

Medicine – the Healing Art

Launde Abbey

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Two strands came together to make the warp and woof of this year's meeting. The first was an article in the Journal of Medical Ethics by John Saunders, consultant physician at Nevill Hall hospital in Abergavenny and Professor of Philosophy, Humanities and Law in Health Care at the University of Wales, entitled "The Practice of Medicine as an Art and as a Science" in which he argues that although the practice of modern medicine is the application of science, the ideal of which has the objective of value-neutral truth, the reality is different: conclusions are applied by value judgements that may be impossible to specify in particular circumstances. "For medicine as an art its chief instrument must be human faculty....the ability to listen and empathise.....for the doctor to be part of the treatment; but although part of the art of medicine may lie in these areas, it does not exclusively do so. The art and science of medicine are inseparable, part of a common culture." The second strand, which kept coming up in our discussions last year, especially in the context of Diana Brighthouse's talk on her work as a psychotherapist with "heartsink" pain patients, is the concept of healing, of restoration to health and wholeness, which includes but is so much more than the relief of "physical" pain and which we can still aspire to even when this fails.

We were doubly fortunate in having both John Saunders and his friend and colleague Martyn Evans, Professor of Philosophy at Durham University to guide us in our explorations of these inter-related subjects.

Unfortunately thanks to the temperamental recording system (and the incompetence of it's operator – me) the record is incomplete and omits much of the discussion which is such an important part of these meetings. Where this was preserved contributions from the floor are reproduced in italics.

The practice of Clinical Medicine as Science & Art

John Saunders

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University of Wales.

My title does emphasise the practice of medicine. So I don't want to get too stuck into medical research. But equally I'm not going to get distracted into an ethical debate; nor into so called alternative medicine, most of which is wholly nonsensical and practiced by those with an attachment to magic and an aversion to reason; nor do I want to spend a lot of time in etymology - what the dictionary defines as science or art or medicine. It may be tautological, but I shall regard medicine as the thing doctors do; & science as somehow linked to knowledge and historically the most stunning achievement of Western culture - even beyond the Sistine Chapel ceiling or Handel's Messiah or Shakespeare's plays.

At the start of Cecil's textbook of Medicine is a discourse on medicine as an art. Its focus is the patient - defined as a fellow human seeking help because of a problem relating to his or her health. Not a bad definition, I think. From this emerges the comment that for medicine as an art, its chief and characteristic instrument must be human faculty. What aspects of the faculty matter? Well, we are then offered the ability to listen, to empathize, to inform, to maintain solidarity: for the doctor, in fact, to be part of the treatment. Now I don't want to dispute the desirability of these properties but I think they describe firstly moral dimensions - we listen because of respect for persons and so on - and secondly, skills. Interpersonal skills may be frequently lacking, just as technical skills may be. But they can, at least, in principle, be observed, taught, tested, their value assessed, just like any practical technical skill. And I think we could probably say much the same about the third part of the mantra of medical teachers, attitudes. Skills, attitudes, knowledge. Let us come back, as western philosophers always do, to knowledge. This links us with science. I want to suggest that the art & science of medicine are not in fact inseparable, but part of a common culture. Knowing is an art, science requires personal participation in knowledge.

Medicine in industrialized countries is scientific medicine, write Glymour & Stalker. The claim tacitly made by US/ European doctors and tacitly relied on by their patients is that their palliatives and procedures have been shown by science to be effective. Although doctors' medical practise is not itself science, it is based on science and on training that is supposed to teach doctors to apply scientific knowledge to people in a rational way. Intellectual problems have an impersonal, objective character in that they can be conceived of as existing relatively independently of the particular thought, experiences, aims and actions of individual people. Without such an impersonal, objective character, the practise of medicine would be impossible: "Medical practice depends on generalizations that can be reliably applied and scientifically demonstrated. Without understanding people as objects in this way, there can be no such thing as medical science." In the accumulation of such knowledge, doctors - like engineers - share experiences individually through meetings & publications. And this inter-subjectivity establishes the objectivity of science, it is knowledge that can be publicly tested. (I shall say something about the testing later). We can sum up this approach as a *doctrine of standard empiricism* in which the specific aim of inquiry is to produce objective knowledge and truth - and to provide explanations and understanding. Science as pure science is knowledge of our natural environment for its own sake, or rather, for understanding. Science as technology is the exercise of a working control over it. Such is medicine. In its methodology, scientific thinking should, indeed must be insulated from all kinds of psychological, sociological, economic, political, moral and ideological factors which tend to influence thought in life and society. Without those proscriptions, objective knowledge of truth will degenerate into prejudice and ideology.

So the aim of standard empiricism is value neutral truth. That is not to suggest that science is insulated from outside factors - only to state that such factors are not integral to it - e.g. social context Doctors (& other health carers) are, of course, enmeshed in the obligations & responsibilities of their profession. Their role as technologically trained practitioners according to the canons of standard empiricism does not exclude them adopting other roles - as a consoler or healer, for example. There is no logical bar to combining several roles; nor does standard empiricism form any logical bar to caring, empathy, compassion, 'moderated love' or, simply, personal medicine. Nevertheless I think we might pause to look at what happens in practice.

Many doctors like to bask in the reflected glory of medicine as a scientific undertaking that transcends national barriers. In fact much clinical practise is more influenced by national culture and character. Take the French disease, 'spasmophilia': it is a condition that increased sevenfold in the 1970s & is diagnosed on the basis of an abnormal Chvostek sign and oddities on the EMG. In the US, if it exists at all, it is panic disorder. In Britain, it doesn't exist - so presumably sufferers in France might be cured by a trip on Eurostar. Being romantics, the Germans regard the heart as an organ with a life of its own: they consume six times as many heart drugs as their British counterparts, with cardiac glycosides being the second most prescribed group of drugs after non-narcotic analgesics. One ECG survey of supposedly healthy citizens of Hamburg showed a rate of abnormalities of 40%. Germans have 85 drugs listed for treatment of low BP and annual consultation rates of 163 per million. Hardly anyone in Britain gets treated for low BP. Doctors in the US think treating low BP amounts to malpractice.

Fashion is another powerful influence. There are treatments of fashion, investigations of fashion, diseases of fashion, operations of fashion. Hypoglycaemia comes and goes; chronic mononucleosis is probably on the way out, please God so is ME. Mitral leaflet prolapse syndrome caught our fancy in the 1970s when everyone had it; then we've had temporomandibular joint syndrome, post traumatic stress syndromes, osteoporosis, fibromyositis, candidiasis hypersensitivity syndrome, total allergy syndrome, Gulf War syndrome, repetitive strain injury - and so they go on, a disease of fashion almost every month. I could make similar comments on treatment or investigations.

Now you may object that all this is rather unfair. It doesn't (I agree) demonstrate any admirable art in medicine: merely bad science or inadequate science or no science. And its practise is bad medicine; bad medicine pressured by the degree to which disease is the sustenance of TV dramas, magazines, commercial ads, the food industry, the publishing industry, sport and even the weather forecast. Aren't I simply demonstrating that 85% of medical procedures are unproven - a figure I understand is widely quoted, poorly defined, based on abysmal evidence & almost certainly wrong - but very fashionable of course. Isn't what we need more & better clinical trials? - the gold standard (ghastly phrase) on which to base practise? The controlled, randomised clinical trial has been a powerful instrument in furthering medical knowledge and, of course, a doctor should know its results, but it is often not enough in recommending treatment for this patient. The double-blind, randomised, controlled trial (RCT) is an experiment: but experiment may be unnecessary, inappropriate, impossible or inadequate. A dramatic intervention such as penicillin in meningococcal meningitis does not *need* a RCT to demonstrate its efficacy. A RCT would be *inappropriate* if the effect of random allocation reduces the effectiveness of the intervention when active participation of the subject is required, which, in turn, depends on the subject's beliefs and preferences. For example, in a trial of psychotherapy both clinicians and patients may have a preference, despite agreeing to random allocation. As a result, the lack of any subsequent difference in outcome between the comparison groups may underestimate the benefits of the intervention. The RCT may also be inappropriate if the event is a rare one (the number of subjects will not be sufficient) or likely to take place far into the future (it can't be continued long enough). For example, in the UK Atomic Energy Authority mortality study, 328,000 person years experience among radiation workers was examined. This was still many times too small and yielded unsatisfactorily wide confidence intervals. In interpreting low order risks, study situations are usually complex. In a multi-factorial disease, a factor which increases the risk by less than half will almost certainly be undetectable. A RCT may be *impossible* if key people refuse participation, or if there are ethical, legal or political obstacles. Finally it may be *inadequate* if the trial involves atypical investigator or patient groups or if patients in the RCT receive better care than they would otherwise receive, regardless of which arm they are in. One answer to the failings of the RCT is a plea for 'observational methods' (cohort and case control studies). In a recent BMJ paper, Black argues that the RCT provides information on the value of an intervention shorn of all context, such as patients' beliefs and wishes and clinicians' attitudes and beliefs, despite the fact that such aspects may be crucial to determining the success of the intervention. By contrast, observational methods maintain the integrity of the context in which care is provided. He concludes: There is no such thing as a perfect method; each method has its strengths and weaknesses. The two methods should be seen as complementary.

How then does one balance the information from two different approaches? If they are complementary, what rules exist to decide how much one looks to one method rather than the other? The answer is surely none. The good doctor uses his personal judgment to affirm what he believes to be true in a particular situation. His knowledge is not purely subjective, for he cannot believe just *anything*, and his judgment is made responsibly and with universal intent. It is practical wisdom. Medical practice demands such judgments on a daily basis. The good doctor is able to reflect on diverse evidence and to apply it in a particular context. No computer could replace him, for the judgment cannot be reached by logic alone. Here medical practice as art and science merge.

