



## Special Interest Group for Philosophy and Ethics

# Suffering and the World's Religions: The Search for Meaning in Pain.

Rydal Hall, Ambleside, 2<sup>nd</sup> to 5<sup>th</sup> July 2007

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### Contributors:

Diana Brighouse: *Consultant in Pain Management and Psychotherapist, Southampton*

Sam Lebens: *PhD philosophy student. Leadership Training Co-ordinator at the Jewish Life Education Centre..*

The Rt Revd Michael Hare Duke: *Former Bishop of St Andrews*

Khaled Sultan: *Consultant Psychiatrist, Hull*

Jay Lakhani: *Physicist and Director of Religious Education Council of England and Wales, Director of Hindu Council UK*

Cindy Cooper: *Mindfulness teacher with the Centre for Mindfulness Research and Practice, University of Wales.*

Michael Bavidge: *Philosophy teacher, Newcastle-upon-Tyne*

Eileen Palmer: *Medical Director, West Cumbria Hospice at Home*

Ian Yellowlees: *Consultant in Pain Management, Melrose*

Caroline Waterstone: *Clinical Specialist Pain Physiotherapist, St.Albans*

Bernd Strathausen: *General Practitioner, Norfolk*

Michael Platt: *Consultant in Pain Management, London*

Natasha Curran: *Advanced pain trainee, London*

Rydal Hall in the Lake District was the magnificent setting for the seventh annual meeting of the British Pain Society Philosophy and Ethics Special Interest Group. It was a gathering of people with diverse attitudes to religion, but united in their commitment to searching for some sort of meaning in suffering which would help them and their patients to accept their pain and to find some positive way out of their situation. Paradoxes remained unresolved and comforting certainties were elusive, despite the excellence of the speakers' expositions and the depth and breadth of the discussions which followed. (Not all of these were recorded, nor of course any of the informal conversations which are such a vital part of these meetings). It is to be hoped, however, that the reader will find much in these pages to guide them in their own personal search.

The second part of the meeting was devoted to examination of the purpose of and direction for pain services in the new century. So much can be achieved at the primary care level, especially in the prevention of chronicity, that pain clinics will be left with the most difficult problems where outcomes acceptable to a managerial ethos are difficult to quantify, but nevertheless involve those with the most desperate needs. This session identified an urgent need for clear direction and new thinking.

This report will also be available for download as a link to the Philosophy and Ethics SIG page on the British Pain Society website [www.britishpainsociety.org](http://www.britishpainsociety.org)

Requests for extra copies and enquiries regarding future activities of the Group to:  
Peter Wemyss-Gorman, Lyndhurst, Hickmans Lane, Lindfield, West Sussex RH16 2PX  
[peter.gorman@matmosonline.co.uk](mailto:peter.gorman@matmosonline.co.uk)

# Suffering and the World's Religions

## Introduction

Diana Brighouse

Suffering - physical or mental pain - is interpreted in different ways in different religious traditions. In Hinduism, Jainism and Buddhism suffering is the direct result of the actions, the karma of the person. In the Chinese tradition it arises as a result of an imbalance between Ying and Yang. For Judaism, Christianity and Islam there is a problem of trying to relate a loving God with the seemingly inevitable suffering in the world, which is seen as having been created good but which has become subject to suffering by humanity's disobedience. They look forward to an age when suffering no longer exists. Islam sees suffering as a test sent by God. I came across the following which you may think all the more interesting when you hear its provenance. "Suffering is something which is still wider than sickness, more complex and at the same time still more embedded in humanity itself. Insofar as the words suffering and pain can to a certain degree be used as synonyms, physical suffering is present when the body is hurting whereas moral suffering is the pain of the soul. The question of pain is one of a spiritual nature and not only is the psychological damage a pain which accompanies both moral and physical suffering, the vastness and many forms of suffering are certainly no less in number than the forms of physical suffering; but at the same time these many types of suffering seem less identified and less reachable by therapy." I thought this could well have been composed for a chronic pain clinic but were actually written by the late Pope.

Contemporary philosophers have written about utilitarianism and the question of ever being able to escape suffering altogether. An American philosopher has written "it is hard to underestimate the ramifications of the re-writing of the human genome as the millennium unfolds. The abolition of the biological substrates of suffering promises to mark a major discontinuity in the development of life on Earth. Our genetically enriched descendants may regard existence without pain and the abolition of suffering as the ethical foundation of any civilized society." I found the following in the Welcome foundation website: "At the beginning of the twenty-first century in Britain we have inherited this crossover in belief systems (she is talking about secularisation, loss of belief and materialism) perhaps at some cost to ourselves. If bodily pain is simply something to be alleviated at all costs then those that make it possible to bear it and suffer it with Christian fortitude have largely made their exit. And the sufferer is left with pain itself and a bottle of pills rather than an internal system of understanding to assuage it."

## From theology to action

### A Jewish response to pain and suffering

Samuel Levens

I'm going to present a Jewish approach – one of the things that is distinct about the Jewish religion is that even within our denomination of Orthodoxy there is this old adage that if you have two Jews you have three views. You see we have the Torah – the five books of Moses (the first five books of the Christian Bible) which we call the written Torah. We also believe that on Mount Sinai Moses was given what we call the oral Torah which was passed down from generation to generation and eventually written down in the first and second century, and then there is the continuing literature and commentaries written on that which is called the Talmud. The thing about this is that it was written so late after we believe it was given that it already has within it disagreements: it doesn't tell you what the Jewish law *is*; it tells you what the arguments are. So this really is just a Jewish approach (amongst many others).

The classic problem is that monotheism believes in an omnipotent God who is also omnibenevolent and loving but we have to accept the existence of pain and suffering in the world, which seems an inconsistent triad, and belief in God seems incompatible with pain and suffering. There are many classical responses to this. One is the sort of blind suggestion that there is no such thing as evil, which we see in the work of Maimonides and some Christian thinkers such as Aquinas and Augustine: there is no such thing as pain – pain and suffering are a privation of good, just as there is no such thing as darkness which is just a lack of light. So we can't blame God as God didn't create it: if you have to blame anything it has to be human agency - the so-called freewill defence. All of these things exist in Jewish thought; just like the idea that one day the Messiah will come and save the world and we will see at the end of time that all pain was really worthwhile (known as eschatological verification). But I want to suggest that that's not the mainstream in Jewish thought.

I'm going to start with a French bishop called Irenaeus. His basic idea is that pain and suffering are redemptive and that when a human being goes through pain and suffering they become a better person. John Hicks (a Birmingham philosopher) writes that we shouldn't judge the world according to how comfortable it is and how pleasurable our lives are but rather that we should understand what the function of the world is: its purpose is to make people great – it is a “vale of soul-making.” He says “By the pain of this world we become better people”. C.S. Lewis puts it beautifully: “We are but blocks of stone out of which the sculptor carves the forms of men; every blow of the chisel, though they hurt us so much, are what makes us perfect.” This may bring a lot of comfort to those who suffer. Martin Luther King in his “I have a dream” speech exhorted his followers to work with the faith that unearned suffering is redemptive, and the idea is central to Christian thinking that God incarnate suffered on behalf of his people and that we are redeemed through the suffering of Jesus. His obviously isn't a Jewish view but it is close to what I am going to suggest we find in Jewish sources but the difference is this: according to these it isn't pain and suffering but our *battle against* pain and suffering, and our struggle to finally eradicate it, that makes us perfect. Pain itself is just bad and there is nothing good about it.

Noah is the only person in the whole of the Bible to be called righteous; in Genesis he is described as “a man of righteousness and whole heart [who] walked with God.” Neither Abraham nor Moses nor any of the prophets are called righteous. As we shall see the Rabbis and the Torah always twist things round so if the Bible says someone was righteous they are bound to say he was an absolute scoundrel! The famous Jewish biblical commentator Rashi who lived in France and Germany in the 1000s says: look at the verse carefully - it says Noah was righteous *in his generation*; he was an awful generation, so to be righteous in it was very difficult, so for Noah to rise above it was a great thing. But it might be said that to be righteous in that generation wasn't all that difficult – if he was only viewed as righteous in comparison to the rest – he may have been only a little better than the rest of them – and if he had lived in the generation of Abraham he would have been considered as nothing. Rashi didn't pick Abraham for nothing: there is a Rabbinic tradition of comparing Noah and Abraham which comes out with Abraham on top. Why should this be? Abraham was confronted with something you could compare to a nuclear holocaust: God had told him

that he was going to wipe the cities of Sodom and Gomorrah from the face of the Earth. Straightaway Abraham complains “will you really sweep away the righteous with the wicked? Perhaps there are 50 righteous people in the city – will you sweep them away? Far be it from you to destroy the righteous with the wicked – shall not the judge of all the earth do justly? “ Abraham stands up to God in the face of what he deems to be injustice. God says there aren’t 50 righteous people in Gomorrah so Abraham says what about 45? God says no – what about 30 – no – 20 – no... and finally Abraham gives up at 10. So Abraham is seen as better than Noah, who just builds his ark when he is told the world is going to be destroyed; but he stands up and complains. The trend continues with Moses. He was told that when the Jewish people are to wiped out after making the Golden Calf not to worry as his children will survive and become the new Children of Israel – but he wasn’t pleased with this and rather than regarding it as an honour he complains and says to God “if that’s what you want to do blot me out of your book – I want no part of your religion or your world if you want to wipe out the entire Jewish people even though they are sinners.”

So to compare all three characters let’s look at it carefully. The Zohar, which represents the birth of Jewish mysticism in the twelfth century, is the central cabalistic text. But not all of it is mystical and it leans heavily on Rabbinic sources and all of the people it quotes are from the first and second centuries. It says Abraham drew near and said “will you also destroy the righteous with the wicked?” Rabbi Yehuda says on this “who has seen a father as compassionate as Abraham? Come and see.” Regarding Noah, it is stated: “and god said to Noah the end of all flesh is come before me and behold I will destroy them from the Earth. Make yourself an Ark of Gopher wood.” And Noah held his peace and said nothing, neither did he intercede.” And Rashi says that Abraham is greater than Noah because he interceded when Noah failed to do so. But the Zohar goes on; Rabbi Eliezer says even Abraham’s actions can be criticized as he pleaded earnestly for the righteous not to perish but stopped at ten without concluding with a prayer for mercy for all people – as if he doesn’t want to be seen to be trying to push God too much. The Zohar sees this as a bad example: the perfect example is seen as Moses, who as soon as the Holy One said to him “they have quickly gone off course ; they have made a golden calf and have worshipped it,” straightaway Moses beseeched God, concluding with the words “and if not, blot me out of the book you have written”, and although the whole people had sinned and there was not one righteous person, and Moses knew he wasn’t pleading for the righteous, he did not stir from his place until God said “I have pardoned according to your word.” Abraham was inferior in that respect as he only asked for mercy for the righteous, “and there was never a man so sure who walked in his generation as Moses the faithful shepherd”. So Moses did something great by standing up to God.

This is quite a radical religious idea. The Concise Oxford Dictionary of World Religions defies Islam as “entering into a condition of peace and security with God through allegiance or surrender to him” so perhaps the Islamic world vision is one of peace with God. The words “Jewish” and Judaism” are not names we gave ourselves. We traditionally called ourselves Israelites, and I want to look at the origin of the name Israel. Jacob wrestles with an angel all night – a very beautiful image in the book of Genesis – at the end of which the angel says “your name shall be no longer Jacob but Israel: he has striven with God and with man and has prevailed.” Israel literally means to struggle with God, so to be Jewish is to be in a wrestling match with God – not to accept divine justice but to fight against it.

The Talmud presents a really beautiful debate between Rabbi Akiva who was the Rabbi par excellence of the Talmud and Tineus Rufus who was a Roman governor of Israel just before the destruction of the Temple. Rufus says to the Rabbi “if your God loves the poor why does He not provide for them?” – the classical question: if God loves people why does he allow them to suffer? Rabbi Akiva replies: “So that we may be saved through them from the punishment of Gehenna (a sort of temporary hell – we don’t believe in eternal damnation in Judaism) – poor people exist so that we might make them no longer poor.” Rufus says “that’s ridiculous – God made them poor – if you fight against that you’ll be fighting against God”. Karl Marx called religion the opiate of the masses because it convinces the poor that they should be poor and the workers remain workers because it’s the divine will. Tineus Rufus says exactly this: it’s clear that your actions in trying to save people from poverty will condemn you to hell. “I’ll make this clear by a parable: A king of flesh and blood became angry with his slave and ordered him to be put in prison with neither food nor drink. A man went to the prison and gave him both – when the king hears of this will he not be angry with him? And after all you are no more than God’s slaves.” Rabbi Akiva’s reply is purposely

contradictory: "I will prove my point with another parable. A king became angry with his child and ordered him to be put in prison without food and drink. A man gave him food and drink – shall not the king reward him?" The only difference between the two parables is that in one it is a slave and the other a child, and the man is rewarded for an action of love. It seems difficult and contradictory that in Akiva's view, apparently we should help people that God is punishing; and we shall come to this again and look for a way of resolving this tension.

So there is this idea in Judaism that evil comes from God. In Christianity you have this idea of Lucifer, the fallen angel. In Judaism Satan is one of God's angels. Evil is just the name we give to those actions of God that we don't like; in Jewish thought it's quite right to call them evil. Some people have said there is no evil, but we say it comes from God but it's still evil and we're going to fight it. On our fast days we say "O God our father, our king, tear up the evil decree of our verdict" – God has passed the decree but it is nonetheless evil. The Rabbi said in the Ethics of our Fathers, another Talmudic text "The main thing isn't study, it is *action*". The Jewish identity is *active* in this struggle against evil: to feed the orphan, the widow and the hungry and to fight injustice. In another argument between Akiva and Rufus, Rufus asked which is better: what God made or what man made? - implying that it was the latter. "Here's the proof: here's some wheat and here's some bread; which would you rather eat? If God wanted babies to be circumcised, why didn't he just make them without a foreskin?" Akiva replied "if God wanted babies to be connected to their mothers by an umbilical cord perhaps we shouldn't cut it?" What he thinks is that – yes, the world is glorious and beautiful, but it is *inherently incomplete*. God made an incomplete world *on purpose*. Our task - the task of humanity – is to complete an incomplete world. So Rabbi Akiva accepts that it is God's fault that people suffer – he made a world in which people suffer and He is to blame – but it's our job to stand up to him, and this is the job he gave us. The Jewish mystics (the Kabbalists) even say that on Yom Kippur – the Day of Atonement – God asks us for forgiveness. God repents of having made an imperfect world.

But the moral life is a difficult life. It may be difficult to do the right thing. It's never good to hit your child but it may be right. In philosophy there is a debate between contradictory maxims, e.g. if you have to lie to save a life does the lie become good? Or do we sometimes have a duty to do something wrong? Is lying or hitting sometimes right although it's always bad to lie or hit? So God had to make an imperfect world, he finds it very upsetting and cries with us if we are in pain, and our job is to fight against the natural order. As to why he had to make an imperfect world, one answer to be found in works of theodicy is that God made the world to be good. To be good you have to give things to people; as he was alone he had to create others in order to sustain his goodness. Then he decided that an unearned gift is less worthy to the recipient than an earned one and God wanted to give the greatest gift that he could. Had he just made us and bestowed goodness upon us the goodness wouldn't have been as great as the goodness we earned. So in order for there to be a realm in which things are earnable he had to make a world in which there were still things to achieve – of necessity an imperfect world. This doesn't contradict the freewill argument as we perhaps have made the world less and less perfect. The doctrine of the Fall which informs much Christian theology implies that it's all man's fault (more woman's really!). The world was made perfect but they ate the apple and descended into this horrible realm. Interestingly the Rabbis place the eating of the apple on the sixth day - not on the eighth or ninth - on purpose as it puts the fall of man into part of the creation of the world. God meant to create a world in which Adam and Eve fell, and it wasn't their fault – pain and suffering weren't their fault. I think Catholics and Jews are rather similar in having been born with a guilt complex; but the Rabbis don't have the idea of a baby having been born into sin – we don't blame humanity ultimately for human suffering, we blame God and we fight with him. Nachmonides says we are quite justified in resenting God and should get angry with him.

Actually Jews don't talk about God very much – words such as omnipotence and omnibenevolence don't even exist in Hebrew. We talk much more about human action and what we should be doing – a characteristic response to a question about suffering would be "don't talk so much about God – just get on with relieving it." But this won't perhaps help the person struggling with his faith.

The Talmud reports an argument in the Rabbinic court about whether a certain oven was pure or impure and a voice comes from heaven saying "the law is this – it's impure" but the Rabbi retorts "the Torah is no longer in Heaven – you gave it to us – we say it's pure, and we are overruling God!" According to the bible Elijah never dies – he is taken up to heaven – which the Rabbis find useful as they can meet with him and sort things out.

The modern Hebrew word for a draw in football is an anagram of ‘we’ll leave it for Elijah to decide’ when he comes back one day, and the Rabbis use the word when they cannot resolve a dispute. When one of them meets Elijah he asks how the Holy One reacted to being overruled in the oven dispute and he replies “He laughed with joy ‘because my children have defeated me!’”

The Chief Rabbi, in a beautiful pamphlet entitled From Renewal to Responsibility (as well as in his book “To heal a fractured world”) has written: [addressing Karl Marx and his characterisation of religion as the opiate of the masses]

“Judaism is not a religion that reconciles us to the world. It was born as an act of protest against the great empires of the ancient world, Mesopotamia and Egypt, which did exactly what you accused all religions of doing – sanctifying hierarchy, justifying the rule of the strong over the weak, glorifying kings and pharaohs and keeping the masses in place. It was God who removed the chains of slavery from His people, not God who imposed them. It was Abraham, then Moses, then Amos, and then Isaiah, who fought on behalf of justice and human dignity – confronting priests and kings, even arguing with God Himself: "Shall the judge of all the earth not do justice?"

Opium of the people? Nothing was ever less an opiate than this religion of dissatisfaction with the status quo. When they asked Rabbi Chaim of Brisk what was the role of a Rabbi, without hesitation he replied: "To redress the grievances of those who are abandoned and alone, to protect the dignity of the poor, and to save the oppressed from the hands of his oppressor." When they asked Albert Einstein what his identity meant to him, he answered, "The pursuit of knowledge for its own sake, an almost fanatical love of justice, and the desire for personal independence – these are the features of the Jewish tradition which make me thank my stars that I belong to it."

Judaism is not the opium of the people. There are religions that transport the believer to his or her private heaven. Not Judaism, which is the impassioned, sustained desire to bring heaven down to earth. Until we have done this, there is work still to do.”

What I am trying to suggest is that the Jewish religious identity is quite radically different from what we naturally assume a Western religious identity to be. The homo religiosus stands in awe of the beauty of the world. The design argument for God’s existence says look how beautiful the world is: surely there must have been a maker for this? William Haley in his book Natural Theology likens this to stumbling upon a watch. “Look at all its parts: a cylindrical box containing a coiled elastic spring which in its endeavour to relax itself turns around the box... He basically says it’s clearly designed, but every manifestation of design which exists in the watch exists in the works of nature, except that they are greater and more beautiful in nature, so clearly there is a God. I want to suggest that Jewish religious faith is quite different from this: Rabbi Isaac in a book about legends (the Midrash) talks about Abraham stumbling across God – something very different from stumbling across a watch – “It can be likened to a man travelling from place to place when he saw a building in flames. ‘Is it possible that the building lacks an owner to look after it?’ he wondered. The owner of the building looked out and said ‘I am the owner of the building’. Similarly Abraham our father said ‘is it conceivable that the world is without a guide? The Holy One, Blessed be He, looked down from Heaven and said to him: ‘I am the guide, the sovereign of the universe.’ It is very strange that Abraham asked this question: ‘could there be no God?’ He saw a burning building – not a watch.” In his lecture on the occasion of the introduction to the National Gallery of a painting of the Temple in flames the Chief Rabbi talked about the image of Abraham being confronted with a burning palace.

“In the history of humanity’s attempts to understand itself two ideas and countless variations have prevailed: the first sees the miraculous intricacy of the natural world and concludes that there is a God – a design must have a designer, a creation a creator and a watch a watchmaker. It sees the palace that Abraham saw but it ignores the flames. The second sees the brutal randomness of the human world: the pain, the injustice, the oppression, and concludes that there is no God; there is only chance, necessity and natural selection and the inevitable cruelty of the strong

against the weak. It sees no building – it only sees the flames. Both views are coherent and each excludes the other: if God exists, there is no evil, and if evil exists there is no God. But what if both exist? - order and chaos, God and evil, the palace and the flames? That is an almost unbearable contradiction but it was in this contradiction that Judaism was born. So said the sages talking about Abraham but surely were also talking about themselves in the wake of the destruction of the second Temple. I made the world, says God, and men have set it on fire. I call upon you, Abraham, and your children throughout the ages, to put out the flames and restore the palace.”

That is the Jewish story. The only point at which I disagree with the Chief Rabbi is when he says that man put the building on fire. I am suggesting that other sources may be even more radical in suggesting that man may have stoked the flames but God initiated the fire.

To end with I would like to quote Reish Lakish, one of the great Rabbis who lived just after the destruction of the Temple - something that Jewish doctors like to read:

“The Holy One, blessed be He, afflicts not his people before He has prepared a cure for them in advance”

What it means is that for every ailment that exists, there exists a cure; it may not have been found yet but the onus is on us to keep searching. When you see a watch and you are awed by it there is a temptation to keep marvelling. When you believe, in the words of Martin Luther King, that unearned pain and suffering are redemptive, perhaps you'll sit by and allow yourself to suffer nobly, and will be reconciled to your loss. But Judaism was born in a struggle against God. It says that suffering is unfair and we must struggle to alleviate it; that's why I subtitled this talk from theology to action .

## Discussion

*In the light of your contention that we must never stop looking for new ways of preventing suffering, what is the Jewish view on stem cell research and genetic testing?*

The Rabbinic authorities have been unclear to date on this issue, which is rare. But Jewish orthodoxy is surprisingly permissive even on abortion: a baby can be aborted even up to birth to prevent certain amounts of suffering by the mother – not just her death – so for us, anything from a Zygote to an unborn bay has less sanctity than a fully developed human being capable of intellectual suffering. So as our mission is to prevent suffering, not to engage in stem cell research would be wrong. We do believe that the body - be it unborn or dead at any time - is sacred, but over-riding that sanctity is the need to prevent suffering. It's about getting that balance right.

*What is the Jewish attitude to suicide?*

It is not permitted. To use a metaphor, if we are engaged in a struggle with God, suicide would be giving in and we have a duty to continue the struggle. We might look upon euthanasia more sympathetically but only in the circumstance of the ‘double effect’ of relieving pain at the end of life.

