ultimately an integrative and holistic approach is not only the best but also inevitable. In appreciating our foundations in these religious communities, it is good surely to be on friendly terms with their key figures. Thomas Aquinas is a giant in this context.

Truth be told I could never cope with his writings. I could not read him. They are clothed in the style of mediaeval logic.
and philosophy, very dense, very particular, and not made for a mind such as mine.

So I welcome this accessible, engaging and eloquent book of Thomas’s life and philosophy by Denys Turner, Professor of Historical Theology at Yale University. He knows his subject so intimately that — following Einstein’s edict that the evidence of understanding is the ability to communicate clearly — he can explain Thomas’ twists and turns of subtle opinion and scholastic philosophy in a manner that is not only easily understood but also entertaining. More than that, Denys Turner has a lit to his prose style that is beautiful and elegant. I think perhaps this lit comes from his Irish background.

Turner also has a gift for metaphor. His explanation of Thomas’ understanding of the Christian trinity, God as one but also three, had me guffaw out loud. One in three, three in one, like a highway with some lanes going in one direction, other lanes going in the opposite direction, with a division down the centre. Three aspects but nevertheless a single highway, one in three and three in one.

I liked too his clear exposition of why Thomas in his theological work always started with an assertion of God’s presence and only later in the text addressed Christ or the Church, because for Thomas God is the source and the environment out of which all of the Christian story manifests. There is great clarity here that Thomas’s ‘God’ is an incomprehensible mystery, not some anthropocentric patriarchal projection. The more I read of Thomas’s God the more my mind kept ineluctably translating ‘God’ as ‘Tao’, the great ocean and flow, suffusing and permeating all that is.

Thomas’ understanding of the soul is also Taoist, deeply physical and body based. For him the soul is the life of the body and not some separate entity. This is at odds with how other Christian and Catholic parties may have demonised the body. So, for me, there is something very modern and integrative here, a body-centric approach that is part of a greater mystery. But the most powerful integrative element is Thomas’ simple acceptance that the mystery of deity, albeit a mystery, is nevertheless known and felt through its beneficence and love. Deity then is not some transcendent other reality but is a presence. More than just a presence it is friendly. This presence, this mystery, this ‘God’, wants us to know that we are its friend. Always there, always on our side.

This is the greatest good fortune that Thomas had. He experienced God as a friend and from his earliest years he felt loved by this friend. This was his definition of grace too. Grace is God’s friendship. And by all accounts Thomas himself, although a workaholic and compulsive writer, was also always available as a friend to his companions.

Now you may have no time for spirituality, religion and Christianity. You may have no time for Thomas’s Catholicism. But if you are looking into the roots of European medicine and its instinct to care and relieve suffering, its instinct too for rigour, it is not bad, is it, that one of its prime influencers be a man of love, experiencing that we live in a mystery that is also love.

William Bloom
Exercise prolongs life in cancer survivors

Research has already established that exercise prevents illness in already healthy people. But the medical world is only just beginning to realise how exercise benefits people with serious illnesses such as cancer. A new study headed by Kathleen Y. Wolin at Loyola University in Chicago has shown that physical activity extends the lives of male cancer survivors significantly.

Her study which extended over more than 20 years tracked men who had entered Harvard as undergraduates from 1916 to 1950. In 1988 the study identified 1,021 of them who had a cancer diagnosis. These men completed a questionnaire on their physical activities, estimating their levels of physical activity during the previous week — walking, stair climbing, sports, and recreation. The researchers followed up with a similar questionnaire in 1998. The team used the National Death Index to determine which of the men had died by the end of 2008. The mean age of these men was 71.3 years, and the mean age at cancer diagnosis was 66.0 years. 30% of them had prostate cancer. Even after adjusting for age, smoking, body mass index, family history and diet, the most active men had 48% the mortality of the most sedentary men, the study found that more physically active men were the less likely they were to die. Those who burned more than 12,600 kJ a week had half the risk for death as those who used less than 2100 kJ.

The research suggests that men with cancer should resume normal activity as soon as possible, and exercise regularly if they want to live longer. Even with a serious illness.


Yoga helps fatigue in breast cancer patients

Many people who have been ill won’t feel like exercising of course. In fact research shows that about one third of women with breast cancer feel fatigued even years after treatment. The problem though is that avoiding exercise reduces fitness and invites depression. Fortunately a recent yoga study offers hope. Janice Kiecolt-Glaser, professor of psychiatry at Ohio State University in Columbus thinks yoga might be a gentle way to get people moving. Her research showed that survivors of breast cancer participating in yoga reduce their inflammation and fatigue.

At the end of the 12-week study, the yoga group had significantly less fatigue than the control group, measured on the Multidimensional Fatigue Symptom Inventory—Short Form (MFSI-SF) (P = .002). These women also had significantly more vitality than the control group, biomarkers for inflammation were also significantly lower in the yoga group. Interestingly though, depression scores did not differ between the two groups.

The inflammation and fatigue findings are particularly important, because inflammation may increase the harm caused by cancer.

Lead author Janice Kiecolt-Glaser; professor of psychiatry at Ohio State University in Columbus, points out that yoga because it involves breathing and meditative elements, may have the added benefit of offering some buffering against stress.


Chinese Medicine helps prevent diabetes?

A new study from the Tang Center for Herbal Medicine Research at the University of Chicago, Illinois could break new ground in diabetes management by using herbal medicine alone or as an adjuvant to current conventional medicines. The results of research, published online in the Journal of Clinical Endocrinology & Metabolism, showed that a combination of 10 Chinese medicinal herbs in a capsule, known as Tianqi, reduced progression to type 2 diabetes in people with impaired glucose tolerance (IGT). In this randomized controlled trial (which was performed in China) Chinese herbal medicine compared well to pharmaceuticals in reducing progression to type 2 diabetes. The results seen with Tianqi were similar to those found with acarbose, at 25%, and metformin, at 31%.


Which doctors are most burned out?

Doctor burnout continues to be of international concern. In a 2013 report from the USA, characterised burnout as ‘a loss of enthusiasm for work; feelings of cynicism, and a low sense of personal accomplishment’. 39.8% of all doctors who responded to this Medscape Physician Lifestyle Survey said they were burned out. This rate varied depending on the specialty. These figures suggest US physicians suffer more burnout than other American workers, but possibly fewer than our own GPs. According to last year’s PULSE survey 43% (of the 1,800 GPs who responded) were at a very high risk of developing burnout. Partners and those working in deprived areas were particularly badly affected. 97% of the GPs revealed that they did not think they were positively influencing other people’s lives or accomplishing much in their role.