Perhaps part of the art of medicine lies in those non-scientific rules of thumb that guide decisions in practise. These cannot be and are not science. Let me list some of these.

Occam's razor tells us to go for the simplest unifying hypothesis in diagnosing the patient's disease; Button's law (based on the bank robber who told the judge he robbed banks because that's where the money is), tells us to go for the commonest explanation. Perhaps you could subsume those two principles into the structures of science. But what about extrapolation: it works in the old or the male, so we'll use it in the young or the female. Or we won't in certain other cases. Instead we use the "show me" principle. Practolol was shown to reduce post MI deaths, but other beta blockers were not assumed to be effective until huge trials had been mounted. Or we treat numbers: cholesterol, blood glucose, blood pressure are shown by science to benefit by reduction at certain extremes; then we lower the threshold. Or we assume we know more than we do. Because nothing grew on throat swabs, we assumed sore throats were viral and avoided antibiotics. We now know from DNA sequencing data that fewer than 2% of identifiable bacteria were being isolated. Or we treat through plausible hypotheses e.g. in the 1960s, nitrates weren't used to treat angina, because of the supposedly well known phenomenon of coronary steal. Or we believe our tests are more discriminating than they are e.g. the claim that no PE if pO₂ >80 mm Hg. Or we have expectations that are too great. Remember that premarketing safety data of drugs reveal acute toxicities occurring more than 1 in 100 administrations. If it's < 1 in 1000 it will take 6 months to find out. Chloramphenicol was removed as a front line antibiotic because of 1 case of aplastic anaemia in every 20,000. Or our expectations are too low: 'flu immunisation, around for decades, really does work; diabetic eye examination is highly worthwhile.

Or our definition of disease is too narrow: Thus we have angina without pain, toxic shock without shock, asthma without wheeze. Or we over-investigate & undertreat, because all treatment becomes subservient to diagnosis. Or we operate on the asymptomatic because we believe it will be worse later -forgetting that it may not be or that technical breakthrough may occur (laparoscopic surgery for gallstones) None of these processes of decision are logical or scientific in the usual sense of that word or based on evidence.

Scientific medicine is based on evidence; there is a Malthusian growth of uncertainty when multiple technologies are combined into clinical strategies. Two strategies can be used in 2 different sequences; 5 in 120. Does anyone here know how to treat an acute MI? So some may espouse minimalism, some intervention based on inference and experience.

Fortunately paralytic indecisiveness is rarer than it might be. Indeed we become so easily confident in our educated guesswork that it is easy to confuse personal opinion with evidence, or personal ignorance with genuine scientific uncertainty. Alas, guideline writers often fail to distinguish fact from fervour. Clinical reasoning, with its reliance on experience, extrapolation and the other rules I listed must be applied to traverse the grey zones of practice. The prudent application of evaluative sciences will affirm rather than obviate the need for the art of medicine.

Eliciting patient preferences is especially important when there is doubt about the best course of action. This is difficult with long term treatments when a patient's preferences may change as time passes, but decisions are needed now. In a recent article a Norfolk physician pointed out that the largest trial of antihypertensive therapy studied 17,000 patients with mild hypertension - over 90,000 patient years of accumulated treatment. No benefit was found in lives saved from or coronary heart disease prevented & the reduction in stroke implied 850 patient years of treatment to prevent one stroke. Or put another way, if 25 people take antihypertensive treatment for 35 years, only one can be expected benefit. Thus 24 people will take 38,325 pills - a total of 919,800 tablets of no proven benefit. Or 3 miles of tablets. I know most of us estimate our gin consumption in units per week rather than swimming pools per lifetime, but this example does suggest a different perspective than $p < 0.05$. No matter to what extent information is provided, the doctor decides its nature and by his advice almost always determines the outcome. As Theodore Fox said, 'the patient may be safer with a physician who is naturally wise than with one who is artificially learned.' At the risk of causing both controversy and grave offence, isn't this one of those qualities that the apprenticeship system of teaching at the bedside has traditionally given the British graduate in contrast to the fact packed foreign graduate - and a quality that is both important and now actively excluded by the politically acceptable explicit mechanical processes of making appointments? Denigration of value judgement is one of the devices by which the scientific establishment maintains its misconceptions,' (JK Galbraith) Judgement and its bedfellow wisdom are concerned with adding weight to the imponderable, with adding values to the unmeasurable or unmeasured.

Consider this example from a recent copy of JAMA. A 42 year old mother of 2 small girls, despondent over job difficulties, was contemplating genetic screening for breast cancer as she approached the age e at which her mother was diagnosed as having the same disease. Aside from the difficulties in taking an evidence - based approach to assigning quantitative risks and benefits to the genetic screening procedure (How much should I trust the available information?) and uncertainty about the effectiveness of medical or surgical interventions (Would knowing the results make a difference, and, if so, to whom?) the case raised important relationship centred questions about values (What risks are worth taking?), the patient-doctor relationship (What approach would be most helpful to the patient?) pragmatics (Is the geneticist competent

and respectful?), and capacity (To what extent is the patient's desire for testing biased by her fears, depression, or incomplete understanding of the illness and test?). In this situation, book knowledge and clinical experience alone are insufficient. Rather there is reliance on personal knowledge of the patient (Is the responding to this situation in a way concordant with her previously actions and values?) and the doctor (What values and biases affect the way I frame this situation for myself and for the patient?), to help us arrive at a mutual decision. The reflective activities applied equally to the technical aspects of medicine (How do I know I can trust the interpretations of medical tests?) and the affective domain (How well can I tolerate uncertainty and risk?). An attitude of critical curiosity, openness, and connection allowed the patient and doctor to defer the decision and reconsider testing once the immediate crises had passed.

It has been said elsewhere, "we don't see things as they are, we see things as we are." Evidence based medicine offers a structure for analysing medical decision making, but it is not sufficient to describe the more tacit process of expert clinical judgment. All data, regardless of their completeness or accuracy, are interpreted by the clinician to make sense of them and apply them to clinical practice. Experts take into account messy details, such as context, cost, convenience, and the values of the patient. Doctor factors such as emotions, bias, prejudice, risk-aversion, tolerance for uncertainty, and personal knowledge of the patient also influence clinical judgment. Clinical judgment is both a science and an art. It is impossible to make explicit all aspects of professional competence. Evidence-based decision models, for example, may be very powerful, but are like computer generated symphonies in the style of Mozart - correct but lifeless. The art of caring, then, for patients should flourish not merely in the grey zones where scientific evidence is incomplete or conflicting but also in the recognition that what is black & white in the abstract is often grey in practice, as clinicians seek to meet their patients' needs. Good clinical practice will always blend the art of uncertainty with the science of probability.

Pilgrimage and self-betterment: some provocations from the humanities

Martyn Evans

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I want to talk about flourishing and what it means to enhance people's ability to flourish, and when it is a proper thing to attempt in a professional context. I hope not to emulate Sybil Faulty as introduced by Basil: "name Sybil Faulty: specialist subject the bleedin' obvious"!

To start with, three philosophical questions about pain: is it private, is it sensibly measurable, and is pain a noun or an adjective?

I'm fond of saying that human beings like all other creatures have this curious attribute of being meat, but meat with a point of view. We can map the distinction between pain on suffering on this: the meat feels the pain but the point of view endures the suffering. So this morning is to explore the idea that there is a philosophically distinguishable distinction between them just as there must be clinically. Part of that will be to look at whether we take subjectivity seriously – as distinct from objectivity and generalisability in the hope that it will steer us towards something the humanities do quite well. Just as science does evidence and knowledge about the material world quite well, humanities do something like evidence and understanding of the inner world – the world of subjective experience – quite well, and I think there is a place for both in clinical health care.

So to return to the first of our three questions: is pain private? The answer is yes and no; yes because you can't have my pain but I can, and I can't have your pain but you can; neither you or I can see or hear my pain; and even the most sophisticated imaging technique can't image my pain either. It can image some kind of surrogate or vehicle for pain but can't image the pain itself any more than it can the taste of chocolate. But we can all see and hear the expression of pain and other surrogates for it. And that leads us then to think about the relative status of the experience and the expression. Are my pain reactions biological? – yes. Are they psychological? – yes. Are they cultural? – yes. This is all a bit awkward as the public and the private get mixed up. I'm not going to try to disentangle them but to apply the mix in a minute. So the answer to the question is pain private is that it is logically private and yet how it comes out is not entirely private even though we are dealing with surrogates like expression.

Is pain measurable? My wife says that men and women have demonstrably different thresholds to pain but I say nobody can know that. She replies oh yes you can as if the same thing happens to us both I will scream but she will only grunt or say or bother! But we're not measuring pain here: we can measure the stimulus but we can't measure what goes on inside. It may be that men exhibit more extravagant pain reaction to what appears to be the same stimulus but there may be a perfectly good explanation for that: it might actually hurt guys more, and nobody can prove that this isn't the case. The problem is that the only bit of pain we can measure objectively is the severity of the stimulus which is meaningless in terms of what we really want to know about what's going on for people and the suffering they want treated. So what do Likert scales tell us? I want to stick my neck out as a philosopher and say that they tell us nothing whatsoever that capable of any sort of generalisation. They only tell you what someone's response is at one moment; they don't even tell you from one hour to another whether the stimulus is experienced by them in the same way. All these VAS's need a big health warning on them and I'm getting at anthropologists and sociologists as well as doctors here. There does seem to be something fundamentally nutty about confusing a surrogate measure of an externality with a subjective reality. I can't think why this isn't more widely recognised. They may just be useful to speak taking someone's existential temperature at one moment but give you nothing that you can transfer elsewhere.