*If you can struggle with God and possibly prevail this implies that he is not omnipotent.*

There are various moves that could be made in response to this question. It has been suggested that it would be a lot less trouble if we just ditched this word omnipotence – after all it isn’t in our Bible – God is powerful; he’s the most powerful thing in the universe but he’s not *all* powerful and he wishes he could get rid of all the suffering, but he’s not powerful enough. Another move is towards the idea that God ‘hides his face’. In the book of Esther -

the only book in the Bible not to mention God – by the way Esther means hidden – the idea is that as man withdraws himself from God, God withdraws himself from man. For instance the answer to “where was God in the Holocaust” might be “He wasn’t looking”; as man turned his back on God He was forced to turn his back on man and could only weep for him.

I sometimes think we could replace the concept of an omniscient omnipotent transcendent God which came partly from Greek thought and which has made life difficult, with the older Jewish one of an essentially immanent God (as well as transcendent) – in other words panentheism. Partly as a result of the Holocaust experience it’s been hard for us to accept God’s immanence – that he is in touch with the world – and some of us have bought into this compromise that he needs to be immanent and will be immanent again.

Maimonides said that it was impossible to say anything meaningful about God, which is one reason why we don’t talk about him much. The Kabbalists brought in the idea of *tzimtzum*: that God is infinite but created a finite world and has to contract himself to fit in it – and if he isn’t omnipotent it’s only because of the necessity of fitting into a finite world. So we don’t talk about him much and are more concerned with what we should be doing. There are two realms of Jewish law, one concerned with man and man and the other with man and God, and we’re much more concerned with the former. I am happy to accept that talk about God is largely meaningless and I’m much more concerned with what will our faith inspire us to do. And even if it doesn’t make total sense, the idea that we’re fighting against the natural order is one that will inspire people to change the world for the better. There’s a growing idea within moral philosophy called moral fictionalism which suggests that things which aren’t true can still be useful, like the tooth fairy. This sounds very heretical but there were Rabbis in the Middle Ages saying much the same thing: we can never make head nor tail of theology and anything we say about God may not be strictly true but what really matters is the impact of what we’re saying on us as human beings – how we treat one another. So we say no to the idea that pain is divinely ordained – it is something we must fight against. There was a movement after the War in the USA called Reconstructionism which held that the Holocaust proved that God didn’t exist but faith and religious practice could still go on even if their basis was not literally true. I am not a Reconstructionist (I believe in God), but I understand the move they’re making. We needn’t concentrate too much on God.

I ask this question: this theodicy may inspire us to try to prevent and relieve pain but does it help those who are going through the suffering? Of that I’m not so sure.

## A Christian perspective

‘The pain that is shared.’ Examining the confusions provoked by singing the wrong hymns!

Michael Hare Duke

Sam Lebans's talk on Judaism covered that conflicting triangle of God thought of as omnipotent, God as compassionate and God as just. One tends to rule out the other: where is the justice or the compassion in someone suffering if He is omnipotent? So we go round and round the mulberry bush in trying to achieve some kind of pastoral practice that helps us to alleviate suffering, work with people who suffer, and motivate ourselves to help. Take Alzheimer's sufferers: their identity has gone – you cannot give them anything which will help them relate to themselves. You're just left with someone in a psychogeriatric ward who can only endlessly repeat: “I want to go home....I want to go home....” – and there's nothing you can say to this. No religion, no prayer – nothing can resonate; there's just this sad lost person. If one confronts this but has no resources it is incredibly difficult to stay with the person and yet staying with them is the one thing that really matters: the being with someone who isn't there. So all the world religions are faced with the fact of pain and suffering from birth – as the New Testament says when a woman is in travail has sorrow because her hour is come – we are born in pain. We go through life and there are tears surrounding our death because it is loss – the letting go of many valued relationships and loss of those who are gathered round them. We start with tears and we end with tears. What sort of faith justifies this sort of existence?

In fact religion is socially useful partly because people have seen it as a way of dealing with guilt and sin (“we've earned this for ourselves”) and partly, because society has been suffering, as a form of social control. Whether it's putting people in prison or threatening the pains of hell – the mediaeval church's way of keeping people in line, as witness some of the words of the requiem masses which seem to be about what awaits us if we haven't got it right, and the depictions in mediaeval churches of the last judgement and separation of the sheep and the goats – all these are intended to make people behave better and society a better place. We also use this sort of thing politically as in the Cold War and Mutually Assured Destruction. But the increasing use of prison doesn't work as a deterrent at all; the preaching of hell didn't really make the mediaeval world a better place. The agreed anxiety about MAD didn't work as such until Gorbachev came along and seemed to move back to his old Orthodox roots and the value of human life and what we should do to all people: only then did MAD resonate.

When we try to look at this we find ourselves caught up in a series of popular myths as expressed in some hymns such as those written by Mrs Alexander, the wife of the Bishop of Dublin and the writer of There is a Green Hill Far Away. Her notion of the point of the Cross was “There was no other good enough to pay the price of sin. He only could unlock the gate of heaven and let us in.” Where is she coming from theologically – is it all about a God who needs to be satisfied, whose justice is a demand for recompense? As the Dean of St Albans said recently “what kind of a father is it who wants to be satisfied by pain – he must be a psychopathic character”.

There is another way of looking at the Incarnation: Irenaeus, the second Century Bishop of Lyon, said: “The Son of God became the Son of Man so that the sons of men could become the sons of God – it was a divine exchange; He made His home among us so that we might forever dwell in Him”, thus making possible a restored relationship – the broken covenant between man and God is thus restored, but not by paying a price.

Another potentially damaging hymn is Mrs Alexander's Christmas carol “Once in Royal David's City” where she clearly sees the point of the Incarnation as “Christian children all must be mild obedient, good as he”. This seems to tell us more about Mrs. Alexander's nursery in Dublin and how she would like it to be than the incarnate life! When I'm asked what I think Jesus was like as a child I think he almost certainly ripped his jeans. But this notion that “he died to make us good” ... it isn't about this; it's about holding a relationship and the suffering is not instrumental in this.

Another hymn which involves a considerable distortion of a better kind of Christian theology is “Happy are they, they that love God / whose hearts have Christ confess / who by his cross

have found their life, / and 'neath His yoke their rest." (Written in the 18<sup>th</sup> Century by Coffin and translated from the Latin by Robert Bridges.) It's important because social and historical effects set a context in which you want to say certain things; for instance the Lisbon earthquake of 1755 raised theological questions such as where was God when so many churches were destroyed – it makes Him seem rather inept even though it might have knocked out a few brothels. The hymn goes on: "sad were or lot, evil this earth, did not its sorrows prove / the path whereby the sheep may find the fold of Jesus' love": We come back to God through the pain. This doesn't really ring bells but perhaps when you've been living through the 1914-18 war and you're translating a hymn from the 18<sup>th</sup> century, you begin to ask yourself about Flanders and the first holocaust as it were of all those young men, and the same challenge arises "where was God?" as in the Holocaust. There is a story of some Jews in Auschwitz who staged a trial of God and eventually pronounced him guilty; then the senior rabbi said "and now it's time for prayer". The worship, the transcendence is there as much as the struggling with the history and the facts.

So in all our religions we are trying to make sense of a God who is omnipotent, just and compassionate. And we need to know what is important for you as pain doctors. In taking away pain are you taking away opportunities for learning obedience? - spoiling it all: God set it up brilliantly and you come in and mess it! And what about all the modern interventions that are possible, be they anaesthetics or antibiotics, which upset the mathematical progress of life. Pneumonia used to be called the old man's friend because it ended life peacefully and in time and now they recover and are left with their Alzheimer's. I had an interesting discussion with my GP the other day; he was offering me not only the regular flu injection but also something to prevent pneumonia. I asked him if that wasn't closing off my options - like allowing me to go out before I become too difficult? He was slightly shocked by this! So much of our Christian thinking is infected with this sort of thing.

Cardinal Newman, in the Dream of Gerontius, wrote " O wisest love, which did in Adam fail, / shouldst strive afresh against the foe, / should strive and should prevail. / And that a higher gift than grace should flesh and blood refine; / Gods' presence and his very self, and essence all-divine. / Oh generous love, that he who smote in man for man the foe/ the double agony in man for man should undergo. / and in the garden secretly and on the cross on high, / should teach his brethren and inspire to suffer and to die." Are we looking at the death of Jesus as a kind of sharing, with humans being at one with him in some way? Certainly this was some of the thinking in the first world war when there was a hymn about people dying in the trenches and describing it as 'their lesser Calvary' .

We need stories to make unbearable things manageable. That seems to be the point about much theology. I have a friend Jock Sutherland who was director of the Tavistock at one time whose great thing was to say there's nothing so practical as a good theory to help us cope with the uncopable. But then the theory – the story – gets messed up. We take it on board as part of our background thinking and use it as a way of dealing with unbearable things; this applies to much of the content of the Old Testament. In Daphne Hampson's book After Christianity, she looks at that extraordinary story of Abraham and Isaac in which Abraham is prepared to prove how much he is devoted to the Lord God by sacrificing his child. She tells the story from the point of view of a feminist theologian in the voice of Sarah, the mother. When Abraham comes to take the child... "Sarah said 'a shrewd move – this God is no fool – it's her way of testing you. What did you say to her?' Abraham replied: 'I said nothing – I wanted God to know that I will obey him without question; whatever he commands' and Sarah threw up her hands in despair and said 'Abraham you are a bone-headed fool – what kind of God do you think you are dealing with? What kind of God would want you to kill your own son to prove how religious you are? Don't be so stupid – she is trying to teach you that you must challenge even the highest authority on questions of right and wrong. Argue with her – wrestle with her'. Sarah's words smacked to Abraham of blasphemy, and he went into the mountains with his son Isaac. Sarah said to God 'sister, you're playing with fire – he's too stupid to understand what you're up to. He won't listen to me and he won't challenge you. If you don't stop him he'll kill our precious son – is that what you want?'. And God said 'it's a long journey into the mountains – I'm hoping one of them will see sense.' And Sarah said 'like father, like son – you'll have to send an angel' and it came to pass as Sarah had foretold and the Angel of the Lord spoke to Abraham and told him not to kill his son, and Abraham sacrificed a ram as a burnt offering. And the angel spoke to Abraham the second time and told him his offspring would be as numerous as the stars in heaven and defeat all their enemies. And the angel spoke a third time and said 'because you were ready to kill your own son in the name

of your God you will be known as a great patriarch, and millions will follow your example and will believe in a jealous and demanding God; and they will willingly sacrifice their sons to his name and to his glory, and there will be bloodshed and slaughter in all corners of the earth.' And Abraham returned to his wife Sarah and said 'God is well pleased with me: I am to be a mighty patriarch'. Sarah said ..... nothing. But she took the garments of Abraham and Isaac which were stained with the blood of the ram and carried them to the river to be washed. And the river ran red with the blood of generations to come. And Sarah wept bitterly. And God came to Sarah at the water's edge and said 'my sister Sarah, do not weep. You were right. It will take time. Meanwhile hold firmly to what you know of me and speak it boldly. I am as you know me to be. Many generations will pass and a new understanding will come to the children of Abraham, but before then I will be misheard and misrepresented except by a few. You must keep my truth alive. So Sarah dried her eyes and sighed 'as if I didn't have enough to do...' "

We're faced with the facts of suffering – they challenge us. We have deployed our medical skills, our biochemistry , all sorts of ways of intervening and reducing the suffering and yet we haven't really come to terms with it. Is it something we ought to be seeing as character-building ("no gain without pain") – pushing on through the pain barrier in order that we might learn to live more obediently to God? Or is it something over which we must stand up and wrestle with the creator of this painful world. It isn't "then shall they know, all they that love Him, how all their pain is good". We must discover that we don't achieve things by our own pain or try to reconcile people to it by using it as a tool for social control. It is a way of learning to put aside wrong things and mistakes and instead become more human, more compassionate. It challenges us not to bear but to obviate – to take away.

## Discussion

*[Some of this was unfortunately inaudible on the recording. The following was in response to a contribution regarding the relative importance of quality and duration of life at its end ]*

I think most people in the modern world are sensitive to the idea that there are two kinds of axes, of sanctity of life and quality of life ( NICE have these peculiar algorithms for working these out) ;and I think that's why you get the 'double effect' doctrine at the end of life. The difference that religious faiths makes is that they are life affirming – they say that life has a purpose: David says in the Psalms "what is the point of killing me , God – can my rotting carcase praise you? – only while there is breath in my lungs can I sing your praises." You can only do a good action while you're alive. I don't think religious belief takes away quantity of life considerations; it just adds quite a lot more to prolonging life because it says today you might smile at someone and make them happy – you couldn't do that if you were dead. So it puts a bit more weight on prolonging life.

*Victor Frankl said you can survive anything, even Auschwitz, if your life has a purpose – ideally religious faith but any sort of purpose.*

*You need a faith position, be it only Atheism – the problem nowadays is that so many people have no faith position at all.*

People can't understand why bad things happen to them when "they've always led a decent life" and I think it's because we've built in this notion that pain is in some way about punishment . I don't believe in a God who says one day "we need some more arthritis!" We live in a world which is full of mischances and I don't believe there is a causal connection between your pain and your past life. Things happen.... like the tsunami – people ask how can you go on believing in a God who lets these things happen – but we live in a world where things happen and I don't think he planned them.

*But what do you say to people who are seeking comfort?*

What I would want to say is "whatever is happening, you haven't fallen out of the love of God." – and that's the important thing to think about.

*I can see how my Jewish faith would inspire me to fight against other peoples' pain but I don't know that it would comfort me if I were suffering: I don't think I would lose my faith but I don't think it would have a role in comforting me. So perhaps the answer lies as you say in convincing people that they are still 'more embedded in humanity', loved by God when they are in pain – perhaps this is where they can find comfort in faith.*

The love of God is the important thing: how one responds to it is a secondary question. The thought that I am held in the love of God: that I can affirm every night before I go to sleep.

*If our belief systems are to give us any comfort in suffering it is important to remember that faith is absolutely not certainty – it is uncertainty. It is certain that we will die - we hope without too much suffering – and will not reach the end of our lives without at least suffering the pain of loss – but you are saying the only certainty is that God stays with us through all this.*

## An Islamic perspective on Suffering

Khaled Sultan

I want to start with a true story of a famous scholar, a grandson of the Prophet Mohammed, (peace be upon him). He developed gangrene in his leg. His physician advised him to have his leg amputated if he was not to die. Of course at that time there was no anaesthesia and they could only make the patient drunk with wine. But for him wine was forbidden and even though it is permitted to breach religious law as a matter of necessity he refused it. So he agreed to have the operation – and putting his limb in boiling oil to prevent infection – while he was praying. He finished his prayer, looked round and asked “why didn’t you do it?” He had not been aware of the pain. There are lessons to be learnt from this story. Distraction is very important, but more than this there was this man’s relation with God and his state of mind during the operation.

There are many psychological factors that affect our perception of pain and our ability to cope with it. Peoples’ perception of their pain affects their suffering - the way we perceive and interpret it and what we think was the cause of it, whether or not it is curable, anxiety and depression; our thoughts and beliefs all affect the experience of pain. How we feel is less determined by events than by our interpretation of them.

What about Islamic behaviour and practice with regard to health? We are accountable and responsible for our bodies, so we are encouraged to look after them and our health and seek treatment when we are sick. We should not give up hope because to do so would deny the will of Allah and that will affect our experience of pain.

Research in Saudi Arabia among cancer patients showed that all the group accepted their fate of suffering and believed that it would lead to the expiation and reparation of their sins and elevation of their status before God. They believed that prayer and supplication were the main means of reducing their suffering. They all believed that their prognosis lay in the hands of Allah and accepted His will. They also believed in the importance of family support. It is very important in Islam to look after the elderly, especially one’s parents if they are suffering – indeed it is an obligation. This is considered as a duty second only to prayer.

In Islam suffering is believed to be both a means of expiation of our sins and a test from God. He gives pain to those He loves. With this belief someone suffering from cancer, for instance, instead of asking “why me?” and reflecting that they must be “bad”, to have this illness, will accept the illness and pain as a blessing from God because He tests those he loves. The Prophet Mohammed (peace be upon him) said that whenever God wills good for a person he subjects him or her to adversity. The history of prophets reveals that many of them suffered much; it was recorded that Mohammed himself underwent terrible suffering while he was dying. So if the Prophet, who was so close to God, suffered in this way, my suffering is nothing. Another implication of this is that it is all right to acknowledge and express our feelings of suffering.

Another important concept in Islam is the causation of all things by God. It is not bacteria that cause illness, it is Allah’s will. As scientists you ask me for proof. Take for instance two people sitting side by side or living under the same roof. One will catch severe flu, the other has nothing wrong despite exposure to the same virus. There is much we cannot explain other than that Allah has willed that one person should become ill and the other not. Another example: a man dies of cancer at the age of 50 while his father and mother are both still alive and well. And again, two people having the same treatment, say antidepressants or painkillers: one will respond well and the other not. From a scientific point of view there is evidence that our psychological wellbeing can affect our immune system; thus if I am living a happy life my immunity to infection will be strengthened. A lot of people can identify a stressful event in their lives shortly before developing a mouth ulcer, which could be interpreted as a due to a reduction of our immune system. Who controls our immune system? – it is in God’s hands.

There is a famous saying: “who causes your disease? The same one who accuses you cures”. The prophet Abraham stated in the Quran that if we become ill Allah will cure us.

It was narrated within Islamic study that on the Day of Judgement God will have a dialogue with his servants (that is us). Allah will say “Oh my servant, the son of Adam, I became sick and you didn’t visit me” and the servant will reply “O my God, how could you, the master of

the universe, become sick so I could visit you?" God replies: "My servant was sick and you didn't visit him; if you had visited him you would have found me with him". So God is with the sick person.

The Prophet Mohammed (peace be upon him) said "Whatever happens to a Muslim, any type of pain, however little, it will be all from God to expiate his sins".

In Islam you are not allowed to express your anger with God (although in other religions and cultures this can be acceptable) – you can be angry with anyone but not God. When you become sick you shouldn't feel angry with God but instead become patient and accepting of his will . The Prophet Mohammed (peace be upon him) says "Allah says if I test my servant and he becomes blind and he remains patient and says 'this is my fate' I will compensate him with paradise; if I test him and he is successful – he passes the exam – he will get the big reward: paradise."

We believe in Islam that if someone dies of cancer or in a road accident or with a lot of suffering he will be afforded the status of martyr. We believe that martyrs will go straight to paradise. If we visit someone with cancer we can tell him that if he dies he will be a martyr. Allah says "those who are patient will be rewarded."

It is also very important to give the sufferer hope. The Prophet says "if you visit a patient, give him hope of a healthy long life. By doing this you acknowledge that this will not change his fate and that he will live only until his life's end as written by God, but this will give them hope."

The patient's prayer is very important: we ask him to pray for us because during illness or suffering he will have a special status during that time – he is very close to God who will listen to his prayers. In Islam we don't have a moderator between us and God but we do seek someone in this holy state to pray for us. It's like when a boy wants something from his father but knows he has been naughty so he goes to his mother or his sister and asks them to ask his father. The Prophet (peace be upon him) said "When you visit a patient ask him to pray for you as his prayer will be equal to the prayer of angels."

Some people may interpret illness as a punishment from God. We have in Islam two concepts: hope and fear. We look for mercy and forgiveness from God but at the same time we fear Him – his punishment in hell fire.

For some bad people who have been cheating, deceiving or lying, pain and suffering could be a punishment or test from God. It could also be a reminder from God to come back and to make repentance.

To conclude: those who suffer most are not the most bad – indeed this is the opposite of the truth.

## Discussion:

*Nobody can be blamed for having cancer but what about something like HIV?*

If your illness is caused by someone else this may also be a test for you but you are accountable for your own actions. But if you repent and come back to God before your death he will accept it.

You must not ask "why me" when you suffer because this is a question of the Judgement of God – you must accept his judgment without question.

Not all Muslims have this knowledge and understanding of their religion so what I have been saying doesn't necessarily apply to them.

*If I visit someone who is dying should I try to give them hope that they are going to get better? – this doesn't seem realistic.*

As a physician you must be honest with your patient but as a visiting friend or family member your priority is to give hope.

## A Hindu perspective

### The problem of and resolution to the issue of Suffering

Jay Lakhani

Let us begin with a story. A devout and religious man went mountain climbing. He was climbing well until he slipped over the edge of a sheer cliff. But he managed to grab a root that was sticking out of the rocks. As he hung there for dear life he looked up at the sky and prayed: "Oh Lord please help your devout servant – I am struggling, I am suffering ..." A booming voice came out of the sky: "My son, worry not. Listen to me and just let go". The man said "are you sure My Lord?" and the voice again said "Yes – just listen to me and let go" The man hung there sweating for a while and then asked "Oh Lord, is there somebody else up there?"

This is a question that all theistic religions must face: if there is an almighty, all knowing, all compassionate God, why is there so much suffering in the world? I'm not here to put down any religion but simply to help put into perspective the contextual limitations of every religion. If we are human we must relate to our spiritual dimension through human lenses; it cannot be otherwise. We cannot simply jump out of ourselves and abstractly relate to spirituality. This is why for thousands of years mankind has developed a belief in a superhuman personality: someone who is not just compassionate but all-compassionate, not just powerful but all-powerful, not just knowledgeable but all-knowing. We then struggle to resolve the issue of suffering which is so clearly visible in the world. There doesn't seem to be an answer. The invention of such a super-personality comes with this baggage. We have to pay a price for it. So all world religions struggle to come up with an explanation, but when challenged, all fall short of the target because the end does not justify the means. It is as simple as that. Something seems to be wrong, but what? And why is it such an important issue?

What we are facing this century is not just strife in the name of religion but strife over the need to reconcile the religious oriented world view with the science oriented, rational world view. We no longer have the luxury of living in the Wittgenstein-ian 'schizophrenic universe' in which rationality can be switched off with religion, or religion can be switched off when it comes to rationality. What is putting a wedge between these two world views is the issue of suffering. Many people dislike religion for not being able to resolve the issue of suffering. How do we reconcile these vastly differing world views and yet arrive at a resolution to suffering?