Is pain a noun or an adjective? Grammatically of course it's a noun but existentially it's an adjective. My pain is a way of being me (which in a sense is true of all experience); your pains are ways of being you. It's very hard to know from moment to moment or certainly from illness episode to episode quite whether they are the same and in what sense they have been modulated by what is happening to you, physically, materially socially, psychologically and culturally in the meantime. And therefore pain like all experiences needs to be addressed not simply by examining what's going on in me and the stimulus but by addressing who what and how I am at the time – addressing the sufferer and not some isolable external bit.

I want to explore these issues further in the context of palliative care. [*as well as its direct application, readers will find much in the ensuing that relates to or at least finds parallels in chronic pain management or can be mentally translated, so to speak, to apply to it – particularly in the ways in which it is different from “curative” medicine – and much of the treatment of chronic pain is of course essentially palliative. ed*] You may find it a bit hackneyed but the image I find most useful in thinking about this is that of a journey; it's value for me lies in its flexibility. I have in mind more than the illness journey of the patient. Their families and friends also journey (sometimes with trepidation) into the physical and spiritual territory of those receiving palliative care. There is an educational journey to be taken by professionals trained in curative biomedicine, yet motivated to serve in palliative care. Even philosophers are like intellectual itinerants, and I am pausing on my journey as a visitor on *your* turf.

But the wayfaring of patients and their families is obviously rather unlike the journeying we ordinarily do – the image is perhaps too tidy: a sick person's journey is an enforced one unplanned at the outset; if taken without help, the route may be chaotic even though the destination is, as it were, a clearly marked terminus – or perhaps better a border-post, depending on your view of the hereafter; there is an irreducibly spiritual dimension of palliative care toward the end of life. As Philip Larkin put it, writing of the patients around him in the Hull Infirmary who:

*“.....have come to join
The unseen congregations whose white rows
Lie set apart above – women, men:
Old, young; crude facets of the only coin
This place accepts; all know they are going to die.
Not yet; perhaps not here, but in the end,
And somewhere like this*

A related metaphor is provided by adapting the 17th century physician Sir Thomas Browne's rather unreassuring characterisation of the world as “not an Inne, but an Hospitall – a place not to live, but to die”; I suggest that palliative care is “not an Hospitall but an Inne – where one might die nonetheless. Interestingly for Thomas More the word hospital seems already to have gained on of our modern connotations of being the repository of sickness rather than that of hospitality. A popular perception today would be that palliative care aims to acknowledge both senses – that one could suffer sickness unto death in a context requires both a scientifically grounded practice *and* a humanly very distinct vision of whom they are trying to help, why, and how. In the journey from sickness to death a point is reached when the curative projects of the Hospitall give way to the comforts of the Inne. I have four reasons for thinking this. To state the obvious, the Hospital does profess the fight against disease, whereas the Inne professes the means to rest, draw breath, take shelter, gather one's spirits, perhaps reflect on the road behind and in front. Secondly, the biomedical conception of curing involves paying attention to what patients have in common, whereas preparing to die seems a much more individual matter. To comfort and console is to take the sufferer's individuality very seriously. Thirdly there is the matter of experience: a concern for which is the central “driver” in all our health needs an health care but which should be supreme in relieving and comforting the chronic sufferer of pain, distress or disability. Palliation is an irreducibly *experiential or existential* undertaking. Thus it represents a place of as it were of existential respite, in some senses over and above physical respite, a place where physical relief is there to support or make possible existential relief (even though palliative care is becoming increasingly

technological and interventionist) Fourth is the idea of shelter. Perhaps the dying in particular are travellers in need of shelter – as well as companionship and someone to light the way, in a land without maps shelter seems among the most important needs. Effective palliative care provides shelter – physical relief, spiritual or existential re-gathering and recollection and perhaps for many a kind of preparation.

It might be objected that there is, and must remain, a good deal of the Hospital *behind* the *Inne* – after all it is medics who do most of the business, and I acknowledge the limits to the extent to which we can demedicalise palliative care. But in the palliative context medicine serves the goals of shelter, respite and consolation which would be out of place in the curative context. Neither a hospice nor an *Inne* is the same thing as home, but the business of an *Inne* is to provide shelter for someone who – physically, spiritually or experientially – is some way from home and who may have no real prospect of ever returning there.

In Thomas Mann's novel *The Magic Mountain* an *Inne* actually becomes a hospital as a luxurious Alpine hotel is converted into a TB sanatorium where the wealthy come either to die, to linger, or to be cured. For Mann himself (whose wife had been treated in such an institution) there is symbolic meaning in this, as if the physical and institutional spread of the hospital within the premises of a palatial hotel heralded a physical and institutional and moral spread of disease and our morbid preoccupation with it. He charted a cultural journey away from real life into a life of sickness. It seems to me that palliative care attempts to reverse this: not that one can leave the life of sickness, but rather if only for a brief time to restore it to *real life* in the sense of a world of living colour, of rich recollections, of the sense of individuality and connectedness – indeed to flourishing. And dying *is* a part of life, and accepting this *is* real life; denying it is unreal, a fantasy: in itself as much a sickness as morbid fascination with it.

Relatively speaking, health and life consist in acknowledging and perhaps preparing to face sickness and death, and in facing this, both to re-gather inner resources and to take hold of comfort, I think I would need not a hospital but an *Inne*. I would want its staff to be qualified but its medicine to be a consoling one. I would want to be comforted by a doctor who was also an *Innkeeper*.

It is difficult to think about such matters hypothetically. I have watched two close relatives die of cancer, one in severe pain that could only be intermittently controlled. You may share my private fear that if we were in severe pain we would want *nothing* but for it to stop. When I hear of patients who so value lucidity that they are willing to trade away pain relief in order to get it, I marvel at their courage. Perhaps instead it just means that we don't know ourselves what we would want until we were in the same position. Maybe although I take myself to be a physical coward I would bear up a little more strongly than I anticipate when the time came. I suspect few of us really know in advance what it is that we would most value in such hypothetically extreme circumstances, which makes me rather cautious about exploring the perplexities greeting a visitor to palliative care.

The image of a wayside *Inne* prompts us to recognise the idea of a *story* – a narrative, or an interpretation, or a continuation of a story which goes on until it stops. Should we think perhaps of palliative care as having a role in the sustaining of a story – the individual story of any patient who comes to the hospice in search of comfort in dying? By this I mean more than clerking and responding to what Anselm Strauss calls the “dying trajectory” – the individual variety of patients' decline, entry and re-entry into the medical domain, the so-called final descent or “death watch”. Of the two deaths I have watched closely I was dimly aware of what this trajectory describes, but much more aware (and gratefully so) that palliative care addressed not so much the physiological causes of suffering and weariness as, rather, the sheer suffering and weariness themselves – items in the sequence of experiences which go to make up a life, including its ending. Finlay and Ballard describe the perceptions of a group of hospice patients in terms of the life-narratives that led up to them: what they call the rich histories that led arising in the chapels and churches of the Welsh valleys, the decline into post-industrial communities, “moving accounts of past bereavements, of the terrible trauma of war and grinding poverty” Whether or not our biographies influence our physiological

narrative, the certainly form our understanding of our own suffering: today's pain, breathlessness or immobility is what it is and has the character it has partly because of the earlier events in our stories.

In my father's case, the cancer ward and the hospice were reprises, returning elements in his own story; as a chapel minister he had visited numbers of his own congregation in those very same rooms; for him the endings of their stories must have moulded the ending of his own. The end of a story is part of the story – and what is a story without an ending – or vice versa?

Leo Tolstoy opens *Anna Karenina* with the remark that every happy family is alike, but every unhappy family is unhappy after its own fashion. Could it be said from a clinical point of view that all healthy lives are alike but each unhealthy life is unhealthy after its own fashion? If so, then perhaps it might be true that all must prepare for death after their own fashion.

At least some writers on the subject seem to assume this. Reading the poems and prose extracts gathered together in Robin Downie's "The Healing Arts", I'm struck by how sure each writer is of his or her own insight. When this is a first-hand account of suffering bereavement (C.S Lewis, *A Grief Observed*) you simply have to say "fair enough" when it is an account of observations of many clinical cases as in Florence Nightingale's *Note son Nursing*, you must suppose that the generalisation is a reasonable one – even though it may discount the whims of the odd individual who really would like to hear bland optimistic encouragements. On the other hand Matthew Arnold (in *A Wish*) writes of the state in which it seems he *takes it* that he will find himself; spare him the banalities of embarrassed friends, officious doctor, pompous parson telling *him* of death - he who right now "feels death's winnowing wings".

Of course I can have no quarrel with these assumed certainties without assuming certainties of my own. But individuality comes across most fiercely with certainties like this, particularly where they do not align with each other. And they are *prospective* certainties; conjectural certainties (if that be not a contradiction) When the time really comes, what then? How can we properly hear, interpret and enact the wishes that are authentic to the actual dying? – the dying that goes on at the time and not in some imagined future, the dying that seems more or less incommunicable because of the gulf of understanding, experience, consciousness, between the person who dies and even those at the bedside.

Another perplexity: consider the idea of "authenticity" – of the essential self and its freely chosen choice of action. How clearly can we - or should we – distinguish between the choices of the suffering individual and the choices and views of his family and friends? I suspect some may find this question disgraceful, but do we have so clear an idea of identity? Is the person so different from those around and close to him? And therefore should palliative care also palliate the dying for those who stand in attendance? In my father's last two weeks of life I gained almost no sense of his wishes beyond knowing when he wanted a sip of water. The professional care he received became increasingly effective during that period and he certainly didn't seem to unduly suffer physically, but beyond him there was a sense in which it was our family who were palliated. I raise the question of the identity of the sufferers in genuine perplexity but at any rate I am glad that palliation in its larger sense was available for us.