To take Hinduism as an example: there is a misunderstanding that Hindus believe suffering is caused by the Law of Karma, paying a price for something bad we did in a previous life. This is actually a cop-out. This is not what Hinduism teaches. The Law of Karma simply states that all objects and events are complexly linked together by the law of causality. The law states that if something is set into motion, it will inevitably bear consequences that have to be borne. It is an impersonal law which doesn't need a God sitting in judgement, but makes us aware of our responsibilities. Every small or big thing we do has consequences. However when this law is misunderstood it can be seriously counterproductive. The worst example of this is in modern India itself. Rich, lavish weddings take place on the doorstep of poverty. Everyone is in beautiful clothes but as soon as you step outside, there is a girl in tatters. No-one pays much notice, 'they are paying the price for their Karma and we are reaping the benefits of our Karma.' This can best be called indifference *in the name of Karma*: it reflects misunderstanding the Law of Karma.

The law of Karma has two sides to it. On the positive side it makes one very responsible for everything one does but on the other side if the law of Karma is not properly understood it can turn to indifference to the suffering of others or even ones own suffering. This is often something that Hindus forget. It is easily misused by Western academics to explain the Hindu response to suffering.

Hindus have thought hard over the issue of suffering, and one of the offshoots of Hinduism, Buddhism, specifically addresses the issue of suffering here and now, rather than in the hereafter. There is no eschatology where God will sort things out and reward us in the future. Problems are here and now, and must be resolved in the here and now. It is the most pragmatic of religions, and does not invoke a God. Hindu terminology is slightly different from that of Buddhism but our analysis and resolution are the same. Hinduism concludes that what

we are searching for in the highest heavens, that which we personify as a super-being, is not sitting there but is very much here and now. The underpinning to everything including the material universe is essentially the *Spirit*. It is spirit that manifests itself as the physical universe and becomes more clearly visible in living things and is most transparently visible as men and women. What we have been searching for in the highest heaven is very much alive and sparkling in the eyes of every living thing. This is the conclusion of Hinduism. Everything we see is not just matter and its epiphenomenon. Matter is not the primary phenomenon. Matter is a secondary phenomenon, it is an epiphenomenon of something which is non-material (the spirit). This is the finding of quantum mechanics.

We are going to address the issue of suffering taking into account this esoteric approach of Hinduism. What we thought of as a super-personality called God is in fact a grand principle that underpins the whole of reality, and shows itself most clearly in human beings. Coming to the issue of suffering, we have to recognise that it is never an objective reality; it is always someone's suffering, and therefore invokes the idea of a subject. There are four areas where science begins to struggle: when dealing with the very small – at the quantum level; when we are dealing with the very large – at the cosmological level; at the level of complexity – of life itself; and when we try and explain the subject. Who is the subject who can make sense of the universe? Many scientists will say that what really amazes us is that we *can* make sense of the world.

Hindus divide suffering into three categories: physical, mental and spiritual suffering. Hinduism says physical suffering is not a form of evil, but our defence mechanism kicking in, like hunger which ensures survival, or withdrawing our finger from a fire. Pleasurable things help us survive; anything that threatens survival we classify as pain. So once again physical suffering is a price – or a tax – we pay for inhabiting a body.

The second and equally important category of suffering is mental. Medical science is doing a marvellous job in controlling or at least reducing physical suffering. But the concern is shifting towards the issue of mental suffering. The stress and tension we are forced to operate in the modern world leads to a great deal of mental stress. Why is there so much mental suffering? Desires keep mushrooming. We keep thinking: this is the final one – when I have fulfilled this I won't need anything more. The child thinks when I have finished school I will have done it: but then we must have a first class degree; then I must get a good job – then I must find a wife... Desires seem to go on and on; there is no end to them. And in a very naïve way we never stand back and take stock of all this; we do not realise that something is seriously wrong. What is it that creates these unfulfilled desires and causes so much distress? The answer is because we feel that we are incomplete, we feel there is something missing in our lives, which forces us to look around and try to fill the void in ourselves. But what are we lacking? *We are trying to find a resolution to something that is lacking within ourselves by searching in the external.* Hinduism offers a way out of this.

This brings us to the third category of suffering (very appropriately here in Wordsworth territory). This is called spiritual suffering. It becomes visible in the lives of the mystics – the mystic poets and the mystics of every religion. They seem to struggle to make sense of the human condition; and when we ask: what are they looking for? – the reply is that they are not looking to fulfil any desire, they are looking to break free from every bond that we can imagine: not only the physical bondage of the body but the mental bondage under which we operate. They are trying to manifest their inner divinity free from every limitation. This is what is meant by spiritual suffering.

But we might think that all this is just an intellectual exercise – it's all very beautiful and poetic but it doesn't work in practice. Can it really give us a practical way of overcoming suffering in our own lives? What is the pragmatic resolution to the issue of suffering? Remember we said right at the start that suffering is always someone's suffering. It is not an objective reality but invokes the idea of a subject. We had brought in the subject without really addressing the question of who is this subject. Hindus say that the subject is something which is neither physical nor mental. The way we classify ourselves is first by looking at the mirror and saying that is me; or we might be a bit cleverer and say : no, that's just my body, that is not me; I am made up of my mental mode, the intellectual mode in which I operate, that is me. We have a habit of linking ourselves with what we think we are: I am of this age, I am male, I know about this subject etc - rather than what we truly are. The resolution lies in recognising that we are essentially something different from the body and mind we use. We are essentially the spirit that percolates through the body and mind complex. In the process we pay a price, *and the price is suffering.* But using the body-mind complex is a two edged

sword, just as it gives rise to suffering it also gives rise to pleasures. The things that allow me to continue to exist in the body are seen as pleasurable, and the things that threaten this process are experienced as pain. We all feel that it is our God given right that we can experience pleasure and we are even told by some theologians that when we die we will end up in paradise where there is only pleasure. Now this may sound like a wonderful thing because all the suffering we undergo here will be compensated with an unlimited amount of pleasure in the here-after. With the slightest bit of insight we can immediately see that this cannot be true! Pleasure and pain are both relative concepts; in a way they define each other. If we did not have one the other could not exist either. If a tongue can enjoy sweets it has also be open to tasting bitterness. If we keep eating sweets all the time the things that are more sweet will be nice but those that are less sweet will begin to be seen as bitter. What spirituality claims as reward is not infinite pleasure but the transcending of both pleasure and pain so they no longer continue to infect us with desires for pleasure. The spirit is sticking a hand in a world where it doesn't belong (body and mind) and pays the price of experiencing both pleasure and pain. Physical suffering is the price it pays for ensuring that the body continues to survive. Mentally it pays a price because it is exposed to insatiable desires which continue to create mental stress. The only way out is to pull the spirit out of the body-mind realm and recognise itself as the spirit. Desires arise because we feel we are lacking in something. The only way out is to recognise oneself as the spirit, pristine and complete. Desires fall away. Unfulfilled desires are the source of mental stress and this is the only way of overcoming it. This is not a mere intellectual exercise: it is something to be experienced. The fact that our prophets experienced this is not good enough, we have to experience it for ourselves to resolve the human condition and to overcome physical and mental suffering. There is no other way out. This is called experiential religion. The idea that all our suffering will come to an end in the hereafter is seen by Hinduism as baby's prattle – if we are the spirit we must experience this for ourselves. This is the heart of experiential religion. Recognising ourselves as the spirit – as a spark of the divine – we will no longer feel that we are lacking in anything so mental desires disappear.

But many people – including many Hindus – may react: we thought we were good but surely not God – this is just too much! Let me use a story. A little boy goes to Hinduism class and learns whether we recognise it or not, whether we believe it or not, we are essentially divine - we are God! The boy thinks this is good stuff; he is in a different mood now. He has found out that he is God! He goes home and into the kitchen where his mother is cooking. He picks up the most expensive piece of crockery, and drops it. It breaks into a thousand pieces. The Hindu mother brown in colour turns pink, then turns red and raises her arm and approaches the boy. The boy says, 'Stop, do you know who I am? I went to the Hinduism class and learnt that whether I believe it or not I am God'. His Mummy says "Good; now my next question is who am I?" The boy has learnt his lines well and replies "believe it or not - you too are God!" "Good," says Mummy, "we are making progress. You are baby God and I am mummy God, now the third lesson in Hinduism is this: whenever you, the baby God goes around breaking plates mummy God has to do a special worship ceremony of the baby God and that is to turn him round and smack his bottom." Of course, she must not hit too hard or leave a mark else the Social Services God will arrive on to the scene!

I told this funny story at this point because the idea that you can only overcome suffering is by acknowledging your inner divinity may sound outlandish, arrogant and egocentric but it is nothing of the sort. In fact it abolishes your ego forever because now we no longer live in one body, it is we alone who live in everyone. We have now spread ourselves thin, living in every living being. Why be compassionate to other living things? Because we cannot help ourselves, we live in every living thing. The reason why I need to look after others is because I can't help myself. If someone is down and I lift them up I can't even call it charity – I am just helping myself – what's the big deal? This is the endearing aspect of Buddha that steals my heart. Even though I am a Hindu I am also a Buddhist. Buddha did not leave his palace to find a solution to *his* suffering. Again Christ did not die for himself. To see ourselves as part of whole of humanity – part of the whole living kingdom - this is spirituality. That is how Buddha started his journey. He was not looking for his own salvation; he was looking for a way out of suffering for the whole living kingdom. This compassion, this altruism was very evident from the start. How could he not achieve enlightenment? He was already plugged into it. A marvellous modern Hindu prophet has said: "If we seek our own salvation we will go to hell but if we seek the salvation of the rest of mankind then we have understood the meaning of spirituality."

So what are the practical aspects? Hinduism has always been a pluralistic religion and not a polytheistic religion. Different prophets – in different locations and at different times in history have tried to invoke and infuse spirituality in the society they lived in. The pathways they promoted ossified into different religions. All these pathways are valid. The pathways they promoted were different because they related to different needs of different societies in different times. This idea is called religious pluralism. It allows for a theistic approach in spirituality. For the majority of mankind relating to a super-personality this has been a wonderful way of relating to spirituality; it works, let it be. There are other religions like Buddhism and Jainism which use a non-theistic mode – let that be. There is a third approach which I promote strongly which says you can make spiritual progress even *in a non-religious mode*. Why be fixated on mere religious pathways for making spiritual progress? One can become spiritual through music, through art, through drama or through poetry – why do we confine spirituality to religious expression? Spirituality cannot be confined within religious boundaries.

This is what I promote at universities. “Are you looking for spirituality?” I ask the youngsters. It underpins everything. Every disciplined human endeavour in every field will reveal a spiritual dimension. Some modern scientists become very arrogant. They claim that science has answered all questions and the questions that are not answered yet will be answered in days to come. The only place left for God is in the gaps left by science. This is termed: “The God of the gaps.” I object, I say according to me the gaps are bigger than the brickwork! God is doing very well!

When science examines in detail the very small, the very complex, the very large or the subjective it begins to show its frayed edges. When at the heart of physical science we come across quantum mechanics – looking at the smaller than the small – conceptually science struggles. At the heart of neuroscience we see a struggle to explain consciousness. Coming to terms with the concept of life we come across complexification which defies the simplistic reductionist approach. The conceptual leap needed to come to terms with these issues are non-materialistic, for the lack of better terminology they can best be called spiritual in nature. We are not an epiphenomenon of matter, but something far superior, far more dynamic, far more fluid, that underpins reality: the *spirit*. Spirit becomes visible at the heart of every disciplined human endeavour. Mind you spirit does not appear on the periphery of science it appears at its heart!

So we say, full marks to the medical profession and allopathic medicine for reducing the physical suffering that mankind has undergone for thousands of years; we should never underestimate what a boon the medical profession has been. But suffering in this century has shifted to the mental realm. The resolution to the issue of mental suffering lies in the realm of the spirit.

But the real germ of this discussion is the issue of spiritual freedom. The spirit is trying to express itself through matter and mind – we are essentially quite different from that; hence this difficulty. Different religions use different ploys to come to terms with the issue of suffering. I am not here to say that the Hindu way is the best way; on the contrary I am saying as we are different with different starting points, we will view the issue of resolving suffering in our own uniquely different ways. Hinduism recognizes the validity of other methods of dealing with suffering. People or nations can only progress spiritually from where they are and not from where I am. There can be no one single prescription fit for everybody. This is not a patronising or compromising comment. We see different religions using different ways of addressing the issue of suffering: saying, for instance, in a way God is using different ways of testing us and in the process makes us stronger. Suffering is not a minor issue: the tears of joy we shed in a lifetime would fill a teaspoon while the tears of pain would fill a bucket! The only redeeming feature of suffering is that it continues to prod us, to push us to rethink our position. It forces us to dig deeper to find our essential nature. This is the only acceptable aspect to suffering. It is not a curse; it is a price we pay for the way things are. To put it simply, ‘this is the way the cookie crumbles.’

A final comment. This may sound very poetic but it carries the essence of what I have been presenting. We are not material beings aspiring to spirituality to improve our material status, as the atheists claim. Hinduism claims that we are *spiritual beings caught on a material journey*. But I am sure someone in this learned audience is going to ask me: “Why should this pristine spirit bother to go on this material journey where it undergoes physical and mental suffering? Why, oh why?” The answer to this blunt question is equally blunt. Hinduism gives an honest and candid answer, it says, “We don’t know.”

## Discussion

*I'm struck by the many similarities to Christianity.....*

Yes – sometimes when I present these ideas they sound very exotic and Hindu but they are nothing of the sort, these ideas are visible in other religions. For example this wonderful idea that you are a spark of the divine is very visible in Christianity too. Jesus asked “if you cannot love the brothers you can see, how will you love the father you cannot see?” This is pure Vedanta; it is at the heart of Hindu teaching. You find the same thing in Islam: “He is closer to you than your jugular vein”. The ability to reconcile various religious world views is necessary. One of the greatest problems in this century is fighting in the name of religion, and the only way we can overcome this is the idea at the heart of Hinduism called religious pluralism. I push this concept in the Religious Education Council of which I am a director. When they say “teach children to tolerate other religions” I point out that this is very poor use of language: ‘tolerate’ is like ‘giving others permission to exist’ – this is no good. So they now use: “respect other religions” but this is still not good enough. I suggest the need to assert, “That there can be many pathways for making spiritual progress, theistic, non-theistic as well as non-religious”. You might think this an easy thing to put into religious education but alas it is not so. I am put in my place; I am told in no uncertain terms pluralism is for you Hindus but not us Christians. The attitude of ‘respecting’ other religions hides apologetic exclusivism. It can be translated to mean: “I know I’m right - you’re wrong and going to hell but I’m not going to make a fuss about it.” This is actually what is meant by showing respect to other religions.

*There is a very old idea in Judaism that God first made a covenant with Noah which was for all human beings and then he made a particular covenant with the Jewish people, but that didn't exclude God making other covenants with other peoples. Lord Jacobovits said: "every nation is a chosen nation. The Jewish nation was chosen to bring the Bible to the world; the British nation might have been chosen to bring parliamentary democracy to the world!" And the idea is prevalent in Jewish mysticism that God is 'inside' everything - we are all part of the living God. Yet when the present Chief Rabbi wrote in his book, *The Dignity of Difference*, he said that Islam is the voice in which God speaks to the Muslim, Christianity the voice in which he speaks to the Christian, and Hinduism his voice to Hindus – an archetypal statement of religious pluralism for which he was chastised by most of world Jewry who felt threatened...*

I meet many Christians who admit to being religious pluralists, although they might not admit that publicly. I say to them: I’m not asking you to ditch your religion, but want you to simply recognise the contextual limitation in which it was presented then you will have no difficulty in appreciating pluralism. When the Prophet said I am the only way he was talking to his group of devotees – not to the whole of mankind for ever and ever. Every religion, including Hinduism, has its contextual and linguistic limitations. If you dig deep within your own faith you will come up with the correct way of relating to other faiths. Let me finish with a story. Two boys are playing together and start arguing about whose mummy is best in the world. They cannot come to any agreement and eventually come to blows. A wise man comes by and offers them a resolution. He says, “Assert that your mum is the best but then add two magic words at the end of this sentence. Say, ‘My mummy is best *for me*.’ ” We hope the theologians of world religion use the same language when describing their religions. They can say with all the love and devotion they possess, “My religion is best for me and my congregation but not necessarily for the rest of mankind.” If this was possible religions can once again become the cohesive force rather than a destructive force in society.

## Being with Suffering

A Buddhist view of Suffering, Wisdom and Compassion and what this means to me as a sufferer of chronic pain and a mindfulness teacher.

Cindy Cooper

I was asked to present the Buddhist view on pain and suffering, as “something to stimulate discussion” rather than a long technical dissertation. So I thought about what stimulated my own exploration of pain. Years ago I asked my Buddhist teacher how to work with my own chronic, un-relenting physical pain. Her answer was that she herself didn’t have much experience with physical pain, but that “Buddhas experience pain as bliss”. At the time I thought ‘What a totally outrageous statement!’ But it did make me stop and get curious. What on earth could it mean that pain could be experienced as bliss?? That question certainly has been the stimulus for my on-going explorations into what pain is and how I can work with it.

Buddhism is not just of historical or intellectual/philosophical interest. It is about the deliverance from suffering. It is entirely practical. It is about how we can deal with difficulties – pain – suffering in this life here and now. As the Buddha said: “All I teach is suffering and the deliverance from suffering”.

When Prince Shakyamuni (the Buddha to be) was born it was predicted that he would either become a great world leader or a great spiritual teacher. His father the King, wanting his son to follow in his footsteps and become a great king, decided to keep the prince in the palace, where he would want for nothing, thereby shielding him from all suffering in the outside world. He would therefore never have reason to become a holy man. However, when the Prince was a young man, he secretly slipped out of the palace. And for the first time he saw a sick person, a very old person, a corpse and finally a holy man. Overcome with the suffering of the world, Prince Shakyamuni decided to devote his life to finding the answer to universal suffering.

The Buddha (whose name simply means Enlightened One) vowed to find the answers in himself, and Buddhism teaches that we too must find the answers for ourselves, within ourselves. There is no God either to turn to or to blame. And we are not to take even the Buddha’s word as gospel truth. The only route to enlightenment is through self-knowledge and exploration of our own experience.

The foundation of the Buddha’s teaching is the Four Noble Truths, which, particularly for this audience, can be seen as the Statement of the problem (i.e. suffering), the Diagnosis, the Prognosis, and the Prescription.

The First Noble Truth – the Statement of the Problem - is simply that *there is suffering*. The First Noble Truth declares unflinchingly, straight out, that pain is inherent in life itself. The Sanskrit word for this is ‘Dukkha’ which means ‘unsatisfactoriness’. There is somehow something wrong with all of our experiences, whether they are joyful or painful or indifferent. There is ordinary suffering caused by the facts of birth, sickness, old age and death, which we all experience. And there is the additional suffering caused by change or impermanence – even the happy experiences change, and we are left with a sense of loss.

Suffering is to be understood, not just intellectually or conceptually, but by embracing and knowing it from inside ourselves. We need to be open to suffering, to turn towards it and let it be there in order to investigate it and to see its cause clearly. Seeing the suffering in the world, in our own bodies and minds leads us to an understanding of the universal, shared experience of suffering, which is the nature of the human condition. We begin to understand that “there is suffering” rather than “I suffer”, moving away from its being ‘my problem’, and reducing our identification with it. This acceptance of the shared nature of suffering leads to compassion for both for oneself and for others. This change of attitude and direction represents a crucial turning point in our journey towards understanding and enlightenment.

The Second Noble Truth – the diagnosis - is concerned with the cause of suffering, and states that suffering arises from attachment and aversion - our need for things to be or not to be in a certain way, and especially our aversion to the way things are. It involves resistance, struggle, and trying to shut off experience. Suffering is what happens when we struggle with

whatever our life experience is rather than accepting and opening to our experience with a wise and compassionate response.

There are actually 2 layers to what we call ‘pain’. The first is the unpleasant feeling itself. But on top of that we usually pile a second layer – the worry, the grieving, the tensing, the bracing – that intensifies the original pain. It is this aversion to the original pain that intensifies and perpetuates the pain. So the second noble truth says that pain is inevitable, but suffering – the aversion - is optional.

It is of course absolutely natural to want happiness and not want pain. But the problem arises in the way we go about trying to achieve that. By resisting our experience and shutting down, we block the energy of our innate wisdom and compassion, which can actually help us achieve the happiness we all seek. Opening to being with the difficult can lead to wise, creative responses.

This aversion to what is and struggle to make it different is a denial of what Buddhism calls the Three Signs of Existence: Dukkha, Impermanence and Not Self.

Dukkha, the suffering or unsatisfactoriness described above is an in-built sign of our human existence.

Impermanence is the truth that everything is changing all the time, and everything dies.

Not Self is sometimes mistakenly taken to mean that there is no self. In fact what the Buddha said was that what we take to be the self (our bodies, our thoughts and emotions, etc.) is impermanent and conditioned, and is not the True Self. The true self is Buddha Nature, which is the essence of everyone, but it is obscured by our clinging to the small, impermanent ego self. We take this false self – this ME - to be solid, something to hold onto, something to constantly protect and shore up, but it's always changing and it inevitably dies. Trying to protect this ego self from impermanence is impossible and inevitably leads to suffering. Attachment to this false self – the small ego Me - and aversion to what is, hinders our True Self and its innate wisdom and compassion which could guide us out of this dilemma.

The Third Noble Truth – the prognosis – concerns the cessation of suffering. Is it curable? Buddhism says categorically that yes, it is curable. But the cure depends upon an action on our part – our letting go of attachment and aversion to what is, and our letting go of our defensive and protective strategies, the armour we put on to shield ourselves from reality. This is of course totally counterintuitive, and seems opposed to evolution. We are hard-wired to protect ourselves, to survive.

So how can we let go of attachment and aversion to what is? First we have to see attachment and aversion clearly as mind states, involving thoughts, sensations and emotions which come and go, rather than as some solid thing called ME. And this involves turning toward the aversion or attachment, investigating it with curious awareness. This is *not* a passive, resigned acceptance of suffering. Rather it is a dynamic and actively mindful process. Once we are no longer fuelling the aversion or attachment we can begin to understand it in new ways. It is important to realise this is not the same as trying to get rid of aversion or attachment.

There is a story of the Buddha on the eve of his Enlightenment, when he declared that we was simply going to sit in meditation as long at it took, until he reached enlightenment. And Mara – the evil one - came to tempt him away from his resolve, with offers of beautiful women, riches, power, etc. The Buddha did not try to get rid of Mara – or to ignore him – or to change him in any way. He simply said: “Mara, I know you.” And instantly Mara was stripped of all his power to harm, simply by being seen clearly. The story goes that the arrows he was shooting at the Buddha instantly turned to flowers.

This is a very important lesson for all of our Maras – for all our pain and suffering and negative emotional states; if we can turn toward them with curious, gentle awareness, and see them clearly as they are, they lose their power to harm, and are transformed into something beautiful.