How can doctors and nurses, trained in biomedicine's essentially curative culture, best be prepared for the professional commitment to palliation? Not that it is in any sense alien to clinical medicine; on the contrary I should have thought the relief of suffering to be medicine's central goal. But as someone interested in medical education I have long thought that the humanities offer a contribution which has only lately been recognised, and still not completely. In essence the humanities – which I suggest are concerned with the recording and administration of human experience – offer at least three things to medical education, all I hope of value to the palliative carer. First, and of very much an *instrumental* value, is their interest in the business of humans communicating with each other, and above all communicating their experiences "from the inside". I would imagine that palliative care as a mission would insist on the centrality of communication. Second, also instrumental, is the humanities' affiliation to *education* rather than training – where I take education to mean the

invitation to step through a door into a larger room than one had occupied hitherto. That room – a room of literature, history and philosophy as well a scientific enquiry – may contain a large store of the *personal* intellectual and spiritual resources needed to sustain a lifetime of professional palliative care. Third and of more *intrinsic* value, is the development of a sense of wonder at our embodied human nature and of the relation between our physical and our experiential selves. All nurses and doctors could perhaps delight in re-recognising how wonderful and mysterious is the flesh and bone that constitutes their daily work. But in palliative care this seems to be of the very essence. And the fabric of human embodiment is no less wonderful, no less miraculous, even at the hour of its final metamorphosis.

The American actor Audie Murphy once said of his 40-odd appearances in cowboy films "my face is the same, the scripts are the same; only the horses change. This could be an inverted motto for palliative care where the faces and surely the scripts change as well. The point about ethical issues is that in many ways they arise in response to the individuality of choices concerning available medical care. Others today are talking about living wills; CPR; withholding treatment; concept of futility; truth telling; best interests in non-treatment decisions. These issues are adjectival or adverbial with respect to the nouns and verbs of medicine – naming not simply what is to be done but how it is to be done. In that sense, although our attention perhaps starts with the physiological it is redirected to the personal and existential. It seems to me that although this is true of all medicine to some extent, it is of the essence of palliative care. Palliation in terminal care marks a kind of border zone where we leave behind as it were the "Home Counties" of medicine's curative successes.

Perhaps this also means we must rely a little less on the comfortable securities of a moral climate of a largely consumer-driven, autonomist approach to health care ethics. For instance, how much individualism *is* OK? This is a difficult, even unattractive question. On the one hand how do we avoid the conformist excesses of Elisabeth Kubler-Ross's disciples? – from whom the layman might gain the impression that anyone who misses out on a prescribed phase of dying is guilty of some sort of arrested development. On the other hand there are rarely the resources to indulge what you might think of as the excesses of individualism – for instance how could my hospice be asked to facilitate my rather unrealistic wish to die out of doors? Society rates the importance of palliative care very highly. But it is not clear that society is willing to sustain the manner of death of our choosing and the law certainly does not, as evidenced in the continuing illegality of physician-assisted suicide.

Operationally, within the hospice, should a patient who wished to do so be encouraged or allowed to "rage, rage against the dying of the light"? The French physician René Leriche memorably described health as "life lived in the silence of the organs". Since at least a spiritual interpretation of "health" can be sought in dying, then palliative care might sometimes be compared with the attempt to quieten down a runaway piece of broken, shrieking machinery so that the – as it were – music-lover can for a further, perhaps final time hear the tune that she's trying to grasp. Clearly we shouldn't be prescriptive about what one does with the silence, and we shouldn't prescribe the tune, nor claim to co-authorship. But whether silence – literal or figurative – is pursued at all might not be solely a matter of the interests of the index patient, and the legitimate interests of other dying patients suggests a constraint on the pursuit of the individuality of care; noise is one definite means by which patient's interests can conflict.

Perhaps, in sum, the individuality of dying is what presents the most intractable ethical as well as epistemic questions for palliative care. To a visitor like myself it seems important and although I've no tidy conclusions I have tried to explore it a little today

The Physiotherapist as Healer

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Patients seem to have become either neuro/musculo/skeletal entities or psychosocial entities and the link between them doesn't seem to exist yet!

When I was asked to talk about the physio as healer this was rather unfamiliar territory for me, so I looked some manuals and books about what healers are and what they are supposed to do; I came up with a number of models = some religious, some talked about Chakras and Auras and Universal Energies. Patrick Butler lists some of the things that a healer needs: firstly compassion and empathy – its not just all airy- fairy – you have to want to help them. Then you have to tune in to your patient (some add “tuning into the universe which may be a bit difficult - we may have a low signal!) A Japanese healer says you try to become one with the body of your patient. A lot of them stress that healing is done through you and not by you. Patrick Butler suggests that a good cure for thinking you are doing it is to take a short boat trip and get off half way and walk back! Most people use their hands for treatment – putting them on or around the patient. Its important to be non-judgmental. Matthew Manning whose work has been subjected to a lot of tests says lot of it comes from using his right brain and switching off the constant intellectualising about what this happening and just going with what feels right – saying to the patient “I feel like this – does it men anything to you or do any thing for you?”

I found this all very interesting and clearly there is something in it otherwise you wouldn't have so many people flocking to go to healers, but is this just healers and is there a big gap between this and alternative medicine in general? Well there isn't - there is something called therapeutic touch which has been taught to nurses since the 70's - you have your hands around the patient and concentrate . There have even been Cochrane reviews of this wit conflicting results but have you ever read a Cochrane review where that wasn't the conclusion? The fact remains that after 30 years it is still being practiced and there are still patients who feel they benefit from it. Dr Janet Quinn who has done much of the research in this area says the most important thing is intention – you have to be there for the patient and have he intention to heal.

By the way I forgot to mention that I have a background in Chinese medicine and in this intention is mentioned all the time. The mind in Chinese thinking is split into two; the heart that knows, the “heart mind” and the mind that thinks and calculates. The knack exists in the connection between heart-mind (心, Xin) and hand. It can be understood but it cannot be spoken of” (Guo Yu, Han dynasty) Whether or not a treatment works is based on meaning/intention (意, Yi) (Zhao Xuemin, Ming dynasty) So in Chinese medicine we need to connect what we know and we feel and with what our heads are doing. You can understand this but you can't speak or it or each it.. In Chinese medicine, medicine is the dialectic between meaning/intention (意, Yi) and method (法, Fa) and this is reflected in the characters depicting these concepts: one that looks like a heart and another for sand. It is something that resonates with what you know and feel – not just about knowing how to use a scalpel, needle or tablet.

You may think this hasn't much to do with you but perhaps it does: Dossey has written about medicine having lost touch with meaning and the patient as a person and doing things to patients instead of working with them. Roy Porter in his review of the history of medicine has pointed out that although it has achieved a lot and scientific achievement has been incredible but the flow to alternative practitioners is greater than ever and people are dissatisfied with the way they are treated so there is some imbalance there.

So where does physiotherapy fit in with all that? Does what physios do have anything to do

with what healers say they are doing? The first thing is we have to get pretty close to people and get them to relax and invade their personal space and you can't get an idea of what their muscles are doing and so on if they won't let you near them - it is a hands on profession and there is a difference between therapeutic touch and analytical touch. If any of you have ever been to a physiotherapist you will know that they will put their hands on you and move you around and you will have confidence. It's different when I go to my GP and he prods me because he wants to find the disordered structure – a good physio seems to *do* things through their hands. I can analyse how someone moves scientifically but if I really want to get to grips with it even after years of practice I imitate them and it is this alignment with the patient's body that the healers talk about and getting a feel of how they move and express themselves. Posture and movement are intimately linked with how you feel – Roger Woolger a psychologist has written that the management of trauma must include the body – you can't just talk to people, and once you start helping them to express and explore patterns of movement that they are avoiding and which express tensions then you can start to move forward. As a physio I have to be aware that I am not a psychologist but if I ignore all the psycho-social factors in the patient's background I may not do them much good.

It's encouraging that Mosely and Hodges have shown that the muscles in your lower back that stabilise it and hold you up are strongly influenced by the emotions so we can't just tell people we've shown you how to use your back muscles – off you go your problem's sorted

So I'm trying to say that there are a lot of links between what physiotherapists are doing and what healers say they are doing even though physios are not that conscious of being healers there is a lot going on that they're not aware of that is having a healing effect on patients. This sort of thing doesn't come through on RCT's. Physiotherapy is constantly trying to prove that it is as good as medicine – as science-based etc. In the most research based area ie back pain there is very little evidence that anything we do involving putting our hands on patients does anything although there is a lot for exercise and talking to people and so some people have back pain for a year or more are a step away and we don't touch them any more. We think rather than feel and although I'm glad we have research to back up some things and perhaps more important to stop certain stupid things, I'm afraid there are numerous babies being thrown out with the bathwater. There is big pressure now to reduce the number of contacts and insist on payment by results. One of my jobs is to link with primary care but my employer has begun to realise that if we move things to primary care it reduces their income and they're not so keen on my job any more! So I'm now supposed to set up systems that bring loads of patients in but we also get them out as soon as possible. We're also getting competition from private providers and I don't know where that's going to lead yet. The question was asked in the European Journal recently: why do physiotherapists persist in treating people with low back pain when they go against all the evidence and the patients are not actually benefiting. This is the first time that I have seen any evidence of the physio taking responsibility as healer - they keep going and see the patients from time to time and see themselves as health maintainers, as counsellors, as educators and are responsible for that patient and feel that even though the patient is not getting any better at least while they are seeing them they are not getting any worse and think “ if I let this patient go he hasn't anywhere else to go – the GP doesn't know what to do with them; I don't trust the orthopaedic surgeon and so I keep treating them and talking to them and what is wrong with that if you give someone support. What's wrong is that we don't live in that sort of time unfortunately.

So there is a lot in physiotherapy that helps patients keep well; there is a lot of healing going on that we're not aware of but I'm not sure that we can maintain that any more. I found a nice quote by Claude Larre who is a Jesuit priest who has done a lot of thinking about Chinese medicine:

“If you just treat people in order to relieve their pains, if you are not able to put them back on the right track in accord with the person they are and the situation they are in, then you are only doing half your work, and maybe you are wasting their time not to mention your own.”

If we bear that in mind whatever we do to develop new treatments and health care structures then maybe we have a chance of making the healing aspects of medicine and physiotherapy survive in this technological world.

The Twelve Steps of Alcoholics Anonymous A Model of Healing

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Abstract.

The somatic model of the healing process is initiated by the suffering of a wound. This provokes the activation of an intrinsic physiological process resulting with repair, new growth, and restoration of function. There may remain scarring as evidence of not only the wound but also the competence of the healing process [1].

Alcoholism is a disease [2,3] with physical psychological and spiritual components [4,5]. Modern medicine has had significant successes in addressing the physical aspect of disease, wounds and healing. Attention to the psychological and spiritual elements of illness has been less obvious but there is an increasing interest in addressing these aspects to achieve optimal healing [6,7,13,14,15,17].

The management of physical wounds can be broken down to discreet but integrated processes (debridement, approximation of healthy tissue, protection, nutrition, pain, immobilization and time). The end result of both the physiological reaction and any therapeutic interventions is the optimization of conditions for the innate process of wound healing to achieve maximum benefit and renewal of health.

The 12 step program of Alcoholics Anonymous can be similarly regarded as an extrinsic intervention which facilitates the intrinsic healing of the emotional, psychological and spiritual aspects of the wound of alcoholism.

The 12 steps and “working the program” [8]. will be described. The component processes (acceptance, powerlessness, ego suppression, a “spiritual awakening” and development of a relationship with a “power greater than ourselves”) will be discussed. The subsequent transformation through forgiveness, ownership, development of responsibility and altruism is suggested as a healing process.

The evidence for the success of the program in achieving and maintaining healing and health from this chronic, progressive and relapsing illness will be presented [9,10,11,12]. The difference between abstinence and sobriety will be addressed.

I hypothesise that applying 12 step principles to conditions other than alcoholism [7, 13- 20]. may facilitate healing from disease by addressing the psychological, emotional and spiritual dimensions of illness.

Good Morning, thanks for the opportunity to speak on this subject to you in this special and sacred setting which I feel has a healing atmosphere of its own.

For those of you who I haven't met my name is Paul Martin, I work as a Specialist Registrar in Palliative Medicine in Tayside Scotland. I have for some time been interested in the parallels between recovery from alcoholism and the process of coming to terms with the inevitability of dying and this presentation gives me the opportunity to share this interest and invite comments and discussion.

There is an acknowledgement that it is possible to die healed. To this end I would like to suggest that the course of recovery from Alcoholism, as experienced by alcoholics who go to

AA and “work the program” using the 12 steps as a model for healing. Alcoholics who recover experience healing as their active alcoholic persona is dying.

Before I move on to the process may I consider the language, vocabulary and expression of “healing”. I suggest that healing is similar to pain, living, suffering, joy, happiness, distress, anguish and other notions. We can experience them as individuals and know our personal definition but they are hard to define and share. Although acknowledged as a universal concept, healing is subjective, internal, intimate and individual.

However, there is an area where common understanding and definition is possible. That is in the biological and physiological world. The somatic model of healing (as in a fractured long bone, a laceration or infection) is initiated by the suffering of a wound (the fracture or cut). This provokes the activation of an intrinsic physiological process (the inflammatory cascade) with repair, new growth and restoration (or at least optimization) of previous healthy function. We also know that there may be a residue of scarring that is evidence not only of the initial wound but of the healing process itself. So, we can understand biological healing and look at it in its constituent parts and as a process.

Alcoholism is a disease (there are other models: immorality, social weakness, behavioural disorder etc) but there is much in the literature and indeed definitions and medical diagnostic criteria published (ICD and DSM-IV). There is a returning and growing awareness that disease has physical, psychological, emotional, spiritual and social components and consequences. In the medical model of the disease of alcoholism these constituents are explicitly recognized both in the diagnosis and in the therapeutic approaches.

Physical features of alcoholism include such things as craving, cirrhosis, nerve damage etc. Psycho-emotional issues include depression, anxiety, panic, fear and others. Spiritually the active alcoholic is bereft of meaning to life – some have described this as a “hole in the soul”. The social consequences are seen in relationship failures, employment difficulties, crime and financial crises etc.

In 1935 two chronic drunks met and helped each other stay sober by sharing their stories, feelings and thoughts in an open honest and continuing manner. They visited a third, the fourth, fifth and so on. Not all continued and the attrition rate was high. However, those who stayed sober found they did so by meeting regularly and sharing in the same manner as Bill Wilson and Bob Smith had done. Thus a fellowship, the fellowship of Alcoholics Anonymous came into being. In 1939 this group of men and women who found that now they were able to live life not only abstinent from alcohol (something that had eluded them despite all other efforts) but fully, accepting and experiencing joys and disappointments of real life – I suggest they are “healed”. They went on to look more carefully at how they were achieving this and committed their analyses to print. In 1939 the first edition of Alcoholics Anonymous (the “Big Book”) was published. The book comprises 43 individual stories including those of Bill Wilson and Bob Smith, a description of the recovery process (the “12 Steps”) and endorsements from medical and clerical authorities. Now in its fourth edition (the third having sold in excess of 12 million copies) It is used by over 2 million recovering alcoholics in over 150 counties meeting in over 150,000 active groups.

What do recovering alcoholics do to stay sober and live life on life’s terms – to achieve healing and maintain health?

1. They make a decision on a daily basis to not drink alcohol
2. They attend AA meetings regularly
3. They get a sponsor
4. They “work the 12 steps”

The idea of a “daily” decision gives a manageable timescale. (More attention is being paid to this notion in health and other areas and is described in psychological terms these days as “mindfulness”) There is evidence to support the contention that continued and long-term sobriety is related to attendance at AA meetings – just about

every relapse is preceded by failure to regularly attend meetings.

Sponsorship is a special, closer relationship with another recovering alcoholic who has usually been recovering for a longer period of time and is himself or herself sponsored. Sponsees are often in contact with sponsors on a daily basis.

May I now turn to a description and suggested explanation of the 12 Steps:

Step 1 *We admitted that we were powerless over alcohol - that our lives had become unmanageable* addresses what has been described as a faulty belief system concerning the power of self and control. In psychological terms it is a recognition of ego boundaries and a breaking of the protective mechanism of denial. Step 1 also acknowledges negative and destructive consequences as evidence of that loss of control and powerlessness.

Step 2 *We came to Believe that a Power Greater than Ourselves could restore us to Sanity.* This step builds on the first in suggesting that having accepted that alcohol was more powerful than the person, there could be an even greater power, greater than alcohol and that this could be accessed. This step also represents an introduction to a spiritual experience of recovery.

Step 3 *We made a decision to turn our will and lives over to the care of God as we understand Him* is an example of cognitive restructuring with further suppression of ego and self will and the establishment and commitment to a spiritual experience and relationship, accepting the challenge of trust and a letting go of control.

Step 4 *We made a searching and fearless moral inventory of ourselves* is an example of reflection of who the person is and what determines that sense of personhood. It requires a commitment to rigorous honesty and again disassembles the ego-defending mechanism of rationalizing

Step 5 *We admitted to God, to ourselves, and to another human being the exact nature of our wrongs* reinforces the spiritual experience of relationships with others and a higher power and the fundamental need and reward of communications with others and the cosmos – a placement of self in the community, in society and in a greater perspective.

Step 6 *We were entirely ready to have God remove all these defects of character* builds on that sense of perspective and invites transformation and change and a shift from willfulness to willingness.

Step 7 *We humbly asked Him to remove our shortcomings* is an active step in the spirit of faith and a development of humility

Step 8 *We made a list of all persons we had harmed, and became willing to make amends to them* is the first tangible move towards relocating self and responsibility as an individual and participant in community, society and real life. The concept of giving and receiving forgiveness introduced in steps 5, 6 and 7 becomes more explicit.

Step 9 *We made direct amends to such people whenever possible, except where to do so would injure them or others* moves to repair and restore damage and lays the foundation for renewal and further growth from past actions as well from new and future experiences. The sense of asking for and offering forgiveness becomes a reality

Step 10 *We continued to take a personal inventory and when we were wrong promptly admitted* is a continuation of Step 4 and a means of maintaining a sense of self, appreciation of its fragility and the value of timely attention to movements away from contentment and health.

Step 11 *We sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out serves as active spiritual expression and perspective of self.*

Step 12 *Having had a Spiritual Awakening as a result of working these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs* confirms the recognition of the individual as a spiritual being with relationships outside self. In addition it introduces the concept of service to others and confirms the notion that the problem is the person not the alcohol and as such the solution is applicable to other aspects of a persons life, actions, feelings, thoughts and relationships.

The success of AA for the healing from alcoholism is well documented. Vaillant in particular has summarized the studies and mechanisms of the efficacy of AA and reports that recovering alcoholics “.. lived longer, had better mental health, better marriages, were more responsible parents and were more successful employees...”