It is important to restate that this is not about being passive or resigned. It is actively and dynamically being with the difficult, investigating it in a very alive way, and coming to know the difficulty with clarity and openness, from which an appropriate and accurate *response* can arise from our inner wisdom. This is the opposite of our usual automatic *reaction* arising from our more limited, habitual, thinking mind.

So the acceptance of what is, in this investigative and clear way becomes the springboard for skilful, responsive action to achieve change in our inner or outer worlds. Being with the difficult in this way requires kindness for ourselves and courage. But it is always a process of softening, not hardening and tightening.

The Fourth Noble Truth is the prescription or the treatment. The Buddha prescribed an Eight-fold Path, a detailed outline to lead to enlightenment and the cessation of suffering, which includes right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness and right concentration. I won't go into these in detail here, but just mention that together these form the three foundations of Buddhist life: Ethical conduct, Mental Discipline and Cultivation of Wisdom.

Ethical conduct is simply directed to not creating more suffering for ourselves and others.

Mental Discipline includes Mindfulness and Meditation as the means for investigating our experience and reality and for being present with what is.

Cultivating Wisdom involves both the mind and the heart. In eastern countries there is no distinction made between heart and mind as there is in our culture. So it is very important to understand that when Buddhism speaks of 'mind' this is a western translation of the Sanskrit word 'chitta', which means heart/mind. So cultivating wisdom involves not only insight and clarity, but compassion and loving kindness.

So what does all this mean in real life? How does it help anyone to cope and live with pain and suffering? First of all, Buddhism is not anti-medicine. If relief is possible it should be sought and gratefully accepted. But all too often, as this audience knows only too well, relief isn't possible. In this situation a single-minded problem-solving approach, seeking the goal of eliminating pain, only gives rise to more frustration, anger and hopelessness when it fails. It robs the sufferer of the ability to live fully or to see any beauty at all in life, locking them in a tight prison of 'Me' and 'My Life', entirely dominated by and defined by pain and the inability to get rid of it.

What we need is to learn is to work with, *be with*, and have a new relation to pain as an integral part (not the whole) of life and growth. This involves learning to live with pain, to somehow live around the edges of pain. We need to empower people to 'heal from within' – not to be helpless and dependent on doctor and medicine, but to help them to find joy and happiness in their own lives despite the pain. Pain becomes not a 'problem' to be solved as much as a universal experience to be worked with.

In my work as a Mindfulness Instructor I teach an 8-week Mindfulness course using these basic Buddhist principles and meditation in working with people with all kinds of difficulties – including chronic pain, depression, anxiety, stress, substance abuse, eating disorders – really any difficulty.

The 8-week Mindfulness Based Stress Reduction (MBSR) course was developed 25 years ago in the US by Jon Kabat-Zinn at the University of Massachusetts Medical Centre, where he has used mindfulness, a form of meditation, to help thousands of people cope with stress, anxiety, pain and illness. Though Jon developed his programme from Buddhist principles, the course is secular, requiring no commitment to any belief system. More recently, Mindfulness Based Cognitive Therapy (MBCT) has been developed through the work of Zindel Segal, Mark Williams and John Teasdale in the UK, adding cognitive therapy aspects onto the basic stress reduction course to work with specific difficulties, such as depression. Considerable scientific evidence-based research has proven these mindfulness-based approaches to be highly effective in working with a wide range of physical and psychological problems. Mindfulness-based approaches are being used in the UK and the rest of the world in private courses, businesses, universities, clinics and the NHS. MBCT is included in the NICE guidelines for the treatment of depression. The mindfulness approach involves turning towards difficulties rather than trying to get rid of them. By becoming interested in and curious about the difficulty, much of the resistance and struggle can relax, taking with it the second layer of suffering we tend to add on top of the actual pain. Very often what is left after letting go of the resistance and struggle is surprisingly manageable. Mindfulness is also about learning to come back again and again to the present moment rather than having our minds constantly jump back to the past or leap ahead worrying about the future. People discover that being in the present moment is manageable – even with severe pain. What isn't manageable is the thought that I'll have to have this pain forever. But right now, in this

moment, it is almost always manageable. And in becoming more present in their lives, people also begin to see the beauty in and around them, and realise that there is so much more to their lives than just pain. With this change of perspective comes a sense of kindness and compassion for ourselves and others in the realisation that everyone suffers – that is isn't just ME and MY problem – that we are all connected through suffering. So even if the problem itself doesn't change or disappear, people learn to relate to their problem in a new way, which can make an amazing difference to their lives. By turning toward and fully experiencing the whole of their lives, including the painful, people discover that wisdom and compassion naturally arise within them.

As I mentioned at the beginning, it was my own experience of physical pain that led me to explore the nature of suffering in this way. I was already a practicing Buddhist and meditator when I had an operation which left me partially paralysed and in fairly constant pain. I went through cycles of fighting the pain, trying every possible 'cure' imaginable, giving up and feeling helpless and hopeless, and then returning to fighting it. My life was totally dominated by the pain and my struggle with it. Eventually I realised that if I were to have any sort of life other than total obsession with my pain, I'd better find a way to live with it, not fight it. It was at this point that my Buddhist teacher stated that "Buddhas experience pain as bliss." This was a totally outrageous statement to me, but it did make me stop and get curious. Initially this led me to explore what this sensation I call 'pain' really was. Did it have a colour or a shape? How was it different from an intense itch? Did it come and go? When it went, where did it go? In the process I discovered that this solid pain actually wasn't there all the time. When I looked directly at it there were seconds when it simply wasn't there. And if my attention was drawn to something else, the pain wasn't there at all. How could that be? How curious! By simply getting interested in the pain and exploring it, I was no long fighting and resisting it. And I realised 75-90% of the pain simply disappeared when I stopped fighting it, only to return again when I picked up the resistance again. Amazing! That might have been enough to satisfy me, except that I was still intrigued by this idea that pain could actually be equated to bliss. So I was led to explore further: what is the 'pain' that is left when the resistance to it is removed? It can't be the solidly physical thing I thought it was. And who is the 'I' who is feeling it? And is the 'I' who experiences a moment of pain different from the one who experiences the next moment of non-pain? Who joins up all these moments to make a full-blown solid pain? I realise that I don't really know anything, that neither this 'pain' nor this 'I' are at all what I thought they were. I'm left with wonder at the very nature of reality. Thinking and analysing can't take me any further into what is profoundly non-conceptual. Only meditation can open up glimpses, where I realise I am connected to all beings through this 'pain', and there is no sense of 'I' or time or space. There is no thinking either. There is only an intense sensitivity to everything, which I suddenly realise is no different from the 'pain' I've been trying so hard to understand. And it is wonderful.

So 'pain' experienced in this way can lead to glimpses of compassion, our connection with all beings and the wisdom of the true nature of reality and self. Is that 'bliss'? Well, I don't know, I'm not enlightened yet! It isn't 'pain' as I know it. It's intense but not a problem. So perhaps that is 'bliss'.

I'd like to finish with a quotation from the 13th century Persian mystic poet Rumi which I think nicely describes the gift in the midst of all suffering: "Grief can be the garden of compassion. If you keep your heart open through everything, your pain can become your greatest ally in your life's search for love."

## A humanist perspective on pain.

Which problem? Whose problem?

Michael Bavidge

I have worried about more or less every word of the title of this paper since I started to think seriously about it. My focus is actually on suffering, rather than on pain; and I am interested in a secular rather than a humanist perspective on suffering; and whatever suffering is, it isn't a 'problem'.

It is easy enough to repair the damage caused by shifting from pain to suffering; if I apologise and ask you to be indulgent, that should do the trick. The other worries are not so easily disposed of.

You may think that there is little to choose between secularism and humanism – certainly they are both fluid terms (the latter has a particularly complex history). The Renaissance was characterised by a form of Humanism which had not yet cut itself adrift from Christian beliefs. Erasmus is an example. And many of the Enlightenment thinkers, even if they aggressively rejected religious attitudes, still counted themselves Deists. On the other hand, there are non-humanist forms of secularism. It is possible to be a secularist in rejecting appeals to the divine or the transcendent either as guides to life or solutions to problems, while still not thinking that only human beings have an intrinsic value and that everything else has a value only in so far as it subserves human welfare.

Personally I have a further problem. I do not think of myself as a Humanist. There are two main reasons why I want to keep blue water between myself and Humanism as it often presents itself. The first is its fundamental position. One of its manifestos, *Humanism and Its Aspirations*, puts it clearly: "ethical values are derived from human need and interest as tested by experience. Humanists ground values in human welfare shaped by human circumstances, interests, and concerns"; it goes on to add that these concerns are "extended to the global ecosystem and beyond". But this an annex to its fundamental position. One of the interesting trends in the way we have recently come to think about values, both in ordinary living and in philosophical thought, is that we are now entertaining the idea that all values are not, and should not be anthropocentric. Once God had been ousted from the centre of value systems, it seemed necessary to put man where God had been. But now we are beginning to see the whole of the natural world rather than the welfare of our own species as the basis of value systems – neither theocentric nor anthropocentric

There is another aspect of Humanism we can do without. Humanism is to a large extent driven by anti-religious sentiment. There are plenty of well-founded complaints that can be brought against religion. But there is no obligation to agree with Professor Dawkins that religion is just bad science that motivates backwardness and cruelty. The history of the last 100 years shows, if it needs proving, that secular ideologies are just as capable of encouraging mass cruelty and that human stupidity and insensitivity can take any number of forms. More positively, religion for centuries has provided and today continues to provide ideals and an aesthetic which have animated our moral and spiritual values. The cultural richness of our religious traditions is not an accident. It is not something that - we can be grudgingly admitted - may have been valuable in the past, but has no relevance to these enlightened times. There is a need to explain, with more sympathy and insight than contemporary critics seem capable of, what it is about religion that enables it to be the bearer, the inspiration and preserver of moral, cultural and spiritual aspirations.

So I am out of sympathy with Humanism's fundamental anthropocentrism and regret the way it has allowed justifiable criticism of others people's beliefs to become an unattractive obsession; perhaps I should have chosen the word 'secular' rather than 'humanist' for my title. It carries less ideological baggage.

Staying with my troublesome title, the word 'problem' is a problem. 'Houston, we have a problem.' has entered the mythology of space travel; it has come to be an icon of technocratic cool. It was how Jack Swiggert reported that there had just been an explosion on moon-bound Apollo 13 and the lives of the crew were in immediately peril. We imagine what we ourselves might have said, or screamed, as we hurtled through space on an exploding bedstead. Their situation was too dire to be a problem.

That some difficulties are too big to be problems has been noted before. Gabriel Marcel, the French, existential, Catholic philosopher - what a burden he carried - distinguished problems from mysteries. A problem is a difficulty which stands over against us that may be very difficult but that can be resolved through some objective methodology. A mystery, on the other hand, is a problem that we cannot separate out from ourselves, when we raise the problem we throw ourselves into question. Back to the moon shot, Jack Swigert did not actually say 'Houston, we have a problem'; what he said was 'Okay, Houston, we've *had* a problem here.' That actually sounds more sensible, perhaps because it is in the past tense. Swigert had already made the first distancing manoeuvre that technological solutions depend upon.

Marcel's mysteries cannot be distanced in that way. As we ask the question, the ground on which we stand shifts beneath our feet; mysteries are never finally resolved; we keep coming back to them; they haunt us; typically they challenge what we take to be fundamental to the sense and value of our lives. Marcel's terminology is unwelcome especially to a secularist. So let's, with appropriate Anglo-Saxon reserve, call his mysteries 'personal problems'. But we need the distinction he makes between ordinary problems and problems that rebound on us and call in question something fundamental about the status of the questioner.

There is another distinction between the different sorts of problem that philosophers exploit: some problems arise when we take a first-person perspective and some when we take a third-person person perspective. The Mind-Body problem, for example, which is central to so much contemporary philosophy, is often formulated in terms of the tension between First and Third Person accounts. The intractability of the problem presents itself as an irresolvable tension between the two perspectives. How can we reconcile our subjective experience with objective accounts of human beings?

What makes suffering not a *mere problem*, is that it challenges and threatens us, as persons and that the intimately personal nature of suffering is visible only from a first person and not from a third person perspective.

We find in our religious tradition a stark example of the contrast between first and third person perspectives on suffering, if we compare biblical responses to suffering to the discussions of suffering we find in the branch of theology called Theodicy. The term, 'Theodicy', constructed out of the Greek words for God and justice, was introduced into philosophy by Leibniz. In 1710, he published a work entitled *Essays of Theodicy on the goodness of God, the liberty of man and the origin of evil* (*Essais de Théodicée sur la bonté de Dieu, la liberté de l'homme et l'origine du mal*). In it he attacked Pierre Bayle who had claimed in his Dictionary (*Dictionnaire historique et critique*) that the goodness and omnipotence of God is incompatible with the sufferings that characterise earthly life. Leibniz notoriously went for broke and established the compatibility of God's goodness and suffering by proving that, as he put it, 'this universe must be in reality better than every other possible universe.'

Voltaire did a comprehensive demolition job on Leibniz's conclusions in *Candide* which I cannot improve on; my point here is that Leibniz treats suffering as a third-person problem: how is suffering compatible with the goodness of God? He presents it as an abstract, theoretical problem, to which he gives an abstract and theoretical answer.

This is not the tone of voice of the Old or New Testament. In the Book of Job, Bildad the Shuhite does indeed pose the central question of Theodicy: 'Doth God pervert judgment? or doth the Almighty pervert justice?' But the whole debate is presented in terms of an apparent personal betrayal by God. This is the way Job understands his predicament: 'God hath delivered me to the ungodly, and turned me over into the hands of the wicked.' (Ch. 16). The drama of Job is seen from a first person point of view. It is not a theoretical problem but a personal problem which arises out of the apparent breakdown in the relationship between a person and his God. In the New Testament this is even more intensely felt: Jesus cries out: 'My God, my God, why hast thou forsaken me?' This contrast has become so painful for contemporary theologians that the cry has gone up for, as Levinas puts it, a 'faith without theodicy'. What now seems valuable about religion is not its justifications of Divine Providence, but the language, the rituals and the institutions it developed in which those who suffer and those who share the suffering of others can express their anguish and their hope.

Humanism, needless to say, despises Theodicy; but it has this much in common, it addresses the problems of suffering predominantly in a third person way. It is strong on the critique of religious explanations of or justifications for suffering in terms of guilt, redemption and atonement. It has little problem in substituting naturalistic explanations for these despised

rationales. It is keen to point out that naturalistic explanations do little or nothing to console the sufferer except, perhaps, to free his mind from the anxieties generated by religious myths.

Nevertheless, though its explanations are uncompromising and unconsoling, Humanism is energetic in its commitment to alleviate suffering. This is also to be expected. Humanism developed in tandem with Utilitarianism which defines morality in terms of the pursuit of human welfare which, in turn, it understands in terms of the promotion of happiness and alleviation of suffering.

However admirable and altruistic we may find these attitudes, they are all still third person. They are the explanations and the policies of a well-meaning administrator. Where Humanism is deficient is that it does not adequately approach suffering from a first person point of view. It will not be easy to address this deficiency because it arises from Humanism's essential character. It adopts, as a matter of policy, a managerial approach to life; it is suspicious of the intensely personal because it sees it as a resort to emotion and irrationality.

Modern science-based medicine, driven by a humanist utilitarian ideal, can suffer from the same deficiency. The scientific approach demands an impersonality and a detachment that can make it difficult for the raw experience of suffering to be brought into the conversation in the clinic or on the ward. Scientific and medical specialists have their professional stance; they have the institutionally defined objectives of their disciplines and the traditions of their art; they have approved methodologies and a shared language; they have the hierarchies and courtesies of their professions. On the other hand, sufferers and those who share their suffering are not members of a profession; they are not supported by a methodology or a code of conduct. Expectations (sometime quite rigorous) are imposed upon them by the institutions in which they find themselves. But there are no agreed standards they have to meet; no conventions that invite their cooperation and demand their compliance.

Why is the first person perspective so important? John Bowker in his book *Problems of Suffering in Religions of the World* talks of 'the common experience of suffering' which he contrasts with 'suffering conceived as a theoretical problem'. It is certainly one thing to suffer and another to reflect theologically or philosophically on suffering. However the common experience of suffering is not independent of our thoughts and beliefs. (I am not suggesting that Bowker thinks it is.) Compare suffering with falling downstairs. There is certainly a difference between falling downstairs and reflecting scientifically on the force of gravity. But falling downstairs is, more or less, what it is independent of our thoughts and theories; it is much the same experience for Einstein as it is for the rest of us. Whereas suffering, as an experience, is intimately affected by the beliefs we have about suffering, even the religious and philosophical beliefs. As Lucy Bending puts it: 'People read the experience in profoundly different ways, and make sense of what they feel in a multitude of fashions'.

It is possible to deny this interaction between our attitudes and suffering. And to deny it on the grounds that suffering is so elemental and brute that it is has nothing to say or at least that it issues in nothing more than cries of anguish and pleas to be ended.

There was a controversy in the Thirties over Yeats's edition of the *The Oxford Book of Modern Verse*. He omitted the war poets, in particular Wilfred Owen. Well, he did not think much of his poetry: he 'is all blood, dirt & sucked sugar stick (look at the selection in Faber's Anthology-- he calls poets 'bards,' a girl a 'maid,' & talks about 'Titanic wars'). However in the introduction to the volume Yeats provides a more sententious justification; he wrote: 'passive suffering is not a theme for poetry' Given he believed that, he would no doubt have added that passive suffering is not a theme for theology or philosophy either, indeed it is not a theme at all. This is the implication of the word 'passive': suffering is silent; it is undergone. It is a voiceless experience. Yeats adds in a letter to Dorothy Wellesley the generous thought that 'There is every excuse for him [i.e. Owen himself] but none for those who like him. . . . i.e. the person who underwent the appalling suffering, can be forgiven for writing poetry about it -- poetry which is inevitably bad poetry because sheer, passive suffering has no authentic voice - but there is no excuse for the rest of us. My guess is that the one thing we in this room can all agree on is that Yeats is wrong. You probably know that almost 20 years before Yeats' pronouncements W. H. R. Rivers was helping his patients, including Sassoon, another war poet, to find a voice to express their suffering. Suffering is not 'passive' in Yeats's sense; it does not drop below the radar of reflective concern; it is not voiceless unless we make it voiceless.

In the past religion provided a personal, indeed an interpersonal voice in which sufferers could express their experience. To a degree some people find surprising or irritating, it continues to do so. I came across an illustration of this when I was reading about the

commemoration of the war dead. Talking about ‘the search for an appropriate language of loss’ after the Great War, Jay Winter in *Sites of Memory, Sites of Mourning*, tries to explain why traditional religious language and symbols were so widely used on war memorials. He writes: ‘The strength of what may be termed ‘traditional’ forms in social and cultural life, in art, poetry, and ritual, lay in their power to mediate bereavement. The cutting edge of ‘modern memory’, its multi-faceted sense of dislocation, paradox, and the ironic, could express anger and despair, and did so in enduring ways; it was melancholic but it could not heal’<sup>11</sup> The power of religious symbolism outlasts religious belief. This may seem confused and weak-minded, even hypocritical. A more positive view is that the enduring value of religion in relation to suffering is not that it provides speculative theoretical justifications like Leibniz’s best of all possible worlds or even a theology, like Anselm’s version of Redemption rooted in feudal blood price. Its real contribution is that it affords those who suffer a space to speak in the vocative case.

If Humanism wishes to be seen as an adequate replacement for religion it must somehow respond to suffering from an insider’s point of view. It has a structural feature that suggests a way in which it could attempt to do this.

Liberal Humanism does not have a theory about what the good life consists in and so it does not impose a particular version of the good life; it leaves it up to individuals to determine for themselves what makes their own lives worth living. However it is prescriptive about the conditions that are required for individuals to shape their own lives in the ways they see fit, by maximising freedoms within the limits set by the prohibition against causing harm to others.

If we outline a liberal humanist view of suffering, it would likewise have two sides to it. It hasn’t got a theory about suffering that engages with suffering as a personal problem, as an overwhelming condition of life; so it cannot recommend, let alone impose an authorised way of suffering or the way of a good death. It can only allow individuals to draw on whatever resources are available to them from their own personal lives and in the shared experience of their communities in facing the burdensome aspects of life. However it can promote the conditions that make this possible.

The primary condition that must be met is a language in which suffering can be expressed and respond to. Not of course just a vocabulary. But a language that people can inhabit, underpinned by relationships that make communication possible and supported in an environment which does not force the sufferer into silence. The recognition of the need to allow suffering a voice, as well as to alleviate suffering, underlies the hospice movement and the various forms of self-help groups that have sprung up to meet the deficiencies of institutional health care. Sandra Clarke, a nurse in Eugene, Oregon, one of the founders of the programme *No One Dies Alone*, puts it simply: “The two things people fear the most about dying are being in pain and being alone”.

Secular Humanism has available ideologies which can lie in the background of its responses to suffering – the most enduring one is Stoicism which recommends resignation and acceptance; just as religious belief has theologies of suffering which encourage believers to see their suffering as filling a role in an economy of redemption and atonement. But there will always be a problem; the shift from the first to third person; the genuine engagement of these general theories with the actual experience of the individual person, believer or not.

The personal problem of suffering does not take the form of a demand for a justification; it is not a search for a convincing story to tell *about* suffering; it is the need for an authentic voice to speak *out of* it. When the chips are down, in the face of the isolation that suffering and death threaten, all we can do is to immerse ourselves in human companionship, in love, if you like. In this respect the believer and the non-believer are not so different.

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## Spiritual Care in a Secular Society

Eileen Palmer.

I have worked in palliative medicine since 1990 as a Hospice Medical Director and as a consultant physician. I have had a strong interest in the care of the dying since medical school days in the 1970's. I was Roman Catholic by birth, which may be related to, but is not the sole reason I have been wrestling with the mystery of suffering for the last thirty years. I also learned to meditate some 35 years ago, and I have taught meditation in Local Education Authority night classes, in a range of interfaith settings and within the Christian Meditation Community. I teach meditation and simple conscious breathing to palliative care patients and staff on a regular basis as part of our "Living for Today" program.