Moreover the principles have been adopted for other addictions with the establishment of groups such as Narcotics Anonymous, Gamblers Anonymous, Sex and Love Addicts Anonymous. There are even groups for specific disease states including HIV Anonymous and Hepatitis C Anonymous. In addition, there are groups for those related or close to the primary sufferers (Al-Anon for partners and spouses, Al-Ateen for children of alcoholics and Families Anonymous for relatives of drug addicts) all of which adopt AA principles for the return to and maintenance of health and lives affected by relationships with the primary patients.

As I mentioned earlier there exists a renewed and increasing recognition and attention to health issues as being more than pathophysiological abnormalities with dysfunction of biological systems and any therapies directed solely at those abnormal pathologies

Keefe has reported the benefits of spiritual activity in living with rheumatoid arthritis. Carson describes the relationship between forgiveness and chronic low back pain and Hutchinson in a study of transitions in patients with end stage renal disease (ESRD) has offered the notion of a need of a safe place to suffer during transitions (cf the community of the fellowship of Alcoholics Anonymous) and such a place can result in healing . Greer in his paper *Healing the Mind – Body Split: Bringing the Patient back into Oncology* calls for the biomedical model to be enlarged to include psychosocial factors and stresses that “...medical care requires treatment not only of the disease but of the patient who suffers from the disease...” and illustrates this with case studies in cancer sufferers. Reporting on survivors from prostate cancer Bowie identifies spiritual experience and activity as improving quality of life

Acceptance has been shown to related to physical healing and recovery in survivors of landmine explosions resulting in traumatic amputation.

Lawlor and others have suggests that a reframing process occurs resulting in psychological healing when forgiveness is practiced and Post has concluded that altruism is associated with well-being, happiness, health and longevity.

In a paper on the rhetoric of transformation in the healing of alcoholism, Swora has suggested that “...healing is not a cure, but a new way of attending to the world and engaging with others, including God, or a Power greater than Ourselves...”

In his book “There’s more to Quitting Drinking than Quitting Drinking” doctor and recovering alcoholic Paul O states “... alcoholism is both a drinking and thinking problem. Recovery can’t take place without abstinence, but abstinence alone is not recovery.....”

Summary

The daily decision to abstain from alcohol, the admission of powerlessness, acceptance, ego suppression , reflection, identification of personhood, spiritual awakening, development of a

relationship with others and a higher power and place of self in those relationships with subsequent transformation through forgiveness, ownership, responsibility, service and altruism all serve to address the alcoholics suffering of the physical, psychological, emotional, spiritual and social sources of their disease and thereby return to health and the prospect of remission from that disease.

May I boldly suggest that these constituents of recovery may be regarded as the psychospiritual equivalent of the cytokines and inflammatory cascade of physiological healing from a wound: that it may be possible to adapt the program to other diseases such that ill people may similarly benefit from:

1. Making a daily decision to accept their disease
2. Communicate with others with similar afflictions
3. Seek guidance from and provide guidance to others suffering
4. Activate innate healing by adopting the AA approach. For example paraphrasing the first step:

“We admitted we were powerless over our terminal illness/bipolar disorder/infertility/chronic pain/diseases etc.....”

References

- [1] Clark R A F (Ed) *The Molecular and Cellular Biology of Wound Repair* – Plenum New York 1996
- [2] *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV)* American Psychiatric Association Washington DC 1994
- [3] *International Classification of Disease Tenth Revision, Clinical Modification (ICD-10-CM)* World Health Organisation 2003
- [4] American Council on Alcoholism www.asa.org 2005
- [5] Kurtz E *Alcoholics Anonymous and the Disease Concept of Alcoholism* – *Alcoholism Treatment Quarterly* Vol 20 (3-4) pp5-40 2002
- [6] Bracken P Thomas P *Time to move Beyond the Mind Body Split* *British Medical Journal* 325 pp1433-1434 2002
- [7] Hutchinson T A *Transitions in the Lives of Patients with End Stage Renal Disease: a cause for suffering and an opportunity for healing* *Palliative Medicine* 19 pp 270-277 2005
- [8] *Alcoholics Anonymous Fourth Edition* – Alcoholics Anonymous World Services Inc 2001
- [9] Caldwell PE Cutter HSG *Alcoholics Anonymous Affiliation During Early Recovery* *Journal of Substance Abuse Treatment* 15 (3) pp 221-228 1998
- [10] McIntire D *How Well does AA Work? Analysis of Published AA surveys 1968-1996 and Related Analyses/Comments* *Alcoholism Treatment Quarterly* 18(4) pp 1-18 2000

- [11] NIAAA Report Project Match www.niaaa.nih.gov 1996
- [12] Tonigan JS *Benefits of Alcoholics Anonymous Attendance: replication of findings between clinical research sites in Project MATCH* Alcoholism Treatment Quarterly 19(1) pp67-77 2001
- [13] Keefe FJ *Living with Rheumatoid Arthritis: the role of daily spirituality and daily and spiritual coping* Journal of Pain Vol 2(2) pp 101-110 2001
- [14] Carson JW *Forgiveness and Chronic Low Back Pain: a preliminary study examining the relationship of forgiveness to pain, anger and psychological distress* Journal of Pain Vol 6(2) pp84-91 2005
- [15] Bowie JV *Spirituality and Coping among Survivors of Prostate Cancer* Journal of Psychosocial Oncology Vol 22(2) pp41-56 2004
- [16] White WL *Transformational Change: A Historical Review* Journal of Clinical Psychology Vol 60(5) pp461-470 2004
- [17] Ferguson AD *Psychological Factors after Traumatic Amputation in Landmine Survivors: the bridge between physical healing and full recovery* Disability & Rehabilitation Vol 26(14-15) pp931-938 2004
- [18] Seeman M Lewis S *Powerlessness, Health and Mortality: a longitudinal study of older men and mature women* Soc. Sci. Med Vol 41(4) pp517-525 1995
- [19] Bush EG et al *Religious Coping with Chronic Pain* Applied Psychophysiology and Biofeedback Vol 24(4) pp 249-260 1999
- [20] Cole B Pargament K *Recreating your Life: A Spiritual/Psychotherapeutic Intervention for People Diagnosed with Cancer*. Psycho-Oncology Vol 8 pp395-407 1999

Metaphysics and Mental Pain

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The overall theme of our meeting “The Art and Science of Healing” points clearly to the dichotomy that it is at the heart of medicine, as Prof John Saunders expressed it in his masterly introduction to the history, ‘Magic or Medicine’. I would not now express the split so sharply but I am aware that when I attend my GP’s surgery, he responds to my complaints with a raft of technology, blood pressure monitor, x-rays, blood tests, scans and all the other exact tools of rigorous diagnosis, but then at a different level he engages with me as a person taking into account my appearance, my emotions using observation and perhaps intuition. This is where art takes over from science and it is on the basis of the former that I would judge my GP to be a worthwhile physician, although that is not to minimise the worth of the scientific discipline that he brings to his work.

In our series of meetings over the past few years this group have struggled to find common ground in our approach to Pain. We have asked whether it is inevitable, whether it is a necessary part of human experience. Is it morally desirable, is it always an enemy to be resisted? How does its presence in human life square with a belief in the love of a God who is behind the whole creation?

In exploring these questions we have been led into areas of moral uncertainty or ethical debate as we face practical decisions. For instance as physicians your field is analgesics or anaesthetics. You have to ask whether the secondary effects of your prescriptions unacceptably shorten life.

By contrast my vocation is to deal in metaphysics and I have found a new level of professional concern in the NHS about the work of Chaplains or Spiritual Care Givers. As we have begun to recognise the multicultural nature of our society an analogous divide has emerged between religious and spiritual care. Religion while not dealing with scientific fact, nevertheless has a coherent system of explanation to cope with questions about the meaning and value of life backed up by sacramental acts and structured organisations to support its adherents. Various religious traditions have pursued divergent tracks, offering a variety of stories or explanations to account for the presence of pain and consequently the means of coping with it. As a patient begins to sense that his or her recovery may be problematic or require some risky procedures, questions will arise about how these are handled, and this may involve reflections about the value of past life, issues over mistakes and the ways of forgiveness and what hope, if any, can be held of life after death. These are questions for everyone and not specifically religious topics.

Recently the NHS has begun to consider the role of ‘spiritual care’ as part of holistic medicine. A working party was set up by the Scottish Executive to provide Guidelines on Chaplaincy and Spiritual Care. This document makes the distinction between Religious and Spiritual care as follows:

“Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community
Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.
Spiritual care is not necessarily religious. Religious care at its best should always be spiritual.”

Here is a split not dissimilar to the 'Art/ Science' dichotomy faced by the doctors. The chaplain out of his faith commitment has a 'prescription' which he or she believes will do the patient good. If he is a Buddhist or a Hindu he will want to encourage an attitude that can rise above the immediacy of the physical suffering. He will point to a doctrine of karma and encourage the patient to the life-style and practices that will deliver him from samsara, the cycle of birth, death and rebirth. The Jewish way will point to the recognition that, as one of Job's counsellors put it 'Man is born to trouble as the sparks fly upward'. There are troubles both naturally occurring and maliciously introduced by enemies and the devout person makes his appeal to God and, as in the Psalms help is found to be at hand. The Christian turns to the story of Jesus' suffering, there is a redemptive element in the passion of the Saviour who prays for his persecutors and offers his life on behalf of others. The believer can be encouraged to imitate the sufferings of Christ. The Muslim can be reminded of Allah the all Merciful and seek a mystical identification with the divine life. This is more specifically a Sufi perception and has an affinity with the Mediaeval Christian mystics like Meister Eckhart. The theology behind each construct is analogous to the 'science'; the understanding of the enquirer and the uniquely appropriate way of expounding the model is the 'art'. The work requires the further distinction between whether we perceive the situation as it is, or as we are.