My talk today is very simple. It is partly based on the article "Spiritual Care in a Secular Society" \* which I wrote for primary care doctors in response to a real and growing challenge. Eighty per cent of patients who come to our local hospice or palliative care services have no regular or familiar faith practice. The figure for our health care staff is not very different. Doctors and nurses can feel out of their depth, unprepared and powerless when faced with spiritual pain, suffering and anguish. The article describes a model for approaching spiritual care which is presently being used to train GP's across the North of England, through the University of Teesside "Practical Palliative Care for General Practitioners" distance learning course and through the North West England Royal College of General Practitioners "Core Competencies in Palliative Care" courses. It also forms the basis of part of a chapter on Spiritual care in the textbook "Palliative Care for The Primary Care Team". (Dr Eileen Palmer and Dr John Howarth, 2005, Quay Books, London)

First of all, although "spirit" and "spirituality" are difficult to define, and can really only be described, we need to attempt to find some mutual understanding of what we are talking about. Two descriptions follow:

"Spirituality is that faculty present in all human beings which causes them to search for meaning in what is happening to them, to attempt to make sense for themselves of the world as they perceive it, and to draw conclusions/beliefs from their own observations that shape their behaviour. This power or life-force (spirit or soul in the language of religion) has the potential to create invisible resources to sustain, motivate and transform the way in which an individual experiences his/her life" (Dufour)

"Our spirituality is akin to the whole of our inner journey, not only through cancer, through loss or bereavement, or through a serious illness, but also through the whole of our individual and unique life experience. It starts with the unique alive spark that is one human being. It travels through the inner journey that is one human life with its loves, its passions, its hardships, its monotony, and its pain. Within that it forges relationships, both good and bad, it feels, it suffers, it laughs, it is moved to tears or it trembles with joy. It contains strength, inspiration and vision. It contains vulnerability, doubt and fear. When it is at its best, it allows us to grow, to transcend suffering, to find meaning, to move on, to inspire or uplift others. When it is struggling, it may leave us frightened, trapped, and tormented by fear, bitterness, cynicism or hopelessness."

Spirituality and religion are often confused and sometimes used as interchangeable words. They are not. A religion is a belief system, often linked with rituals and practices which may help many people to better spiritual understanding by giving a framework for their experience. An analogy Jean Radley (district nurse and Anglican priest) uses is that spirituality is like a hand, something everyone has, an integral part of the human form. Some people may find a glove into which the hand comfortably fits and this glove is religion. Other people may choose to forgo the glove, yet they will still have the spiritual part of themselves. Others may choose a glove with a poor fit, or even one that does not fit at all, but looks like the neighbour's gloves.

Thus we can sometimes meet people who are regular churchgoers who may have great difficulty and immense spiritual pain. Someone else with no particular religious affiliation or faith may face a terrible situation with immense courage and inner resource, inspiring all around them.

\* The full text of this can be found at <http://www.northcumbriahealth.nhs.uk/palliativemedicine/clinical/spiritualcare/02.php>

Spiritual care is care that encourages and supports reflection on experience, the search for meaning, and the development of inner resources to travel on. Spiritual pain arises when there is a gap between a person's innermost sense of value and meaning and the external reality. It is a deep pain. It threatens the integrity of the whole person...life falls apart or seems utterly meaningless, devoid of all hope. To use religious language it is a "dark night of the soul". This pain can be experienced as real suffering and anguish. It can make physical symptoms almost impossible to address. It is important to recognize the uniqueness of each individual's response to suffering and spiritual pain , which is often independent of faith or religious practice. An event such as a serious illness challenges all of this. It challenges our beliefs about life, about ourselves and about the future. It challenges our inner sense of meaning. Somehow, painfully we have to let go of everything we thought "ought to be" and enter a separation, adjustment or grief reaction. Some individuals may have an inner life, a spiritual self that allows them to adjust easily to this. For others there is a painful journey as they let go of deeply held beliefs. They travel a dark and difficult path, a "dark night of the soul", with familiar securities and survival skills overwhelmed by confusion, anguish, depression and "a terrible fatigue of the spirit". Gradually, they may come to a new and different sense of things, they may find a meaning that is utterly different to anything they had previously believed, but that allows them to make sense of things, to move on, and a peace comes again.

How do we recognize spiritual pain? Its symptoms are derived from a lack of love and a loss of meaning. The first core spiritual need is to love and to be loved, to be accepted for who or what we are. This need for love is not always expressed through relationship with others. It can also be expressed through a relationship with a transcendent force, with god or spirit, through a love of the earth, or of the natural world. Lack of love leads to low self esteem, and the feeling that one is unloved, misunderstood, isolated and abandoned. This in turn leads on to bitterness, regret and guilt, a sense of powerlessness, and the conviction that nothing or no-one can be depended on. We can "diagnose" spiritual pain due to lack of love from such remarks as "I feel so on my own"; "no-one wants to know"; "They don't care" ; "there is nothing I can do about it". Powerlessness and guilt may come out as "there is nothing I can do about it" and "if only I had....etc..".

The second core spiritual need is the need for meaning and purpose in life. The search for meaning is deep in humanity. Viktor Frankl, a psychiatrist who spent three years suffering unimaginable physical and emotional horror in concentration camps in Auschwitz and Dachau described how suffering even in this extreme situation could be transformed by the power of the individual to give it meaning. Loss of meaning, of lack of point or purpose in life, gives rise to hopelessness, and is accompanied by rigidity, anger, fear and failure to cope. We can recognize loss of meaning from remarks like "I can't see the point"; "Why should this happen to me?"; struggling for control is often revealed in the assertion that "he/she will never be able to manage without me"; anger for instance in "I will never set foot in a church again " and fear as "I'm too scared to go to sleep at night".

It is important to recognize the transpersonal nature of suffering and spiritual pain. Suffering spills out to affect the family, the team and ourselves. It is critically important that we recognise this, and the feelings of powerlessness and vulnerability it can cause for each of us. If we fail to appreciate this it can cause families, teams, and ourselves to retreat into fear, defensiveness, and entrenched positions, with consequent conflict.

How we can develop more helpful responses to suffering? Very broadly, this involves a shift for a busy, problem solving, action orientated doctor from "doing to" to "being with". We must learn to use words and a language that allows us to meet the person *where they are*, rather than where we would like them to be (or where we are) We must try to create "a safe space to suffer", a space of deep listening, a space where we are more interested in hearing the question in the depths of our being than jumping in with quick or facile answers. We have to trust that all our patients have the capacity and the courage to grow, and to open, however slowly. We need to develop within ourselves and within our teams the courage and the capacity to grow and to open, however slowly. This involves developing open, curious, questioning, learning environments for our teams and ourselves. We need to learn to be

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comfortable with not having “all the answers”, acknowledging when we are out of our depth; and know how and where to access specialised spiritual support for ourselves or the patient. We must frequently ask ourselves: are we helping the patient in his or her journey and development of inner resources or are we inadvertently undermining them? It is all too easy to step in with our own beliefs and biomedical models and to believe these are the only truth.

This work is only possible if we are able to recognise and meet our own needs and develop our own wellbeing and resilience. Health care professionals also suffer with palliative care. This demands sharing and support from within the practice team, or from supervisor or mentor. It is necessary to maintain sustainable boundaries between work and home life and to find sources of love and meaningful activity in our own lives. This may involve deepening our intimate relationships, developing our capacity for creativity and spending time in nature. Personal development work, through coaching, mentoring, Balint and support groups may help us to develop emotional insight. It may involve deepening a faith or belief that sustains us or finding a regular spiritual practice such as meditation. We would do well to bear in mind the words of a Sufi teacher: “The thinking mind responds to reason, logic and evidence. The human spirit hears its truth told in stories, poetry, music, metaphor, movement and in beauty.”

The old Roman Catholic prayer for the dying, the “De Profundis”, begins: “Out of the depths, I have cried to you O lord. Lord hear my prayer. Let your ear be attentive to the voice of my pleading”. This work calls on us to discover and work from our own depths, and to commit to our own growth and deepening. We must be able to say: “Out of my depths I am willing to hear and be with you in your depths.”

“But now I have spoken of that great sea,  
the ocean of longing shifts through me,  
the blessed inner star of navigation  
moves in the dark sky above  
and I am ready like the young salmon  
to leave his river, blessed with hunger  
for a great journey on the drawing tide.”

From “Song of the Salmon” by David Whyte

### General discussion of contribution of religion.

*Some of this was lost from recording and begins as Sam Levens was talking about Jewish institutions such as one for cancer treatment, old age care homes and care for children with disabilities.*

This ties up with something we were saying yesterday about shared stories and narratives, which could be a barrier for some people but which on the whole are something which adds to their wellbeing – I assume this would apply to people from other communities....

Is this because they feel more comfortable? – you feel more comfortable talking to someone of the same socio-economic or religious background...

More than this: when my grandfather was very old and confused and couldn't even remember who I was could still remember and join in with Jewish folk-songs which were clearly embedded very deeply into his consciousness and this seems deeper than just comfort.

I once had to anaesthetise an elderly gentleman with a broken hip and when I introduced myself he misheard my name as Cohen and he said that that was marvellous - it seemed to give him so much peace that I decided not to correct him...

We all have those kind of tribal instincts.

I think there's a lot of confusion between religion and faith. Early Islamic communities were set up around the mosque, the school and the hospital. In Europe the monastic orders set up the only health care facilities. Those were culturally specific because everybody was of a faith or religion. So although I think it would be utterly inappropriate as a health care professional to offer words from your religion to a patient – that's the job of the chaplain – the Rabbi, the Imam...

But what if they aren't religious at all ..

Just a connection is comforting... it needn't be religious...

..... the important thing is the connection – you can make it in a religious way if it's appropriate but also in a more human way – just being there and with them ...

It seems to me that there is a mistake in talking about "words of comfort" because that makes it all so verbal; I make sure when I go round the hospital to wear my "uniform" with a dog collar, and I always have a pectoral cross which many people will want to hold – it's about touch and things way beyond the verbal stuff..

When I first started working with people who were dying used to feel I had to sort of perform around them – but I found I just had to be there and connect somehow – by touch or just by presence...

.....Once when I worked in Malaysia I had to go and see the family of someone killed in a horrendous car accident and I didn't yet have the language – I just sat there and sat there – and when I went home I thought oh dear I should have said something – but learnt later that that was exactly the right thing to have done in that situation..

It has happened more than once to me [as a palliative care nurse] that a doctor – even quite a senior registrar – has called me to the room of someone dying and he and the wife are begging me to do something, and I have had to say there is nothing to do: we know that death is very near so I just say: don't be frightened – just take him in your arms – and she has, and I've sat on the other side of the bed and he has died in a few minutes; this doctor is like many in the caring professions who is so busy doing things that he doesn't give himself the chance to be with someone – which may be easier.

Most doctors are terrified of death because it is the ultimate failure – that is the prevalent attitude and I think it's getting worse. It's society's expectation that we will keep people alive

Work has been done in the States accepting and starting from that very fear of failure, and moving into being with silence - the experience of a patient that they are being listened to in silence by a health professional –he is doing nothing but they feel being cared for. It's a relearning of the professional distancing which may be required to a point and then there is the realisation that it isn't working – and being honest about that.

I think one of the problems is we've lost the ethos of care : the medical profession grew up in the monastic and Islamic tradition of care for one's fellow men – I wonder if we've lost some of that ethos with the compulsion to *do something*

I don't think there is a loss of innate wish to care but it's being driven out by the pressures in the healthcare system. Let me give you two examples: the first came up in our consultant committee the other day when it emerged that the decision to do a liver resection on a 90-year old was being taken by a meeting of the multidisciplinary team which didn't actually see the patient – the anaesthetists discovered on the day of the operation that no-one had actually stopped and thought - what are we doing here? The other one concerned fragmentation of care: lots of people doing little bits but no-one taking time and responsibility to be with the patient and identifying their needs - the sitting back and the caring .....

Another element is when it's silent - or appears silent to the bystander. For the person who is silent it's actually very noisy because you allow thoughts to surface... I can see me in that doctor who stood back and was scared... And it's not that you've lost the intuition that you want to care and be empathetic; not even just anxiety and fear – it's just the noise in your head that you have when it suddenly falls quiet. I look at a place like this where you can come on a silent retreat and not talk to anyone for two whole days... I once spent two days completely alone and found it very disturbing ... Life keeps us all busy, we don't have to stop and think.... Sitting with someone dying and simply holding their hand may appear peaceful but for me that has been the noisiest time of my life as all this stuff was coming up that I had been bottling up or running away from...in doing things.

Something which I have experienced recently both personally and professionally and thought about a lot is this business of being alongside: both with oneself and with others. I sense that the poor chap in Chris's story [ of the doctor who didn't know what to do when someone was dying] was not alongside anything except his fear: what a terrible place for him to be.

What do you say in answer to the question: why me?

Can we say anything but "I don't know"?

Do people expect answers to that sort of question?

I think they do and when you give an answer which is patently not an answer they lose trust and faith in you....

I don't actually think people do expect answers... the question is deep, it's not rhetorical but.....

I often say to patients who ask me that: do you really want me to share my beliefs? And it's amazing how often they want me to do that because they find comfort in it...

So what would you say?

It depends on the situation

But can't we just say: I hear your question but it's just a mystery for all of us....

Khaled [*the Muslim speaker who was not present for this discussion*] in his presentation was dwelling on the reasons why people suffer: punishment or reward etc, and saying that in his experience people of the Islamic faith were comforted by this sort of thing. So although it might not be the medical practitioner furnishing the framework to help them understand why they are going through whatever it is it could be said that such a framework should be provided....

Yes – someone might gain enormous comfort from the idea that they would go straight to paradise because of their suffering, but it would be the role of the Imam...

Judaism is very multifaceted and there are Rabbis who would talk in similar terms but as a religious person I would worry that it could be very destructive to somebody's faith to talk in terms of punishment, for instance for sexually transmitted diseases: if you don't want people to hate God it's perhaps not the best way to go about it! It might give some people comfort but it places a huge challenge in the way of the believer: you're not allowed to be angry with God but He has punished the world for promiscuity or homosexuality or whatever by giving it HIV. "I know your husband visited prostitutes but you stayed loyal to him all the way through and you are suffering because God is punishing him – but don't hate God!" I don't want to be critical of another religion and there are Rabbis who would say the same as Khaled – but it's very challenging to our own faith...

And plenty of evangelical Christians!.....

It's certainly the wrong thing to say to some who is dying....

A terminally ill man asked me once what his attitude should be to his family and the rest of the world while he still had time. Since he was going to leave them should he switch off and become cold towards them? Should he start to distance himself from those he loved so tremendously? My reply was: on the contrary - quite the opposite: not only should you embrace and become even more warm to your own little family but you should extend your family to everyone you come across – indeed in the few months you have left to learn to feel warm to the whole of creation. By spreading out like this the pain of detachment will disappear as you find yourself able to love whatever situation you find yourself in. So the idea of distancing and becoming cold is the exact opposite to what I would suggest from the religious point of view. Death puts life into perspective; people have difficulty in facing up to it but it is a major teacher. Perhaps when someone is dying it's not the right time to say: look – get your life into perspective now! But we are all exposed to death be it in our own family or our friends and we all need to undergo this training; death is a teacher but a very harsh one.

To come back to this question: why me? – or wonder if maybe it is possible to ask this question expecting an answer – why me rather than you?! – it does look like a straightforward question but I wonder if what it's really trying to do is to make the person it's directed at to take on board the fact that this is really *me* who is going through this – voicing existential anguish. In a way it is sort of getting it into perspective but not in some sort of intellectual way.

My hesitation is from own experience and my feeling that when people are asking these questions, the last thing they are looking for is some sort of glib answer that trips off the tongue. They are asking to open a quite deep and meaningful dialogue.

One thing you can perhaps consider when asked this question is to furnish the patient with other questions. Something I thought was very profound and goes back in Judaism to the idea of being very active in the face of suffering was the response of Rabbi Soloveitchik, a German Rabbi who had escaped the holocaust but lost all his family, when asked why did that happen? - replied that that was the wrong question; the right one was: *what now?* What am I going to do now? And that can give people hope as even if you only have one day and even if you are very disabled there might still be something you can do...

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This reminds me of a very beautiful story from the Buddhist tradition. The Buddha who was supposed to be the personification of compassion was walking through a village and a lady came to him crying her eyes out, holding a dead baby and saying O Buddha, you are a god man , can you make my baby alive again? And the Buddha replied, indeed I have the powers of magic. Here is what you must do: go into the town and find a house where no-one has died, take a handful of grain from it, and I will bring your baby back to life. So she went off with joy and knocked on all the doors in the village but did not find a single house where no-one had died. So she came back to the Buddha in a quite different frame of mind: she had realized that what had happened to her was universal. So we mature as we realize that it's not just the patient who is dying – it may be us getting the next train.

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## What are Pain Clinics in the 21<sup>st</sup> Century For?

### Introduction

Ian Yellowlees

Although we are thinking primarily of pain management, much what I have to say applies generally to the art of medicine.

It would be wonderful if pain clinics could do much to actually cure pain but we know only too well that there is no magic pill. So what is their function?

To start with, a distinction needs to be drawn, not between physical and mental pain (most of us would agree that this can't be done) but between pain and suffering; some clinics treat only pain and some are perhaps concerned more with suffering. The basic question then is are pain clinics for treating pain, suffering or both?

Whatever the ideal, it has to be recognized that resources are limited. Decisions on use of these have to be based on evidence. But what kind of evidence? Should it be "patient centred" or population based? (remembering that "evidence of benefit" is all population based) The controversies raised by NICE decisions which are population based and may seem at times unfair on individual patients clearly illustrate this dilemma. Should we be striving for the greatest good for greatest number or adopt a classic triage approach and treat those who can be saved, providing those accepted with a Rolls Royce service? The GMC reminds us that our responsibility is to those accepted for treatment.

These are fairly obvious ethical considerations but there is another, usually forgotten aspect. In the 1997 second edition of the patients' charter there is no mention of the responsibilities that go with rights. Is this fair to the professionals? Can it possibly work unless there are reciprocal responsibilities? In *The Healer's Power*, Howard Brody noted that Doctor and patient collaborate in the ongoing process of healing, and it is therefore appropriate to ask what the sufferer, the sick person, the patient - in order to be healed, cured, or treated - is called on to do. If the healing process should be collaborative, then both parties are working. This concept may seem strange but there are two fields in which the notion that the patient is working is not alien: psychotherapy and in rehabilitation medicine. In the former the work is emotional and cognitive; in the latter it is primarily physical. In both fields the process of treatment depends fundamentally on the patient's active participation and on a collaborative interaction between therapist and patient. Pain management often encompasses both of these fields. Psychotherapy, rehabilitation medicine and pain management also share as primary goals, alongside the alleviation of symptoms, the enhancement of the patient's functional capacity (emotional or physical functioning) and sense of autonomy - that is, his ability to direct himself either physically or psychologically. All of these goals require an active, participating - i.e. working - patient. Engagement of the patient in the treatment process is an essential condition for both psychotherapy and rehabilitation and the patient's motivation is considered crucial to the treatment process. A superficially simple model of the working patient is an assumed given fact for many pain clinics – particularly those with a more psychobabble / PMP approach. But what if they don't want to work or engage? Do we label them as 'not ready' or is the situation more complex? This complexity has a very important bearing on the question of what clinics are for.

The doctor-patient relationship can perhaps be described with reference to 3 models. Firstly the paternalistic model in which the patient has had a role most thoroughly described by the sociologist Talcott Parsons as "*being sick - not simply a natural fact, but a social role, with an "institutionalized expectation system" that is "not only a right of the sick person but an obligation upon him.*" i.e. the patient has work to do. It's not surprising that this model has been instinctively embraced by physicians and patients alike. Doctors like it because it calls for unquestioning compliance, unilateral trust, and verbal silence. It appeals to patients, engulfed by pain and suffering, because surrender to powerful, wise, and soothing caretakers is strongly fostered by memories of earlier days when a parent satisfied all discomforting bodily needs. There is the expectation that caretaking by a parent-physician will immediately alleviate all suffering.

Next is the autonomy model, one half of which (rights and expectations) has been pushed in the patients' charter. Jay Katz has written that "*patients are obligated to participate in the*

process of thinking about choices and making decisions or the treatment process cannot start. The patient might have to be encouraged to be autonomous and free". The exercise of choice, the making of one's own decisions, has become a duty. Informed choice is the patient's work. This model is based on an attempt to restore a degree of control and self esteem in a patient. The loss of bodily control is a frequent feature of physical illness, which, depending on the nature and severity of the illness as well as the life situation and personality of the patient, is often accompanied by feelings of shame and helplessness, and at times depression. Loss of bodily control involves a degree of loss of self-control because our sense of self is woven into our relationship to our bodies. Lots of psychological literature from the 1960s and 1970s based on a "learned helplessness" model of depression argues for the importance of active control over one's environment as a key to maintaining self-esteem in the face of adversity or failure. (There is also the consideration that autonomy is likely to cost less)

Third is the mutualist model, which states that patient self-understanding and moral development, rather than patient control and rights, are the central aims of the doctor-patient relationship. If the patient's work in the paternalistic ethic is the performance of a sick role and in the autonomy ethic the making of decisions and taking of control, then what is the patient's work in the mutualist ethic? It appears to be engagement in a conversation, construction of a meaningful life narrative, and the use of illness as a means of self-understanding and change. The hard-working mutualist patient uses his illness and suffering to create something—a narrative that bears witness to his experience or a tool in his struggle with suffering.

There are problems with the autonomy model. It recognizes that one way that people achieve a sense of control is by being informed and making decisions. But is it reasonable to expect a patient "engulfed by pain and suffering," to exercise his right - his duty - to self-determination by making complex medical decisions? Should we condemn the dependency needs or wishes of sick people or assume that those needs are a form of false consciousness created by an authoritarian social structure of which the traditional doctor-patient relationship forms a part? And even if assuming active control helps many people cope with the psychological threats of illness, what of those patients to whom such control is psychologically unwelcome or emotionally detrimental? Should they be manipulated, cajoled, coerced, forced to decide? The autonomy model fails to appreciate that other ways that people achieve a sense of control may include obedience or distraction or denial or telling stories. These ways are recognized by the other models.

**Table 1.** Comparison of Three Models of the Doctor-Patient Relationship

	Paternalism	Autonomy	Mutuality
M.D.	Diagnoses Prescribes Protects	Presents choices Informs Leaves alone (doesn't interfere) Executes/complies	Contextualizes Converses Empowers Interprets Constructs
Patient	Defers Complies	Questions Chooses Decides Controls	Collaborates Converses Constructs Changes

In thinking about service design – what pain clinics are for – we need to recognize that these models may apply differently under different medical circumstances and in different social contexts in the same patient. In an emergency situation the paternalistic one may be OK. Similarly, a straightforward surgical consultation with a specialist might best fall under an autonomy model, in which the patient questions, gathers information, solicits different opinions, and decides for himself. IDDM in a primary care setting is an ongoing dialogue between doctor and patient in which an understanding of the meaning to and impact upon the

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patient of the illness and its treatment form the context within which choices are made and the treatment is conducted.

These models may also apply differently to different types of patient, such as the dependent patient, the “take charge” patient, and the conversational or meaning-seeking patient. All three models are ethically equal. They *prescribe* the nature of the patient's work, as either compliance with doctor's orders or active control over medical decision making or engagement in ongoing exploration of the meaning and place of illness in the patient's life. They also require a recognition from the doctor and prescribe a role for him outside his technical role: The paternalistic model assigns to the doctor the moral function of trustee of the patient's health interests. In the autonomy model, the physician is the facilitator of the patient's autonomy, and in the mutualist model, the doctor's moral function is as interlocutor in a conversation on the meaning and living of the patient's life.

Recognition and acceptance of these different models by medical services allows the patient to be engaged with his illness yet not under its sway. If the patient has work to do, then the patient is not defined entirely by his illness. At the very least, the patient's work—whether enacting the sick role, participating in decision making, or narrating his experience—provides him or her with an organizing set of responses to the condition of illness and, therefore, a framework within which to live in relation to it.

So to return to the question as to what pain services are for: perhaps there is still a role for the oft repeated TP or facet injection, the PMP and the long term psychological conversation seeking meaning and understanding. Perhaps failure to recognize this is excludes some patients from help and is therefore unethical.

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## Early Intervention

Caroline Waterstone (Clinical Specialist Pain Physiotherapist)

I was wondering how such a practical subject as early intervention for chronic pain prevention could be tied up with the theological questions we have been discussing these two days, and the thought came to me: regardless of whether morality is divinely authorised or a human construct it is surely unethical by any standards not to provide resources which the evidence suggests could prevent chronic suffering in an identified patient group.

So I make no apologies for presenting a topic which has long been a passion of mine. Nor do I apologise for quoting from those vastly more expert in this topic than myself, as there is excellent research evidence to support this work and I think it important to put it out in the world of pain management. As an aside, I would like to suggest that one answer to the question ‘what are pain clinics for in the 21st century?’ is ‘for those patients for whom early intervention didn’t work.’

Since working in the field of chronic pain I have sometimes asked myself if this is what I want to be doing for the rest of my working life and the truthful answer is that I don’t – isn’t there *some way* chronicity can be *prevented*? Many clinicians seemed to accept the inevitability of chronic pain: a colleague and I could not, and by finding a few really supportive clinicians who agreed with us, we designed and implemented a pilot programme for chronicity prevention for musculoskeletal patients with back pain.

Steve Linton (2001) wrote: “prevention of chronic pain offers an alternative to the enormous discomfort and expense associated with back and neck problems; the basic idea is to use the limited resources available *at an early point in time* (my italics) so as to prevent development of discomfort and related costs. Consequently prevention is an appealing proposition and an important challenge for the 21<sup>st</sup> century that has already been recognised by various agencies and task forces around the world.” The main benefits of early intervention are very simple: decreased disability, decreased medical utilisation and decreased sick leave.

A subject that always comes up in the context of early intervention and the literature on it is that of work: issues around working while in pain, workplace settings, attitudes to work, injuries at work and much else about people at work.

Pulliam (2003) states that: “we need better and earlier methods for accurate and timely identification of *appropriate* (my italics) patients to improve outcomes....and that early intervention may prevent the demoralising effect that dealing with chronic pain has on the person who experiences it.... This attempt at secondary prevention in a low back pain population will allow the intervention to occur with high risk patients before physical disability has become entrenched.”

This was the group of patients that we identified, using considerable time and effort, not only ours, but local GPs and the MSK physiotherapists who declared an interest in joining us in our project.

Kovacs (2005) wrote: “Disability is dictated by pain duration and quality of life is predicted by disability, but pain severity predicts neither one of them. Changes related to determining the quality of life and prediction of chronic disability appear 14 days after the onset of pain, supporting this as the cut-off point for considering a patient as being sub-acute” – much earlier than we usually think (acute 0 to 6 weeks, subacute by 3 months, and chronic after 6 months). In light of ‘14 days’ our usual definition seems way down the line.

To quote what Michael Bavidge, philosopher, said yesterday: “the common experience of suffering is not independent of our thoughts and beliefs. Suffering as an experience is intimately affected by thoughts and beliefs - even religious and philosophical beliefs - about it; and people read the experience in profoundly different ways and make sense of what they feel in a multitude of different fashions.” So this was a key issue for us: how could we find something which would be generic, yet sufficiently individually tailored, to accommodate as many people as possible in a programme for the prevention of back pain chronicity?

Waddel’s main emphasis (1993), as that of others researching early intervention, is on fear avoidance beliefs: addressing fear of moving and of working. In 1993 he wrote: “The strength of fear avoidance beliefs (FABs) and their powerful relationship with disability has implications for medical management. To prevent chronicity such inappropriate FABs need to be recognised *from the acute stage and tackled directly and changed early before they become*

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fixed (my italics). Indeed it is possible that the first step towards successful rehabilitation may be to overcome these beliefs. These do not arise with pathological severity but rather with increasing uncertainty regarding diagnosis. FABs and FABs re work are strongly related to work loss due to back pain." He goes on to say that back pain and disability are not synonymous, and disability and work loss are poorly explained by any of the biomechanical characteristics of pain. He says that current medical advice and treatment for LBP, particularly *unjustified restriction of activity, prescription of rest and worst of all, sick certification*, would appear likely to reinforce iatrogenic disability (my italics) which is one of the factors leading to the current epidemic of LBP disability."

Waddell continues, "Socio-economic and work related factors are better determinants of low back disability than either medical or biological ones." He talks about patients' self-efficacy determining their pain tolerance, their exercise performance and their treatment outcome. Continuing, he says that coping strategies for depressive symptoms are an important mediator between pain and depression, and depression leading on to LBP disability is largely mediated by and secondary to cognitive factors.

In summary, he writes that the relationship between pain and disability, beliefs and behaviour and medical management are the key to understanding the present epidemic of back pain disability. (ibid)

Pulliam (2003) wrote about adherence and the difficulties of patients adhering to preventative intervention. Patients don't always understand us and they may not even know they don't understand. It is our responsibility as clinicians to ensure that patients have understood what we are trying to tell them. The challenge is to see each patient as an individual and not just another back pain (or whatever) problem – to see the person with his or her pain: this is Mrs Jones who has her life set in a particular context, and has back pain and has come to us for help. How can we respond to her individual needs?

Pulliam talks about the patient in the prevention programme who is still looking for the magic bullet, and also about strategies to maintain engagement. We hope we addressed these issues well on our programme.

Linton (2005) writes: "the psychological factors especially catastrophisation and distress have an early influence on outcome in back pain". He asks why is it when psychological factors are shown to be most influential in determining outcome that medical and therapy treatments are given.

### Implementation of the programme

A pain specialist psychology colleague, Susie Holder, and I ran 2 pilot programmes in summer 2006. Before then most of our work was meeting with GPs, and working closely with the Clinical Specialist MSK Physiotherapist, Sally Allan, going through referrals to identify and prepare those patients who could be appropriate for the programme.

We chose six GP surgeries in St Albans and wrote to every GP telling them what we wanted to do and thought we could offer, asking them to refer patients who might fit the criteria of the patients we were looking for. We had breakfast and lunch meetings with the GPs who were relieved that for the first time they would have the opportunity to offer their patients something other than to be put on a physiotherapy waiting list, which at that time was 18 weeks. We went through many back pain patients' histories, discussing referral and physiotherapy and psychology treatment options in each case. It was a very positive process, and humbling that the GPs were prepared to give up their time to identify the patients we thought we could best help.

Many people go through life experiencing recurrent episodes of back pain and yet continue to function well, fulfilling all that they want to do in their lives. But there is a group of people who experience acute episodes of back pain that get closer together and worse with each episode, who experience increasing anxiety and distress. Our aim was to identify this group and prevent a gradual and inexorable chronicity. GPs had the option of referring patients experiencing their 3<sup>rd</sup> episode of acute back pain to our programme which we called "Back Aware". The rationale for waiting to accept referrals until the 3<sup>rd</sup> and occasionally the 2<sup>nd</sup> episode of acute back pain was because we met resistance from patients to attend a programme, especially one offering psychology, earlier: patients assumed that more of what they had had by way of MSK physiotherapy treatment before would 'fix' them again and hoped to have no further episodes.

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We wanted a pain-free period of 6 months (or at least 4 months) before the current episode, as it was important to exclude people who chronic pain and were having acute flare-ups. Those patients, who the GP stated experienced sciatica or who were picked up at assessment as experiencing it, were referred to musculoskeletal physiotherapists who kept designated slots for them and with whom they could have a maximum of 4 'hands on' treatments. After this the patients were sent back to Back Aware.

The patients were sent a number of questionnaires - Örebro, Fear Avoidance Belief Questionnaire, Hospital Anxiety and Depression Score, Pain Self Efficacy, Pain Catastrophising Scale, Roland Morris Disability Questionnaire - any patient who complained that this was all "too psychological" was put back on the physiotherapy waiting list, so the group self selected. The Örebro Questionnaire was developed by Steve Linton, a psychologist in Sweden, and sets out to identify those patients most likely to develop chronicity, looking at a number of criteria. Some patients got high scores, indicating the potential for chronicity. We also accepted some people with lower scores on the basis of clinical interview. We took particular notice of the fear avoidance questionnaire (FABQ) scores. The patients we identified as suitable, from the GP referral letter, patient phone call and questionnaire results, were then assessed by my psychology colleague and me.

In preparing for the programme, we visited Mansfield, Bristol and Nottingham pain programme units and read extensively on early intervention research. We included the elements of a chronic PMP – thoughts and feelings about pain, with particular emphasis on FABs, exercise and relaxation, attitudes to disability, workplace and "why me" issues; addressing, early on, their physical and emotional functioning and well-being. We incorporated these topics into a 5-week programme, 2 ½ hours a morning, from 8.30 to 11.00, so people could still go to work. We offered follow ups at 1 and 2 months.

Post programme, the PCS and FABQ scores showed most improvement. 2 patients, who worked for large corporations and had several colleagues who were experiencing similar problems, asked why we couldn't take this type of programme into industry - good question! The drop out rate was lower than on our chronic PMP and the feedback was very positive. The statistical power was low, but most patients reported significant changes in their life functioning and beliefs about their pain. Obviously we would want to replicate this research with larger numbers of patients.

This good outcome was in a group of people with early problems, which proved how quickly patients' unhelpful beliefs can develop into chronic attitudes, behaviour and disability. Conversely, it shows how quickly with the appropriate input, patients can change their beliefs and attitudes before they became entrenched. It was also important that the patients learned that they were in control of their backs and could begin to identify and avoid doing those activities and responding to those beliefs which were not helpful in maintaining effective emotional and physical functioning and well-being.

Back to Linton: "prevention is an appealing proposition and an important challenge for the 21<sup>st</sup> century." My question to all of us here is, 'are we going to meet the challenge and if so how?'

*All the major industrial concerns in our area (Southampton) have excellent occupational health schemes except one: the NHS.*

*I really want to know how you achieved all this as we set up a similar scheme (on the Borders) and after 2 months we had precisely two referrals.*

We reduced our clinical load and spent a huge amount of time meeting with GP's – at breakfast, lunch and any other time and badgering them – and convincing them that for the first time things really could move quickly – and selling this door to door for six months –

*This is clearly what we failed to do as I made the foolish assumption that the benefits were obvious!...*

*The sad thing is that there is nothing new here: this was all in the CSAG document of 1993 – and now there is dust an inch thick on it as there is no drive from above - it is very difficult for us and there has to be drive from a political level. It can be done, as witness the two week wait for cancer patients. And it was evaluated as cost neutral.*

## A General Practice/ Primary Care View

Bernd Strathausen

### *What does Primary Care want from a Pain Clinic?*

GP's value easy & speedy access for advice by telephone, fax or letter. This usually involves management problems or drug queries and a working week nine to five helpline would be very valuable.

A 'Fast Track' referral system for all new referrals would provide a more immediate pain team approach at the point of referral by the GP. A telephone or home visit assessment for initial patient contact might be considered. The patient could then be channelled into the most appropriate first outpatient appointment. The GP could be advised on alternative management or referral options, either whilst patient is waiting to be seen, or the referral might be delayed pending the outcome of such measures.

It would be particularly helpful if outpatient consultant letters could be promptly dictated and sent. Consideration could be given to sending a copy to the patient; or to the referring GP if not the same as the patient's 'registered GP'. Letters should be clearly laid out with sections devoted to 'clinical problem and diagnosis' and 'summary and management plan'

A more open team approach to follow-up is recommended rather than an inflexible 3-6 monthly structure. The Multi Disciplinary Team could offer sooner rather than later checks on developments to alleviate patients' fears, provide support and guidance, and maintain trust and rapport. There could be open access to the specialist nurse by telephone, or home support with consultant feed back.

A Pain Clinic Formulary would very useful to establish use of agreed drugs. It would need to be transparent and educative and help non-specialists to familiarise themselves with this to aid to safer prescribing and shared understanding. It would be particularly helpful in shared care to support GPs in the use of less common interventions.

Primary / Secondary Care educational meetings could be held annually or bi-annually under specialist lead with GP support, to facilitate communication, raise awareness of available facilities and for training purposes.

### *What does a Pain Clinic want from Primary Care?*

GPs should be expected to make appropriate use of the analgesic ladder before a referral and/or consider alternative routes, e.g. physio therapy or biomechanics.

Referral Letters should state the clinical problem and other relevant diagnoses clearly; again sectioning the letter into History of Present Complaints, Present Complaints, On Examination, Drug History, Allergies, a Summary and a repeat of the reason for referral.

Shared Care of patients is vital to support the specialist therapeutic approach, offer good communicative channels, keep the specialist informed about interim developments and bring the drug history up to date before the next review.

As part of Continuing Professional Development GPs need to take on board PUNS & DENS (Patients Unmet Needs and Doctor Educational Needs) Educational specialist outpatient letters should provide learning points after referral,

### *An alternative pathway:*

There have been incentives to cut costs for Primary Care Trusts and saving cost on referrals has been a major target leading to Practice Based Commissioning. This has been introduced to allow GPs to find ways of dealing with patients that need specialist assessment or treatment that can be provided outside the Secondary Care setting. Such clinics are up and running successfully for dermatology and respiratory problems. These clinics are staffed by GPwSpl ('gypsi' - GP with Specialist Interest) and specialist nurses. Patients could be referred by GPs to a community based Primary Care Pain Clinic which collaborates closely with the Secondary Care Pain Clinic. Patients could then be referred on appropriately and can be referred back for community based management.

## End Of Road Patients

Diana Brighouse

I formulated a talk a few weeks ago and then thought - what am I doing? - my days of standing up in front of people giving a lecture are long past and my practice now is based on reflection and response which involves reflection on what's going on in my internal world and my external world and going with it. So that's what I'm going to do.

We have been talking about communication and quality of communication between ourselves as caregivers and our patients, but the thing that strikes me most of all is that communication *between caregivers* is really pretty dreadful. I think everyone in this room is speaking a different language. Our pain clinics work in quite different ways; we don't have the same philosophy, the same patients, the same staffing, the same budgets. And when we talk about "end of road" patients I think we should also be talking about end of the road pain clinics. About ten years ago we had just appointed a third pain consultant in Southampton. We were all part anaesthetics and part pain; we served a population of about half a million then and it's gone up to about 600,000. Portsmouth along the road serves a similar size population. Between us we serve some of the most deprived people in the country but also some of the most affluent. Portsmouth have gone down a totally different road from us and we probably represent completely opposite ends of the pain spectrum. At that time our clinic was repeatedly opening and closing in response to waiting lists we couldn't manage. Neither the hospital trust nor the PCT would finance extra staff so we reached an impasse.

We evolved a new model of practice purely in response to this imbalance of supply and demand. We had to serve the needs of a population of 600,000 with two fulltime consultants, me on 8/10ths and two associate specialist sessions. With this very marginal increase in staffing we have gone from a 2.5 to 1 ratio between demand and our ability to supply, to being able to meet our 9-week target from GP referral to being seen by a consultant, and have been held up by the DOH as a model of good practice. We have ticked all the boxes by being fully integrated and primary care based. I think this is sounding our death knell in secondary care. Why do I think this? The entire NHS is based on utilitarian ethics and philosophy. Look at what dictates our practice now: evidence based medicine and NICE guidelines. It is an approach based on population, not patients. We have three triage teams: pain, spinal and musculoskeletal, and the GPs decide which is the most appropriate. They are staffed by a consultant, a nurse and a physio. We insist on a standardised referral letter and any which are not are returned to the GP. At first I thought this was a dreadful way to treat our colleagues but it worked and now we never see a patient who hasn't been through the protocol of analgesics, physiotherapy and TNS etc in primary care. From triage they can go directly into pain management, specialist physio or the pain clinic. This is great in that it has managed the demand but it has totally changed the sort of patients we see in the pain clinic. When I started 17 years ago we had the usual mix of regular injection sessions and patients – we didn't have a clinical psychologist but I did that bit of it – and we saw what most clinics saw. Now we have one injection session every two weeks with a very few RF lesionings and about one block a year for cancer. Everything else is dealing with end of road patients. We never see patients with low back pain – we only see those with global, total complex pain. 80% of our patients fulfil the criteria for severe clinical depression. 90% meet the DSM 4 criteria for somatisation disorders. If you talk to psychiatrists they don't see patients with somatisation disorders as they don't know how to treat them. In response to my interest and retraining, and a perceived need, I now do one day of general pain a week and two of psychotherapy, and we have two pain psychologists. The latter have a remit to the pain management programmes, to individual patients, and most importantly I think to provide clinical supervision for the rest of our staff. This has come about through my recognition that professions such as psychotherapy have clinical supervision as a mandatory part of professional practice. This is different from team meetings: it's reflecting on your practice with somebody else.

The question I now ask is: I see our clinical psychologists who are CBT based who started off with six sessions – pretty standard practice – now offering up to 20 because of the

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complexity of the patients they see. Patients they think are not suitable for CBT and need something more in depth come to me for 40 sessions – a year. 90% of our patients are on subsistence benefits and statistically have no chance of returning to work. Taking a utilitarian approach, can we justify my salary treating patients who will never get off benefits and never cost the country less in order to improve their quality of life? Pain and suffering are subjective experiences; we can't measure them and I can't provide outcome data for my GP commissioners much as they require them; I can't say this patient's quality of life has improved – they're not interested in that; I can't say their family is still together, they haven't got divorced as I can't prove they would have got divorced otherwise, even though this was probable. I can't prove that the children have stopped truanting from school although my gut feeling is that they have. These sort of data are incredibly difficult to collect and it's a long term – 10, 20 years – project. But the Commissioners want data like now so they can make funding decisions like now for next April. I perceive that what was instigated as a response to limited resource and managing demand has been very successful in primary care and mild to moderate pain; as this huge drive for CBT in primary care is going to be very useful in managing mild to moderate depression. But we only have to look at what has happened to mental health services to see that funding in secondary care has gone down year on year (certainly in Hampshire) over the last five years. Consultants haven't been replaced as it's not seen as economically viable to treat those patients and I can see the same thing happening to pain clinics that work in the way that ours does.

But what about Portsmouth? This is still a highly interventional, injection-based clinic: it has at least eight consultants, all working part-time pain and anaesthetics. Currently it's doing very well as the GP's like to buy the services and they make the trust a lot of money. But it's about to change as their PCT's recognise that this is not the way to go and that they could better provide those services in primary care at lower cost. So the PCT's are calling the shots in response to Government initiatives and government intervention. (*Choose and Book* is another issue) I think it's interesting to look at the belief systems of the NHS and how they have evolved over the last 25 years and how the NHS reacts with the social services. I spend a lot of time in the general pain clinic writing to benefits tribunals, writing to housing department urging priority for re-housing – that sort of thing – is this the role of the doctor? I think it is but plenty of doctors including GP's say it's not theirs; but I think it's part of integrated health care and working for wellbeing.

When I see my psychotherapy patients in the pain clinic we very rarely talk about pain. I say to them: "we're working on the assumption that all human beings are disintegrated people to a greater or lesser extent – and you've disintegrated to a greater extent which is why you've ended up in this room with me. Your pain may be part of the outward manifestation of that disintegration. This therapy is aimed at making you a more integrated person. As a side effect of this your pain may (or may not) get more manageable or more bearable." That's the only claim I make. *They almost never talk about pain again.* They do talk about a lot of other stuff! I believe passionately in what I do: I think it's what I went into medicine for; its about listening to patients' narratives, its about being with them, it's about empathy (not sympathy) and about accompanying them on a journey. But I wonder whether as an NHS and indeed as a society whether we value these things any more, whether we're prepared to pay for them, and whether any of us as secondary care pain providers will have jobs in say ten years' time.

### Discussion on what Pain clinics are for.

I think you could measure your success in a different way: the out of hours contact. Those people that you see know they can come again and they have that point of contact. What we are looking at now is a list of people and the out of hours contact, and it's frightening because there is a certain type of patient who will just contact out of hours and as the service goes in the NHS you have less steady contact with your GP. You have a 9 to 5 clinic and you see anybody: the complaints I hear are "why can't I see my doctor?" Well since the first of April two years ago there is no "your doctor" any more – you see the doctor with the problem – so we're losing continuity of care.....

Our patients don't make out of hours contact – they make in hours contact – they ring up and it's very difficult to document this – because they ring up in the morning for an appointment as they can only get one within 48 hours and they get an appointment with someone – its quite easy if you're in a small area but we're dealing with 50 city centre practises.....

We are actually measuring this now. The practice I'm in has 2.5 times the average face to face consultation rate for the NHS and we need to do something as we're sinking all the time and struggling .... and we're in a very deprived area but you can work in other deprived areas and not had that problem; so many of our patients come in and just start crying - one or two patients per session....

We have 24 hour helpline too....

What I'm saying is that the figures may be there to show that you are keeping people from an inappropriate use of another service.

I remember listening to Waddel talking about biomedical characteristics of pain – I mean what are these? I don't recognise them.

Why has there been so little effort to try to short-circuit the progression to chronicity?

I think one of the reasons is lack of integration of the professions involved. If you look at the pain clinic model I think it doesn't work any more. This idea that you see a consultant that gets a treatment plan which doesn't start till 6 months or two years down the line and you may see someone else – an orthopaedic surgeon may refer to the pain clinic and then to a physiotherapist – it's this piecemeal approach which hasn't worked....

So what's the answer?