In such a discussion the Chaplain finds him or herself confronted by the humanist who wants to be rid of all faith structures, perhaps turning to poetry or music to lighten the human spirit and sustain it through the darkest experiences. These may also be a resource for the carer to enable him or her to remain in solidarity with the sufferer. When the scientific cupboard is bare and the myths run dry are we ourselves the ultimate agents of healing because we are willing to share in the impotence of human beings in the face of pain, naked without the armoury of prescriptions or the convincing explanation? This may also deprive us of a convenient scapegoat, like a politician, or the satisfaction of recording a successful conference with conclusions neatly tied up. "Spiritual care" demands of the care-giver an ability to sustain a relationship but always to avoid any attempt to impose his personal system on the other person, there must be no attempt to proselytise. Therefore the acceptance of powerlessness although necessary within the process of caring can never be a prescribed solution for the sufferer who must always be empowered to choose his or her own ends.

Do we know how it works and does it matter?

1 A Short History of the use of electricity in pain

Dr Jean Favier

Consultant in Pain Management, London

When radiofrequency thermocoagulation of nerves was introduced many years ago and indeed most of the time since it seemed quite an obvious and simple matter as to how it worked: one applied a current at 500,000Hz which produced local heating up to 85° which destroyed the nerve conveying the offending noxious stimulus and the pain would no longer be felt – and if it failed you had missed the nerve and if the pain returned it had regenerated, or some central mechanism had supervened. But more recently we have seen the success of pulsed R/F modulation using a frequency of 500,000Hz to raise the local temperature to an innocuous 42° C, presacral stimulation at 50Hz and peripheral nerve stimulation at 2Hz, neither producing any heat at all.

So we have four ways of using electricity from thermocoagulation using a current of 500,000 Hz to produce a local temperature of 85° down to 2Hz with no temperature rise all apparently producing similar results How can this be? To quote Jaques Bossuet, the teacher of the future King Louis XIVth : “The worst is when one wants to describe things to happen the way one thinks and not the way they do”

So how do these things all work? Is it temperature? There is still a lot of debate regarding the temperature effect, with those who would argue that even at 30° there is still production of a “heat wave” which is undetectable. Is it to do with nerve conduction? When you increase the output of the stimulator the patient will say he feels something but what if he feels nothing? I have asked researchers in this area if they have investigated this but they say no because it wouldn't work. How do you know if you are stimulating in the right place? People doing presacral stimulation have published pictures showing their catheters in quite different places and there must be considerable doubt as to what they are actually stimulating; but it still works. Furthermore they are treating a wide range of conditions: for instance they are treating both urinary retention and incontinence with the same mode of stimulation and getting the same results. So what if any thing are they really exciting? The suggestion came up at Harrogate this year of a neural membrane effect. It may be that the neural membrane is being changed by the current and there are fluxes of ions or changes in receptors and their behaviour which could account for these effects, and this might seem to be the most plausible explanation. This provoked strong disagreement with the proponents of temperature effects and changes in nerve conduction. Another contention was the involvement of a magnetic effect and membrane fluxes. This is a pleonasm as whenever you have an electric current you have a magnetic field. In fact Einstein said they are the same thing. *[I have heard the suggestion of a matrix – the tissues are said to be “loaded” either negatively or positively and you stick a needle (acupuncture or with LA) in you change the matrix. Is this another mechanism or is it included in the ones you have mentioned?]* I would put it in with magnetic fields as these can explain almost everything; for instance in the context of the neural membrane among other things you have magnesium atoms which are paramagnetic and will follow a magnetic field. So if for instance you apply a pulsed magnetic field you agitate the soup and create fluxes of Mg atoms across the membranes (not only the cell membrane but other important ones within the cell such as that around the endoplasmic reticulum) So magnetic fields can explain phenomena ranging from the physiological effects of Tai Chi via acupuncture, meridians and Shiatsu to TNS. And there you may have a unifying theory to explain these and all the possible modes of action of electrical therapies.

But as long as it works, do you really need an explanation of how it works? First there is a natural desire for explanation: we have a fear of the unknown. Secondly if we want to make something work better we need to know how it works. Thirdly you need an explanation for

complications; imagine yourself standing up in court and explaining why a patient has become paraplegic but you don't know how the technique you have used works.

Then there is what I have called the "domestication" effect: early man probably first encountered fire as a terrifying result of lightning strike and could only try to escape it. Then someone had the idea of domesticating it and making it controllable, safe and useful.

Maybe there is a Darwinian effect: we are all heirs of those who had the curiosity factor, which helped keep them alive. We seem to have curiosity about how things work in our genes and our memes [*meme: an element of culture or behaviour passed on by non-genetic means, especially imitation. OED*]

Lastly there is the unifying effect. We have a desire to simplify complicated issues and to have a theory which will explain everything at once. Ernest Rutherford used to say that you should be able to explain a good scientific theory to a barmaid. Our brains have limitations and are not as good as we like to think. The fear of chaos pushes us either to teleology e.g. attributing everything to magnetism; or to God. (Einstein: everything I can't explain is God).

Finally we tend to forget the capacity of the body to heal itself: we who practice medicine would do well to remember Voltaire: "Medicine is the art of amusing the patient while nature cures the disease"

Could you tell me what I saw recently: I was passed by three young boys having a race; the youngest who was much smaller than the biggest but just as fast as the biggest appeared to have a blue light surrounding him – what was I seeing?

Optical effects do happen – it might be something to do with magnetic fields as all living things have them because of the difference in potential from the outside to the inside of the cell but frankly I don't know...

It could have been your brain "correcting" the image, so to speak

It could have been an aura?

Yes, some people can see them or feel them; I had a session of Kirlian photography at my home once and one lady had a very poor, patchy flare. It turned out she was very depressed as her husband had recently left her... perhaps people in pain have reduced auras

These things do exist. Acupuncture points can be found by measuring skin conductance

What about ECT?

Its use in pain is limited but I have always wanted to try it for central pain – it has been done – you can get the same effect with deep isoflurane anaesthesia – pulsed electromagnetic fields have been used to determine where to put an extradural brain stimulator for pain control.

Is there anything in the literature about different people's electrical fields or flow of energy from one person to another?

I haven't seen anything. One problem is that in applying electrical current you change conductance and you don't know if this is direct effect or consequence of therapeutic effect.

To return to the question why do we want to know why things work I think it's more than natural curiosity – its also to enhance what we're doing and move on and make things better. It's a fundamental desire...

.... Not in everybody.....I didn't see why I needed to know how a vaporizer worked when I did my primary...

I use pulsed magnetic fields in my practice...fixed magnetic fields have been used to enhance bone healing.... But there are much better studies with pulsed fields showing good results...

2. Trigger Point Therapy

Helen London

Staff Anaesthetist, Aberdeen

I'm sure all of you working in pain services are constantly asking the question "why" – why are you doing this, why is this patient here? Many years ago I moved from Edinburgh to Barrow on Furness where I was lucky enough to get a session in pain management where I my teacher had a very pragmatic approach to treatment: if it worked, he did it, from needles to hypnosis. This did give me the freedom to explore things and since I moved to Aberdeen as a Staff Grade as long as I don't cause any problems I have been given the independence and freedom to do what I like. I did try homeopathy which if nothing else opened my eyes to that fact that what happened in the "mental" sphere was important in people's health. When I took over the acupuncture I was told that "it will all be down to Trigger points" which I did not quite understand at the time but both experience and Peter Baldric's book on acupuncture and trigger points made me more and more aware of them and the ones I was missing. I kept finding them in patients in pain who had been sent by experts in other fields who had failed to make a diagnosis. Nobody seemed to know about them or get taught about them, at least in Aberdeen, and it's very gratifying to provide an explanation for pain that has been undiagnosed for years!

One of the things that I have enjoyed about acupuncture is that it gives you time to listen to patients. After two or three sessions people start to open up and tell you things and I heard many stories, some of which I wouldn't care to hear again. This got me to listening more to other patients' stories and to the realisation that even those with apparently straightforward pain problems all had stories which preceded their pain. So I started trying to put together the stories and the pain. Finding trigger points is great and the patients enjoy the relief from a little bit of local anaesthetic and steroid but of course the pain keeps coming back and so do the patients. So I got wondering if I helped patients with the troubles in their lives maybe they would stop coming back for more trigger point injections. If the source of chronic pain lies within a person's life, helping them to understand this is clearly important. Some might have relatively simple problems like being bullied at work which they can deal with by changing jobs but many have stories that are way outwith their own resources to help: for instance a lady I saw recently who had been abused by four different people, had had violent husbands and destructive children; how can I possibly help someone like this? I'm not a psychologist and we don't have a psychologist. I have tried to learn some psychology and have been able to help some patients in this way but we are being encouraged to have "minimal contact" and to get patients back to their GP's as soon as possible. So having identified someone's problems and provided the potential for relief of their trigger points how can you and they move on? People who have become dependent on the pain clinic have been described as "barnacles" and perhaps the only thing we can do in present circumstances is to accept a few barnacles on our clinics. Trigger point injections may provide a breathing space for people to sort out problems in their lives but where this isn't possible it is very difficult to set any boundaries or to help them without their coming dependent on the clinic for years on end.

A year or two ago I had the experience of a trigger point in my own backside which was most illuminating. It had two qualities: one a sharp stab which was worse on movement and the other a deep gnawing nauseating diffuse pain. It certainly seemed to be associated with stress in my life and went away completely after I attended a meeting which involved guided visualisation and relaxation! It was wonderful as I don't know how I could have coped with so much pain every day, and it made me very aware of what we are expecting of patients if we ask them to cope.