Integration. Now is the time to get together with PCT's and actually create the programme you want. They want to save money - they have GP's banging on their doors saying the pain clinic is closed – I've nowhere to put my patients - so they're keen to do something.

This issue of saving money – I wonder if pain clinics have been a soft target in some areas to save money but there are probably other services which you could probably save a lot more money on.....

I'm seeing patients from Luton, Harrow and Northwick Park – PCT's way outside our area because their pain clinics have closed; they are still paying the NHS tariff for those patients so they're not saving any money.

To go back to the title of this session "What are pain clinics for": it has been suggested that it's only for the complicated patients but I'm worried about the poor GP's - in secondary care we take the top off the pyramid bit GP's have to manage the whole of the base, not only with pain but all the other medical specialities. Now I don't happen to think that that is what pain clinics are for: we have to function at a much lower level than just the complicated patients –

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sure that can be done by other members of the team and not necessarily the consultant but I think we should get away from just dealing with the top of the pyramid.....

It's resource driven – that's the end of it – and if primary care will not pay for any more secondary care - they say they only want to pay for so much - let's call it "intermediate" care in the community - that's the end of it. When our clinic closed the GP's just told their patients they couldn't go anywhere. We don't get referrals from outside our area as GP's say this is not a priority for us. Chronic disease is not a priority.

It doesn't have anything measurable, so there's no box to tick.

I don't think any of this stops us getting together with the PCT's and primary care because that's what we are going to be asked to do – that's where should be in helping them to develop the services they need. For instance there isn't enough physiotherapy in primary care: I refer patients with simple back pain not needing any intervention back to their GP's for physiotherapy and they come back in 12 months not having had any.

Well they're getting referred but there's a 4 month waiting list.

I came to the conclusion that in the borders there were plenty of physio's out there but they were seeing inappropriate patients 35 times and clogging themselves up – or is this a gross injustice?

Certainly not .... The problem as I see it with musculoskeletal pain is the repeated referral by GPs of patients to an acute physio service and that with each referral the treatment becomes increasingly inappropriate since an acute approach is being provided for what is becoming gradually and inexorably a chronic problem. Each time the patient is sent for subsequent courses of physio the myth is reinforced that there is something that physio's can do to patients to alleviate the musculoskeletal pain problem. This clogs the departments so that everyone becomes a chronic problem – it drives me to distraction! To prevent this inexorable slide GP's supporting any interventional approach can encourage the message that patients take their own responsibility to take on board chronicity as do physio's; where all too often patients are maintaining their condition and so are their physios: i.e. they are suffering repeated episodes of pain due to inappropriate lifestyle choices, and unskilful attitudes to pain, movement and work. Physio's are massively complicit in this. (But there aren't going to be any physio's in two or three years because 90% of those who graduated last June have not got jobs and 50 to 70% of those from the previous year are in the same position – and its nearly as bad in OT – so we have two problems: not only are there not going to be enough senior physio's but they aren't up to the task - it's not their fault as they have been taught the same idée fixe of fixing the patient and when people like me - the "wrong kind of physiotherapist" as I have been called – want to bring in this psychology driven stuff.....

How do we take this forward? Do we need a multidisciplinary development team?

It's the same with psychology – we aren't going to have appropriately trained psychologists because although there are hundreds of psychology graduates with firsts trying to get into clinical psychology training programmes if they do they can't get jobs as the funding has been cut back.

One thing we GP's miss is the community based CPN whom we used to regularly meet in the surgery. It's the little chat in the corridor that makes all the difference – all the letters between health professionals don't provide this quick fix on the doorstep and GPS who operate in this way function much more smoothly. And if you extrapolate this to pain services and you have a physio in the building and you can say: I've just referred this patient to you – and you can write back to the GP and say we've arranged this and that - that's what seems to be missing in all this - we're coming back to continuity of care which does not seem to be on the political agenda.

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Yes – you get patients better in acute care, send them back home, and in twelve months they're referred again because no-one's bothered to maintain their level of fitness in the meantime.

The patient hasn't done their work.....

It depends what happens to letters – on any day I get 2 or 3 official letters about 8 pages thick – not patient related; all the latest directives about C difficile etc – which I have to plough through and then someone from the pain clinic writes to me and says this is what we want to do – I'm sorry but this gets lost ; but if you go in the building and say hello and have there coffee while they listen to you and you talk about the patients and you make a link – they remember that the next time they see the patients and then they refer appropriately. We've had so many changes – I have a filofax full of referral pathways and if you have to get it right - if you don't use the right questionaire the referral is returned to you by the specialist clinic . This is not my job! And there is a lot of frustration because there is no communication and that's where these things fall down .....

When we set up our new system one of us took 3 months of from clinical work to go round all the practices and we still make sure that one of us visits each practice once a month to keep up that contact – they know you're there.

We and the CFS physio's shared an office and the other physios were across the corridor, and at first they found us quite scary! – but we used to encourage them to drop in and made time for them – and they would say they weren't sure about this or that – and it was a much safer place not to be sure than across the corridor! And those kinds of contacts were incredibly nourishing for all of us.

That's working in an *interdisciplinary* way – I think the word *multidisciplinary* has a lot to answer for. We have always tried to get in early and we have evidence for that: we almost never now see any post-herpetic neuralgia; or chronic CPS because our orthopaedic surgeons know that I will personally go down and hang one of them if they have been sitting on someone with early symptoms and signs, and educating them and GP's. I have also been teaching GP's on a rolling basis on opioids – going out to practices and making interactive contacts.

We have been doing the same thing which is why we are left with these highly complex patients for whom early intervention probably wouldn't have done anything - I mean when would have early been early enough – at birth? I ask again: do we as a society want to bother with those people or do we simply put them on the scrap heap?

Has there ever been a discussion on what pain clinics are for at the BPS ASM? – no? – why the hell not?! And do these things come up in the discussions the BPS have with government? It seems to me that up to know we have been talking about bottom-up processes but there needs to be a top-down approach as well.

There are but much of it is a long way divorced from reality in pain clinics.

A lot of it seems to bypass pain clinics; I recently became aware of a physio-led pain service in the Westminster PCT which I knew nothing about – I think there are a lot of things happening which are Dept of Health led which we know nothing about.

I read about the Chronic Pain Patient Coalition in the BPS newsletter and I wanted to howl with despair as there seemed to be this expectation that *chronic* pain is what it's all about.....

There should be an overall strategy for pain in society which encompasses acute pain, chronic pain, palliative care etc: its all piecemeal stuff – there's no joined-up thinking

There are strategies for getting people back to work.....

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That's DWP, not NHS..... it works efficiently.....That's good but once again it's piecemeal.... It should be integrated ..... it is integrally related to our patients! .... The SWP took it on because the NHS wouldn't fund it.....

That's good but irrelevant as *there should be an overall strategy for pain and the Pain Society should drive it..*

Is this too wide to be achievable?

The profession has lost its way..... the GP's are under pressure as the government sees them as the one constant – to put it all together – but why aren't we doing the same for problem pain?

I agree. Other professional societies have been more proactive in this way and achieve things .....

Pain is such a vast issue – in general practice hardly a patient comes through the door without mentioning pain in one way or another..... we have to draw a line somewhere.....

We should start with no restrictions – start with a completely open mind – a blank piece of paper...

It's clearly very complicated – we started out trying to decide what pain clinics are for and we seem to have failed!

Hang on – what are the figures? 20% of the population experience chronic pain, and 25% a mental health disorder – another sort of pain. That's half the population! How are we going to devise a strategy for the Pain Society or anyone else? That's not the problem: the problem is to do with communication, societal expectations, values; it's a philosophical question.....

Strategy is not to do with patients – it's an abstract model, if you like, of how you deal with pain – OK the economic and geographical realities of trying to achieve that may be mammoth – or they may be simple depending on what approach you take, but we really need to think about it and we should be able to devise some kind of strategy to deal with pain across the board. Without one everyone suffers – a lot of GP's that I talk to just hold their hands up in despair or become cynical.....

But as a society that's what most people are happy with – what we are prepared to pay for: we are happy to pay taxes for treatment of heart disease and cancer and things that stop us dying .But things that give us pain or mental distress – well, it's not worth spending my money on that - until it happens to you.

But that's political spin – it's not what the patients want.....

Not what the patients who are suffering want.....

They are told they have choice but in reality they have very little choice – if you look at choose and book (a) it doesn't work and (b) where it does work you've probably only got one choice! - it's all sand in your face and I'm very cynical about it. If you break a long bone you are sent straight from casualty to the fracture clinic but if you're an old person and break an osteoporotic vertebra you sit and wait for two months – you don't even get a scan. If I have someone I think has an acute root compression I get a fantastic service from the X ray department who will do a scan within days but I can't get anything more done about it.....

Of course that's not what patients want but that's NHS policy – and voters and taxpayers want that .....

And our patients don't pay taxes.....

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Are things different in Scotland and Wales? More money is spent on the health service there – are there the same problems with employing more physios and so on?

It's often felt that there is more money about in Scotland and it's said that because Scotland is small that communication is easier and it's easier to get things done but it doesn't actually seem to be: pain clinics in Scotland are suffering from just the same problems as everywhere else. Professor McEwen made recommendations and there has been a working party in the Scottish Parliament but nothing has changed – a lot of talk and a lot of paper but nothing has happened.

As I fly on the wall I have been fascinated by the head of frustration you have built up with no attempt to make it go – how do we kick this ball: that's a political question. And when you talk about a strategy for dealing with the resources for pain management you really mean a political strategy – and an educational strategy – but *you are the people who could make this happen.....*

The British Pain Society should be there but it's not .....

That's a paternalistic attitude - why the hell haven't you been there?.....

Good question!

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## The clash of mangerialism and professionalism in modern pain management

Michael Platt

I'm going to diverge from the title slightly and talk about health care in general. I did a dissertation last year on this subject and found it so interesting I thought I would present it to you.

There have recently been fundamental changes in the ethos of health care in the NHS – I think we're all agreed on that. These changes are being prosecuted by an increased managerialism and appear to be challenging the roles and the ethics of professionals within medicine and nursing and allied professionals. This paper will define the concepts of professionalism and managerialism, analysing their origins and extrapolating their context in modern healthcare.

There are problems defining professionalism. A traditional definition is “the status of profession or competence or correct demeanour of those who are highly trained in a discipline” (Chambers 20<sup>th</sup> century dictionary) but the OED 2003 defines it as “the practising of an activity, especially a sport, by professional rather than amateur players”. Possibly its recent colloquial definition equates to the public's changing view of a profession. Parsons (1954) argues that this generalisation of professionalism implies that any occupation in which someone earns a living can be defined as a profession. Beecham (2001) strongly emphasises the importance of restricting the term professional in order to appreciate it in the context of professional ethics. Freestone and Johnson describe a profession as being able to control its membership with those members having a greater claim to an elite professional status. In academic circles it is recognised that there are more essential criteria that professions such as medicine and law have to demonstrate to secure this rewarding status. Bamford lists the criteria of these groups as having a unique body of theoretical knowledge, a legitimacy which is recognized by society, regulation of its membership, a shared collective culture, practising autonomously and adherence to a professional code of ethics. The term professional is associated with many ideas that can make it attractive or threatening to different groups. It embodies ideas of autonomy, of expertise, of a body of intellectual knowledge, a code of ethical behaviour, aiming to improve the welfare of others and to serve the public rather than seeking self-gain. Some of these ideas however are also related to notions of status and culture interpreted by many as power and wealth. A precise definition of professionalism remains imprecise because social structures change and evolve constantly (only that which has no history is definable - Nietzsche).

There is now appearing a ground swell of opinion that is reinstating professionalism, and others are seeking designation as professionals such as businessmen, nurses, allied medical professions, technicians, and pharmacists. Historically the origins of professions relate to Christian service, in a similar vein to health care. It might be said that they *professed* a vocation to serve God and their fellow humankind. The clergy, doctors and lawyers provided respectively services of the Church, care of the ill and defence of property and rights. They all required a literate education and training in institutions that originated in monasteries and became universities. It is often debated whether it is necessary to have a calling or vocation for a particular profession since modern society regards the life/work balance as singularly more important than devoting one's life to a profession and most modern university students would probably make a list of pro's and cons to help them choose a profession rather than listening to an inner voice. However most still see the clergy as a true calling, likewise that of a missionary doctor or nurse, or even philanthropic work as a business consultant. Though perhaps seen as not necessary vocation is seen as a key characteristic of the term professional which helps to differentiate it from other types of work. Morrel, in a study of the term profession in relation to the professionalisation of nurses, emphasises the value of maintaining the term by simultaneously addressing themes of knowledge, organisation and power. He undermines functionalist approaches based on work content. He highlights the complex social and managerial decision making interactions that occur with professional behaviour which tend to make basic work definitions too simplistic; and which ignore other

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aspects of medical professionalism including vocation and the holistic aspects of individual care involving empathy, sympathy, welfare and a general desire to do good.

So what are (for example) the peculiar characteristics of the medical profession? They might be listed as: it is a response to a calling or vocation and preliminary training as an intellectual encounter which involves a body of esoteric knowledge as opposed to mere skill; it possesses a code of ethics; it has a licence to practice from the Government; it is self regulatory; it is pursued for the benefit of others; it puts self interest secondary to that of its clients, and is not pursued for monetary gain alone.

What then is a vocation? The word derives from the Latin *vocare* to call. The words vocation and profession are sometimes used interchangeably but they are very different. Jose Ortega Y Gasset in highlighting the importance of vocation said strictly a person's vocation must be for a perfectly concrete individual and integral life and not for a social schema or career. John Bannisty wrote that "common to every story of vocation in the biblical tradition, both Hebrew and Christian, are four characteristics: firstly a person is called for a special purpose; second the person who is called has a special gift; third, implicit in vocation is the presence of a caller: in biblical narrative the caller has a name, be it Yahweh or Jesus; fourth, accepting a vocation leads to a life of sacrifice. Vocation focuses on obedience, accountability and faithfulness to the caller. It demands life ordering discipline to ensure responsiveness and also requires silence in order to be attentive to the caller". Both writers emphasise a connection between vocation and profession as opposed to that between profession and career – no doubt the latter is more highlighted by many modern university students. A vocation may be perceived as a profession like the monks of old, marking out separation from society to go into training to gain an esoteric body of knowledge.

However a profession can also be seen as a career with no sense of calling to God or human being, resulting in an expert occupation of work, without altruism, sacrifice, human service, heroism or beneficence in its broadest sense: simply the application of expert knowledge. Knowledge and training in the professions have a defined course of training in order to become a professional in a chosen field. The medical profession has a curiously esoteric body of knowledge which is highly specialised and unique to the purpose of providing succour, medicine and caring to suffering humankind. This in itself produces opposing emotional responses from society which requires on the one hand to have the knowledge to administer to individuals and yet is afraid of the power and knowledge that this group has. Traditionally doctors have been trained in specialised universities and teaching hospitals. As young initiates at the end of five or six years' training they have spent a year living in hospitals as housemen learning how to put their training to the practice of doctoring patients, screened away from society like monastrial novitiates and associating with death and disease which are taboos in modern society. This further isolated body of knowledge possessed by doctors marked them out as separate from society and peculiarly defined them in their chosen profession. Postmodernism, the desire for a better work/life balance and less influence of vocation in choosing a career have reduced much of the separateness of medicine from society. Patients are more educated and have unfettered access to esoteric subjects such as medicine via the internet. Trainee doctors are concerned to have a life outside medicine, do not live in hospitals, and have limited hours of work. Medical students, no longer separated from society in specialised university hospitals, are trained in multi-faculty campuses and often live at home. They no longer indulge in esoteric practices such as dissecting cadavers or looking at ancient sealed bottles of pathological specimens. Educationalists - experts in teaching and setting examinations rather than professors of medicine - lead in medical education, further reducing its separateness. Thus has medical training become socialised and may be said to be outside the profession, contributing perhaps to a feeling of loss of professionalism, esoteric knowledge and experience, and possibly a reduction in the altruistic and sacrificial aspects of medicine.

Throughout the history of medicine trainees have been required to swear a code of ethics and allegiance to the profession. Even modern medical schools do this, especially in America. The Hippocratic oath is the oldest code of practice in the world and is used as the model for many others. A version in modern English reads " By Apollo the physician and by Aesculapius the god of healing, Hygaea the god of health , by Panacea the god of remedy, and all the gods and goddesses, together as witnesses I hereby swear that I will carry out inasmuch as I am able and true to my considered judgment, this oath and the ensuing duties. To hold my teacher in this art on a par with my parents, to make my teacher a partner in my

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livelihood, to look after my teacher and financially share with him or her if they are in need; to consider him or her as a brother or sister along with his or her family; to teach his or her family the art of medicine if they wish, to impart all the lessons necessary to practice medicine to my own sons and daughters, the sons and daughters of my teacher and to my students who have taken this oath but to no-one else. I will help the sick according to my skill and judgement but never with an intent to do harm or injury to another. I will never administer poison to anyone or suggest to any patient to do so and I will never procure abortion. Instead I will keep holy my life and art. I will not engage in surgery not even upon sufferers for stone but will withdraw in favour of others who do this work. Whomsoever I visit whether rich or poor I will concern myself with the healing of the sick. I will commit no intentional misdeeds nor any other harmful actions such as engaging in sexual relations with my patients regardless of their status. Whatever I hear or see in the course of my professional duties is strictly confidential and I will not allow it to be spread about but instead will hold these as holy secrets. Now if I carry out this oath and not break its injunctions may I enjoy a good life and may my reputation be pure and honoured for all generations but if I fail and break this oath then may the opposite befall me." Within this oath are both a moral code for the profession and an outline of a system of accreditation by apprenticeship , establishing medicine as a profession society can trust. It contains remonstrations to be loyal to teachers and to the profession, to do no harm, always to do good ( the principles of maleficence and beneficence) , respect for the patient's autonomy and social justice. These have also been discussed as the basis of ethics in modern medicine. It is interesting to note the allegiance to various gods and goddesses – usually omitted in modern versions, although there may be reference to the Holy Trinity - which underlines the sense of calling to the profession.

The medical profession has been regulated in Britain since the 16<sup>th</sup> century. Islamic medicine has been government regulated since the 1<sup>st</sup> century after a caliph demanded appropriate physician regulation following the death of one of his subjects. Since the Bristol hospital inquiry and other mishaps including Shipman and Alder Hay there has been in increasing pressure to control the medical profession. The Department of Health 2002 document highlights the government's response to implementing professional regulation as a result of the Bristol hospital inquiry into the deaths following cardiac surgery of 29 young patients more than average. The medical profession is working towards higher standards amongst its membership by introducing regular appraisal and revalidation. The GMC will grant a licence to practise to all doctors in the Register to take effect from 2005 from which date no doctor will be able to practice medicine without a licence, but it will be possible for a doctor to be registered and not hold a licence. This may have implications for the medical workforce and limit their practice or it may increase their strengths by maintaining their independence and highlighting their adaptability to the challenge of change. Irvine, the president of the GMC, insists that sound self-regulation is essential to the maintenance of professional status and regaining public confidence. The introduction of clinical governance to assure good practice, the Commission for Health Improvement, NICE etc. are in place to strengthen both the public's and the profession's interests. This in turn will help to strengthen the relationship between them, encourage whistle-blowing and an honest and open culture, and prevent the continuance of bad practice. It can also be seen as a way of rationing the service.

To turn to altruism: despite the changes to the health service medical schools in Britain still tend to attract students with a sense of altruism and a desire to aid those in need. A study in the USA however suggested that students express great enthusiasm for being service oriented and doing good but are not necessarily receptive to the notion that they are obliged to these respects; indeed they expressed a variety of utilitarian views on things like codes of ethics and medical oaths to support their stance of non-obligation, both directly and indirectly. This may reflect a different focus in medicine between a business oriented private system predicated to making profit as opposed to a free health service. When people try to define what makes a good doctor the altruistic components of compassion empathy and listening continue to come high on most lists so perhaps individuals with these qualities do still tend to get attracted to the profession of medicine. A summary of 102 responses to a survey on this question came up with the following perceptions: firstly there are plenty of good doctors around and we should nurture them better. Secondly to be a good doctor you first have to be a good human being, a good spouse, a good colleague, a good customer at the supermarket and a good driver on the road. Thirdly it's easier to be a good doctor if you genuinely like

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people and want to help them. A GP from Wolverhampton wrote “to like other people – from this all else flows. Your patients will get you through the grind and tedium of the working day: They will be a source of strength and renewal - and you may even do some good.”

Finally, good doctors, unlike good accountants, good engineers or good firemen are not just better than average at their job, they are special in some other ways too: extra dedicated, extra humane and extra selfless. More traditional contributors want doctors to sacrifice themselves for the good of their patients. Others say they must look after themselves first or they won’t be able to help anybody.

Now to look at managerialism. The Thatcher government began to bring reforms into medicine with the introduction of more managers and managerialism into the NHS. This was a consequence of the famous Griffiths report of 1983 which made clear that the lack of public accountability for provision of health services could no longer continue. Managers or administrators sought to contain budgets and meet targets; doctors effectively resisted these changes yet were the ultimate determinants of their achievability. This was unacceptable so they introduced the tiers of managers which we now see. The senior of these were appointed as heads of units or hospitals and soon acquired the title of chief executive. The management model used was drawn from the private sector and clearly implied managerial accountability to the chief executive of all who worked in the organisation including doctors. In effect the emergence of managerialism into the health service gave managers a structural power to counterbalance the expert power of the profession.

So what is managerialism? It developed with the onset of mass production and major civil engineering projects in modern capitalism with their need for strategic planning, investment, and co-ordination and control of large complex processes. Companies are required to show profit for their owners and shareholders. In the pursuit of profit managers who are given targets and aims by the bosses need the workers to achieve these and keep and maintain the organisation. Managerialism has progressively become a way of working and a political force throughout the world, often being linked closely with the spread of democratic principles. Denhart suggests managerialism in public organisations is imported from commerce in the form of management practices designed for profit and efficiency. Examples might include strategic planning of human resources, reorganisation, redesign and re-engineering. He notes that these approaches have good and bad sides for public organisations, sometimes leading to excessive control and regulation. He also criticizes managerialism for alleged lack of ethical belief and democratic principles with its very hierarchical structure. However managerialism is also said to lack leadership. Managers seek to maintain the status quo while leaders develop visions and blaze new trails which may be dangerous for the organisation. Zaleznic feels that managers fear that risk may lead to failure, possibly explaining why they seem to fear change. In contrast, leaders are more willing to take chances. If they fail, they learn from the experience and try again. Managerialism is associated with bureaucracy with its hierarchical relationships and control mechanisms, resistance to change, risk aversion, turf protection, lack of creativity, rule mindedness and so on. Others define managerialism as an ideology incorporating an assortment of beliefs and values associated with organisations. It is also described as an ideology with analytical and decision-making tools and planning strategies producing a culture of its own and as an end in itself. This demonstrates an element of strong faith in the ability of managers to apply tools and techniques to solve organisational and planning problems to maintain the status quo of an organisation leading to its expression and development. Scott carries this type of analogy further, looking at the implications of managerial ideology for society as a whole. He suggests that at least in American society there is a tension between the idea of individual liberty and those demands placed on the individual by the rules of society. Managerialism allows for belief in the values of human co-operation as well as a conviction that effective co-operation can only be achieved within the organisation. Appropriate values are therefore those which encourage collaboration in achieving the goals of the organisation. Personnel submit to managerial control and sacrifice freedom in exchange for appropriate material awards. This conformity and agreement of the workforce contributes to the ever increasing influence of large complex organisations and their managers in modern society.

Managerialism can therefore be identified with at least four components: the aim of economic efficiency, the greatest output for the least input, the tools and techniques to resolve problems a unified managerial competence which places responsibility for organisational function on management and justifies a reliance on hierarchy and control

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inherent in bureaucratic structures. Managerialism is seen as working as a moral agent to achieve the greatest good not only for the organisation but for society as a whole.

Managers in the private sector clearly owe allegiance to owners and shareholders. Those in public organisations derive their legitimacy from Government policy and legislation, being accountable to the hierarchical structure of officials and politicians. There is debate about the comparability of public as opposed to private sector management. The managers in the private sector are autonomous of capitalist interest or part of the capitalist class whereas in the public sector their objectives are in pursuit of public interest.

Managerialism has often produced various codes of practice to protect the organisation from illegal practice to give managers an ethical basis for decision making and a sense of moral responsibility within the organisation. However the problem with codes of practice is that it is easy to stick them on the wall but hard to make them work in practice. It doesn't matter if a code has been developed to satisfy legal requirements, or whether a chief executive has sought to satisfy a noble sentiment that occurred in practice to lead the organisation into more ethical behaviour, or is designed to provide a set of sanctions for poor behaviour - without an effective implementation strategy which is integrated and engaged with the core issues that concern the organisation the net result is consistently the same: the code of practice remains a piece of paper.

So why is it apparently so different to professionalism which seeks endorse and practice a code of practice as discussed above? Well, managerialism lacks a clear ethic. It is focussed on maintaining the organisation and ensuring its survival and development rather than being interested in the wellbeing of a vulnerable and sick individual. In the NHS managers have now evolved their own code which interestingly puts patients first! Managers in the NHS must "make the care and safety of patients their first concern; respect the public, patients, carers NHS staff and partners in other agencies; be honest and act with integrity; accept accountability for your work and the performance of those you manage within your organisation; cooperate with colleagues in the NHS and the community. This code puts the care and safety of patients as its first concern, demonstrating how managers in health care also possibly have an altruistic concern for patient welfare. This might be related to the fact that the NHS is primarily for the medical treatment of patients so in order to further the aims of the organisation it makes sense to focus on their care and safety. However, whereas medical codes of ethics reflect a unique relationship of trust between doctor and patient, managerial codes reflect a more general approach in terms of responsibility to the organisation and morality in terms of responsibility to and shareholders, owners and governing bodies. Thus there is not the Kantian sense that mutually treating each other is seen as a duty and as an end in itself, since there is not necessarily the same goodwill. However many managers in health care appear to have an altruistic attitude to patients and often identify with this special role – I often wonder if these sort of managers come from a nursing background.

What about the future? Professionals and managers are beginning to work together much more closely – something that will continue as more complex managerial networks develop with seamless interchange between primary and secondary health care. Although the professional doctor appears to be losing autonomy much of this will depend on how he or she leads their particular group and how they interact with other members of the team. It is likely that there will be an increased sharing of knowledge with better care and follow up as is already being seen in cancer care. I think managerialism will become an increasing part of the health care environment and managers will take on some of the characteristics of their professional colleagues. It has been suggested that health care managers feel a vocation to managing the treatment of patients and see their role as ensuring that patients get the right treatment and management, already impinging on the ethic of medicine. It is also likely that doctors will take on managerial positions adding their ethos to that of management. Thus it is my theory that there will be a merging of the ethae of managerialism and professionalism as their roles increasingly grow together in the common aim of treating patients. However managers will be in charge of the corporation of the NHS which will create potential problems for medical practitioners. For example Chief Executives will be able to hire and fire any employee for poor performance. They may make redundancies to save money thereby seriously undermining professional autonomy. This could be described as deprofessionalisation such as has been suffered by teachers. However there is no doubt that the medical practitioner will always be required to treat patients and there is a limit to how much the autonomy of the profession can be dissipated. At the end of the day patients go to

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see doctors to seek expert treatment and managers cannot replace this function. However managers can facilitate the treatment of patients and the development of the infrastructure necessary to make this happen. Managers and doctors will always need each other in the health service. Their ethae may overlap but will never be the same.

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## Patient-practitioner interaction in difficult circumstances

Natasha Curran

As a pain trainee I have slowly come to the recognition of what might be called the dark side of our work: as doctors we usually want to believe and think the best of our patients in contrast to criminal lawyers and their clients – but not all people under suspicion of a crime are guilty and patients don't always tell the truth.

First of all I want to tell you about a patient who made me think about such questions. He was a young man in his thirties. He had already been seen by a consultant and I was seeing him for an intervention. He had been training in the police force; his arm was injured during practice of a restraint procedure. As a result he had dropped out of training and not returned, and was left with pain which had not been explained by investigations including nerve conduction studies. I was asked to give him a lidocaine infusion followed by alfentanil and other pharmacological challenges to see what might be useful for his pain. My first impression was that I didn't like him. I wondered why this might be? Firstly he was overly grateful to me, and then his reaction to alfentanil made me uncomfortable ("oh that's amazing – wonderful – first time I haven't been in pain for years – like six glasses of wine...." etc.- very gushing.) Although perhaps that could have been an appropriate response from someone whose pain of many years had suddenly been alleviated, I felt uncomfortable. The next stage in our usual regime would have been a trial of oral opiates but I felt unhappy about this. On the principle of "do no harm" I was worried that putting him on opiates might over-medicalise his situation and give rise to new problems that might be difficult to address, and I had the feeling that he might try to use me as a means to procure drugs that he might misuse.

Next I want to read part of an article by Tom Main entitled "The Ailment" (1957). He writes: "When a patient gets better it is the most reassuring kind of event for his doctor or nurse. The best kind of patient who having been in great suffering or great danger of losing his life or sanity responds quickly to a treatment that interests his doctor and thereafter remains completely well. Those who recover slowly or less completely are less satisfying. Only the most mature of purpose can encounter the frustration of their hopes without some ambivalence towards the patient. With patients who do not get better or even get worse despite long devoted care major strains may arise. Those who attend the patient are then pleased neither with him nor with themselves and the quality of their concern alters accordingly with consequences that can be severe for both patients and attendants. Some doctors use the devices of omnipotent scorn of illness and death, the treatment of patients as instances of disease and the denial of feeling about prognosis to reach something of the detachment of a research worker, which will permit them to continue their work without too much painful personal distress about the frustration of their therapeutic wishes. Refusal to accept therapeutic defeat leads to therapeutic mania, subjecting the patient to what has been significantly called "heroic" surgical attack, or a frenzy of treatments each carrying more dangers than the last, often subjecting him to varying degrees of unconsciousness, near death, pain, anxiety, mutilation or poisoning." He then goes on to talk about the uses of sedation in hospital. He interviewed nurses about this practice and concludes "a nurse will give a sedative only when she has reached the limit of her human resources and is no longer able to stand the patient's problems without anxiety, impatience, guilt and/or despair" He comments that it was always the patient and never the nurse that took the sedative. "After studying these matters the nurses recognised that in spite of professional ideals ordinary human feelings are inevitable and they allowed themselves freedom to acknowledge not only their positive but also their negative feelings which had hitherto been hidden under pharmacological traffic."

"Where the arousal of primitive feelings can be detected by the therapist he may of course put it to good use. He can proceed to find what it is about the patient that disturbs him in this way. There is nothing new in categorising human behaviour in terms of the impact upon oneself. Men have always been able to describe each other in such terms as lovable, exhausting, competitive, submissive and so on, which derive from observation of subjective feelings; but the medical psychologist must go further. He must seek how and why and in what circumstances specific responses arise in other human beings including himself." He

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goes on to describe events in the hospital treatment of a dozen patients, all of whom were severely ill and before admission had received many treatments at the hands of experts. Some had already been in several hospitals. None had been really well upon discharge, and most were worse. Their diagnoses varied from severe hysteria and compulsive/obsessional states to depressive and schizoid character disorders. He was pushed into recognising common features of these patients by nursing staff who compelled him to take notice of events which had long been under his nose. "It began this way: the nurses were concerned about a number of their members who had been under obvious strain at their work and sought to know if this could be avoided. I had known of two breakdowns of clinical severity but not the others which had been concealed by the individuals in question. Each of these had been associated with nursing of a particularly difficult patient who had not improved with treatment and had been discharged neither improved nor worse. These patients had been the subject of much discussion before and after their treatment but even with the passage of time the nurse concerned had been unable to reach a workaday acceptance of the bad prognosis and the failure of treatment. We now found that in spite of having made intensive and praiseworthy efforts with these patients far in excess of ordinary duty, at least one nurse and sometimes more felt she had failed as a person: if only she had tried harder the failure would not have occurred. This feeling ran side by side with another: the resentful desire to blame somebody else, doctor, colleague or relative, for the failure." It was decided to make a retrospective study of cases that the group regarded as major nursing failures. "The group turned its attention to matters of private feeling as well as professional behaviour but this was not easy as was revealed many times by silences, frightened off-target conversations, and distaste for further investigation." But they did continue and began to perceive a pattern of old unsettled interpersonal scores. They tried to involve doctors but found that they were very willing to discuss their patients in terms of psychopathology and treatment but were uneasy when it came to matters of personal feeling. They had no opportunity of developing in the group and sharing in its members' growth in overcoming their pain, and their pleasure in finding new ways of viewing their own behaviour. He describes admissions to his hospital: "the referring doctors were level headed people of right judgment and some deserved reputation. Each thought his patient was no ordinary person who should be accorded special status and care. They made passionate demands for the waiving of routines because of the patient's distress. Poor prognostic features were often concealed often concealed or distorted and the group came to recognise such phrases as "well worthwhile" and "not really psychotic" as being especially ominous. The referrers had all decided that their patients needed intensive psychotherapy and wished to leave little freedom of choice to the hospital. In all cases the referrers thought the patients had been mishandled in the past. Many people – doctors, friends and relatives had helped in the past in their own ways but few were on sincere speaking terms with one another. Most had been impressed with how little real understanding the others had shown and tried to rescue the patient by giving lengthy unusual services, but all in turn had sooner or later felt that all their aspirations had proved beyond their capacities and had sought somebody better than themselves and begged for their help. The team came to the half serious conclusion that whenever a patient's correspondence file weighed more than two pounds the prognosis was grave. (this was in 1950!) All these patients were female. Eight were either doctors, their wives and families or nurses. The treating team in the hospital consisted of seven doctors of varying experience and nurses who were all well qualified but fairly young. "All the patients aroused in the staff wishes to help of an unusual order so that the medical decision to treat the patient, in spite of their manifestly poor prognosis, was swiftly made. Each patient was felt to be a worthwhile person who had been neglected, who could not be refused. On every occasion one or other of the nursing staff had risen above their best, wishing to make special effort to help, to rise above mere routine and to be associated with a compelling case. These nurses were regarded by the doctors, the patients and themselves as having a special feel for the patients' difficulties. The group came to recognise the sentimental appeal from these patients and the arousal of omnipotence in the nurse, who came to believe that she possessed a quality that the others lacked and began to protect the patient from unwelcome routines, be much more permissive and tolerant of special demands than was her usual custom and would instruct other staff in how they must treat the patient. The patient's need for special attention was however never satisfied except for the shortest periods so that the nurse was led to make ever greater demands on herself. She came to feel that distressing the

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patient was a reproach to the insufficiency of her own efforts. Her handling of the patient became less dependent on her decisions and more by their behaviour. As week after week went by the patient became more disturbed but this was seen only as evidence of how ill they had always been and how much more devotion they needed than had first been imagined. Many of them also developed a variety of minor somatic symptoms. The nurse would remain with the patient through anger, depression and insomnia, soothe them with sedatives, protect them from unpleasant situations and give them immediate attention whenever needed. The favourite nurse came to believe from subtle remarks from the patient that her colleagues did not have the same understanding. There was a queenly quality about these patients in that it became an honour to be allowed to attend upon them and unless the nurse did well, favours would be withdrawn, and she would be classed with all those who had proved fickle in the past. Some nurses became rivals to look after these patients and felt it was a tribute to their own special sensitivity to be chosen, and those not so favoured felt shame, envy and resentment.

All of these patients were given special treatment sessions and the arrangement evolved that if they became distressed in the evening the doctor would be called to settle the crisis with a special session in their bedroom. Increasingly the therapist would grow to mistrust the nurse's ability to manage the patient and take more decisions himself. Other members of the staff who were not engaged in the primary treatment of the patient (the "in" group) but from time to time cared for them in minor ways (the "out" group) and were not regarded as favoured by the patient, would in polite ways indicate disagreement with the handling of these patients with such devotion and resent the disturbance created for them and their own patients, and increasingly critical of the "in group" and blaming them for making their situation worse by morbid indulgence. They described the patients as "hysterically demanding" and "getting away with it" and the ingroup as collusive and unrealistic; the ingroup responded that the patients were "overwhelmed with psychotic anxiety" and accused the outgroup of being suppressive and insensitive. Eventually the main nurse of the ingroup, needing but failing to get justification from her patient's improvement, would become too disturbed to carry on, anxious, ill or suddenly angry with the patient and in despair at the stupidity of continuing to work with such an unrewarding patient.

One nurse told the study group that there was something that she alone knew: a patient had told her in confidence that she had had a criminal abortion. She felt honoured to be trusted more than any other nurse and had respected the confidence. Then one nurse after another revealed that they had been told the same thing and that they too felt honoured and that the others had been too condemnatory to be told. "We subsequently found that other patients used similar confidences which they came to call "precious little jewels" which had been used to form special relationships with several nurses, making each feel more knowing and inhibiting them from communicating honestly with one another."

As Tom Main observes these events were unremarked and hidden until a searching study brought them to light. He concludes "I believe that similar study of difficult patients in other hospitals, outpatients and general practice would show similar hidden events" These words were written in 1950 and are as relevant today.

I would like to conclude with description from my own experience of a "queenly patient". This was a lady who had been seen in by a consultant in a pain clinic for many years. She was an ex-nurse who had stopped working because she had injured her arm at work and had neuropathic pain with no apparent cause for which she was receiving stellate ganglion blocks. This is a procedure not without hazard and she had had a fit due to intravascular injection of local anaesthetic but this hadn't put her off. My consultant began to have misgivings about these repeated procedures but asked me to do one which went well and worked beautifully. When she returned for another one later in the week however I was informed that it hadn't worked and her pain was as bad as ever. I was very puzzled as it had been a technically successful block. It was inferred that this because I was only a trainee. I mentioned this to my consultant who responded "don't worry Natasha – there's nothing you can do about this – *I think I've created a monster*".

We do a lot of practicing on our own in pain clinics without the opportunity to talk to anyone else. If I had talked to someone I might have had different feelings both about myself and the patient. Why don't we have clinical supervision and discuss difficult cases, which would make us think and behave differently? We don't have any specific psychological training or much

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knowledge of personality disorders. And if this sort of thing is happening with us in a short time in hospital what can be happening at home?

### Final discussion

There must be sort of pattern we could recognize in patients like this to forestall subjecting them to inappropriate treatment

Treating the patient as an individual is paramount....

The main problem is that this is all an unconscious process

If there is honest communication between people who are involved with a person it begins to become clear what is going on and you can start to deal with it in a more direct way.

I was involved with a family that only discovered at their mother's funeral that she had been playing all of them off against one another. These people have such power and it has to be stopped because it's bad for them.....

I have a classic case: the 23 year old daughter of a professor of neurology, whose mother and sister are also doctors, and she is manipulating everybody. Her father is part of it and actually crosses off drugs I have prescribed he doesn't approve of, and I backed off at that point. But how can you turn this around? Who can you turn to in this situation?..... Because if we don't do anything.....

Because these patients are in a minority we tend to accept them – I don't know what to do with them but neither does anyone else so I'll just manage them in the best way I can, or just shut them off..... so the pattern will just be repeated and repeated....

I got one of my colleagues to take over management....

But the same will happen again....

Of course – but what do you do?

Defining boundaries is a good start – you find yourself getting seduced and you "act in" to the mythology of the patient – so the trick is to adhere to our professional boundaries. If you can maintain that with some measure of thoughtfulness and consistency and not react in an angry way ..... but it's a two way thing and you have to involve the patient and they must avail themselves of what is on offer – somewhere they have got to do something. Very sadly with personality disorder patients there is this cumulative effect of realisation of a pattern – there has been so much destructiveness in so many of their relationships and somewhere there is a deep sense of despair – but if instead of terror and collapse they can acknowledge that "I would like my life to be different" – then there is a spark of hope.

But what do those of us not working in the psychological field do?....

The danger is that if you have a patient with a physical problem and you explore this and can say that beyond reasonable doubt this is not what you're suffering from – you can exclude cancer for example - then you get a complaint. A recent case like this – I couldn't make out why she seemed to hate me and be out to get me – she was demanding more referral and I had shown her why this was not necessary – and only later I realised that she felt I had closed the door on her.....

Doesn't that bring us back to the first meeting and the fact that Western medicine is embedded in dualism so that when you tell a patient that there is nothing wrong with them they say "the doctor says I'm making it up, it's all in my mind, I'm a fraud". I see many

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sexually abused patients in my psychotherapy practice and have documented the fact that they have alienated every single professional they have come across; as a consequence they have been rebuffed and rebuffed and finish up evincing the sort of responses that Natasha has been talking about. I feel there is nothing I can do for her (on the dualistic model) – that makes me feel bad so I put all the blame back on her and the behaviour is reinforced and the alienation is perpetuated.

..... and that's exactly what happened with the patient mentioned earlier – I feel I probably failed her - not by examining her, I think that was justified, but I re-elicted her fears and expectations by that consultation. And I think that risk is out there 24/7.

What helps sometimes when you're thinking about communication is trying to work out what's mine and what's theirs: for instance both their and your narcissism, like the young man who was inviting Natasha to feel absolutely marvellous, but she quite rightly wasn't prepared to go there because that's not what she wanted. And the other patient would have had a narcissistic glow that you didn't do what she wanted. When I work with patients, and it may take weeks or months, if I can somehow get myself to a position where I can somehow unravel what appears to be the position they have manoeuvred me into, then I see it as a reflection of some kind of profound communication from them, and I feel liberated and that I can find my way better. Then you also feel that the decisions you make professionally are bases on something solid instead of this horrible feeling that I don't know where I'm going

And as Natasha raised we in the allied professions don't get any training in psychology – and you need a strong underpinning to deal with this sort of thing. There is clinical supervision....

Who is best placed to offer clinical supervision? – someone from outside the team or within it?

{in Southampton} our clinical psychologist has at last obtained funding to offer clinical supervision to the team individually (1/2 an hour per person per fortnight) and I facilitate a peer group supervision for the doctors (an afternoon group session once a month.)

And this should involve everybody including receptionists. People are reticent at first and then it takes off – once it gets going it doesn't necessarily need a psychologist....

These patients need time – you can't manage them in six or eight sessions of CBT. It may a long way down the road before you can find a foundation to work on.  
You've got to get your trust to recognize that this is worthwhile use of clinical time – and in the current climate they may not be very likely to.

The sort of people you are describing are out there in the community and they are causing mayhem. I had a similar case in an educational setting with a student who would be allocated a tutor who would be the most marvellous person in the world for a few weeks and then there would be a falling out and there would be letters to the Dean and the Vice-Chancellor.... Not being medical we don't have the facility to deal with this sort of behaviour but neither do we have the obligation – so excluding from the college is the only option to protect the welfare of the other students. I have done this and my only regret is I didn't do it quickly enough. But can you do this?

We're not obliged to treat patients. As a professional you don't like too withdraw treatment as it's not in the nature of the job – but I have to ask why won't psychiatrists and psychologists deal with this sort of patient? – because they clearly need it....

There is also the unpopular idea that such people need to face their own problems and sometimes rejection – realising that we are no longer prepared to play their game and their way isn't working any more - is the one thing that makes them want to change their way of dealing with life. It's very difficult in the medical field because of the ethic and the feeling that we should always be trying to help everybody; but is that the best way to help them – it's a big dilemma.

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Perhaps time is the key – sometimes I despair of an adolescent I have been working fruitlessly with and is locked into a destructive situation and then treatment ends, and I make peace with myself by accepting that what will have to happen is that they will probably get much worse but when things get really bad something within them will propel them into saying..... rather than other people worrying about them - they project their fears and worries on to family and professionals... and if they can relocate their problems into themselves this is good.

There are analogies with work that has been done with serious serial bullying ....[inaudible]

But in a way we potentiate their behaviour as we're the sympathetic ones trying to make them better.

We collude with making people dysfunctional.

We can perhaps provide a useful service at least to our medical colleagues and prevent patients going on round and round the referral roundabout with a policy of containment – if I continue to provide a limited contact and they realise that I can't cure them but I can offer this point of security – for instance a woman who contacts the social services about every two years (and they always give her to the most junior worker!) and it says in her notes always ring me. She's not happy but she can go on living her life – no-one is going to make any difference to that...

But even in that hour a year you are offering some sort of minimal therapeutic relationship - it may be the only relationship they have ever had in their whole lives...

Talking to people from other health care systems, notably in the USA, makes me realise the value of our very structured system which does enable some sort of containment on people because they have a single GP so they're not being cycled round and being reinforced all the time.

It's important to remember that however bad these patients may make you feel it's so much worse for them as they can't get away from themselves.

I would like to conclude the meeting with two quotes from Gnostic philosophy: "How can I overcome mental, emotional or physical suffering? By not treating it as a problem to be solved through one or the other medication or treatment. The first step in overcoming suffering is to stop seeking a solution or healing cure for it." "We think of pain as causing an imprisoning sense of isolation, separation or apartness from our own being and others' being" And I think that's what we have been talking about: being *with* people and not doing *to*. And that's a problem for all of us.