I saw a young woman recently with severe back pain that I thought might be due to a trigger point but whose back was so sensitive that I could barely touch it. This led me via the internet to a book I had been recommended to some years ago but never got round to reading by John

Sandals, and American professor of rehabilitation, called “Healing Back Pain” . His approach to the majority of back pain sufferers with pain largely of muscular origin is to invite them to a couple of lectures on the structure and function of the back (and on how most MRI findings are meaningless) and the relationship of psychological factors – and quotes an 80 to 90% success rate. He has subsequently written a book entitled “the Mind Body Prescription” in which he develops the theme that your subconscious develops pain as a diversion from inner rage (or other emotions that are difficult to handle). This made me ask why should this be so? – why should our brains inflict this on us? Is it perhaps because if your mind is full of fear anxiety or anger you can’t function or think and plan your way out of a situation, but if you are in pain your mind is clearer? Be that as it may I still recommend this book to patients and also one by Dr Nancy Selfridge, who had gone to Dr Sandall with fibromyalgia, called “Freedom from Fibromyalgia” which acknowledges that in many cases there may be many confounding factors.

So do we fully understand what we are doing? Do we really know how trigger points arise and how our treatments work? We understand a lot about the possible mechanisms involved but science alone clearly cannot (as yet?) provide all the answers, especially in the area of the role of psychological factors. I would suggest that there will always be more questions than answers but we don’t need all the answers; the important thing is to be a signpost on the patient’s journey, to treat so long as we practise within our boundaries and do no harm, and above all to listen and to see the whole. If we make the *intention to heal* our paramount principle we cannot go far wrong.

I am currently preparing a teaching programme on trigger points which will I hope save a lot of patients from unnecessary referrals investigations and surgery but I recognize that there is a danger that if I say that pain may be caused by situations in peoples’ lives I may give some doctors an excuse for suggesting that the pain is their fault - or like patients with diabetes whose every ailment is ascribed to this, every pain may be ascribed to stress, and patients may resent this suggestion and feel that their pain is not being taken seriously. (*but this depends how you put the suggestion – if you can help people to find it for themselves they will often grasp it.*)

I think what you’ve underlined is the totally different way in which different pain clinics work. In Southampton we work on the premise that chronic pain is always the physical expression of psychological distress. We only see patients with “total body pain” - complex problems – and they all get some sort of psychological help, either from the psychologist or psychotherapy from me. The GP’s have decided that that’s what they want from the Pain Clinic. Patients are filtered through our triage system so we have no problem in giving them the time necessary. But Portsmouth pain clinic doesn’t see any patients like that. They can’t deal with total body pain – they do lots of injections and see a completely different patient population from us. It’s very much a question of playing to the skills of the people working in your clinic and ascertaining from the PCT’s what they actually want

I tell patients that the problem is that their filters aren’t working. All day long we are getting pain messages but there are filters which stop them from becoming “emotionally” painful. Patients like this but I didn’t really know how well it could be supported until the Harrogate meeting when at the session on functional brain imaging it was shown that parts of the brain that “light up” with a painful stimulus also do so when you think about pain – your own or even that of someone else close to you . It was also demonstrated that there were inhibiting zones which were being progressively inactivated during the pain experience. And perhaps the same thing is happening “as an expression of psychological distress” which gives us an explanation we can give to patients without suggesting “it is all in your head”.

I tell patients that there is good evidence that if one is neglected in childhood structures in the brain associated with pain fail to develop properly. In this way one can get away from any suggestion that the pain is imagined and that we accept it as real. And that can be repaired through a therapeutic relationship.

It’s also important to stress that it’s not “them and us” – we can also have these pains – I tell

patients about my trigger point experience – and we don't see it as a character fault in them. In the therapeutic relationship you should be “at one” with the patient.

But we have to recognize that there are differences. Every single patient I have seen for psychotherapy has a history of abuse.

How do GP's know which patients to refer to you?

They have a protocol to which they have agreed that no patient is referred until they have been through the analgesic ladder, had amitriptyline and appropriate physiotherapy and graded exercise. TNS is offered at triage, as is medication manipulation by our nurse led clinic. Some have been worked up by the GP for the PMP and go straight to that. So the ones coming through are those that the GP's find are frequent surgery attenders with unreasonable demands for analgesia or with a history of frequent callouts with inappropriate hospital admissions.

One sometimes sees people under relaxation or hypnosis who suddenly become intensely anxious and this may be the sudden recall of a horrible childhood experience. The realization that they have been blocking this may in itself be quite useful therapeutically.

There was an epidemiological study described at the Manchester ASM in which a group of children were followed up over a period of 30 years. The ones that developed chronic pain were the ones that said they had had bad experiences in childhood but when they looked at the facts a lot of them had not but remembered that they had and others who actually had didn't develop chronic pain. So there is something going on here which is making some people react in an abnormal way – that it is perfectly possible to have dreadful things happen to you and not develop chronic pain.

I think in the future chronic pain will be defined as excitement of NMDA receptors,. And NMDA receptors are the basis of memory – OK they're different subtypes from the ones involved in chronic pain but they are still related in their modes of action - so we have a n explanation even if it may not be one we can easily convey to the patient or use. Funny things happen; for instance an amputee may experience pain in the foot during sex, because the representation of the foot is next to the genitals on the homunculu - so we do have explanations for phenomena which look a bit bizarre.

We are all different – some of us are very reliant and can deal with any experience and this can turn us into very strong people but we're not all like that. And we make different interpretations..... the circumstances in which pain is first reported may be significant, for instance some event may evoke a memory or stir up a feeling. What pain means to us may be a matter of association: ... a man of 40 whose father died at 45 may start interpreting tightness in his chest as cardiac pain, or if your friend started with the same sort of pain and ended up in a wheelchair.....

Dolphin Therapy

David Wolgroch

This presentation mainly consisted of a video of the treatment of individuals with chronic illness (emotional and physical) at the Dolphin Reef in Eilat, Israel.

Although it is not suggested that this could be immediately be made available on the NHS, it does illustrate the value of thinking of novel and imaginative measures.

The Search for Meaning in Pain

Wendy Callaghan

Clinical Psychologist, Leeds

I am uncomfortable with the term useless when applied to chronic pain as we have a fundamental need for meaning and need explanations of things we can live and work with. We may look for a meaning for pain in philosophy, in science or in literature, but I would like to focus the search on patients' own accounts of their pain, paying particular attention to the language and metaphor they use.

My work centres around the acceptance of pain – helping people to accept the reality and enduring nature of their pain. But few patients have arrived at this point when they first see me. They are still in denial: still demanding that someone must solve this problem for them. The “rights” agenda may have encouraged them to think this way. So I am trying to increase their willingness to have both a pain *and* a life.

To be honest I don't see much character-building in my chronic pain patients. Some try comparing themselves to others and being grateful for small mercies but this doesn't seem to help much. Symbolic meaning is sometimes attributed to pain: a recent patient with throat cancer was seen by psychodynamically oriented colleagues as fearing not just strangulation but not being able to take good things in, and his loss of voice not just in the physical sense but as loss of ability to speak out. Can useless pain be used? I am not very happy with the concept of secondary gain but I have recently seen a patient with a very strange injury which might be self-inflicted, and it turns out that it was to do with getting attention from a family who were focussed elsewhere. Now he has a chronic pain he feels trapped in it and I have been helping him to dig himself out of this hole.

So by and large my patients don't seem to see their pain as having a meaning but they do have some understanding of it. But looking through my notes I have been struck by how consistently few references to pain there are. Is this because I ignore them, or don't write them down because I have heard it all before? Or is it at least sometimes because people make an implicit connection between psychological and physical pain? A woman told me that on her way to her first appointment she had remembered an episode of depression many years before that she had got out of by herself and not thought about since. The first three pages of my notes are about this history with no mention of the pain. So I asked her about her pain. Her replies included: “Pain drains me and shatters me too. I feel useless, a dead loss. I've lost the dignity of labour” As therapy proceeded she told me: “I want to use you as a resource, not a crutch - I want to learn to live side by side with my pain - I need to integrate the pain self - I can look at the benefits of aids such as a grabber which I rejected before as I associated it with old age”

Another admitted “pain dominates – is an excuse not to do things – is a mushroom cloud above me which I allow to encroach” but as she improved “I went out despite the pain and enjoyed it even though the pain was greater.” Another saw the pain “as punishment for doing the right thing”. He felt he had been robbed, was empty and the pain was getting the better of him. He was “no longer the man he used to be and as his pain increased his strength diminished.” He felt like “two different people” Yet another described herself as a wreck – a nuisance: “my mother runs rings round me. I can't ask to be put first”

So what meaning do we make of all this? The meaning and consequences of pain are very closely linked. The battle can be expressed through the over/underactivity cycle (testing themselves again and again) or through passivity/underactivity as in the patient who combats his pain by lying down, and whose behaviour is symbolic of dependence, weakness and failure. The link occurs through thought: “I cannot do that because of pain – I won't try that

until I get pain relief.” “Pain *makes* me irritable”. “I can’t believe the doctors can leave me in so much pain.....” “Why again” (said every morning) “I’m useless”.

So these people’s lives are dedicated to fighting pain – a fight that they can never win, that drains them and starts to destroy them as people.

Our patients tend to be isolated and don’t find the opportunity to share these thoughts. My job is to help them separate thoughts from reality, and to see that there are alternative ways of thinking which might be more useful. They have adopted a meaning which traps them in a cycle of searching for care and cure, which in itself can be punishing (Injections are painful and medication side effects can be unpleasant. Maybe this can act as a sort of aversion therapy – but as with antabuse they keep coming back for more before the penny drops) Accepting that they can have both pain and a life is both the medium and the message and I hope I am helping them to find a more “flourishing” meaning in life and pain.