

BUILDING BRIDGES

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Underlying much of the discourse at last year's meeting at Scargill House on "The Inevitability of Pain" was the feeling that we were faced with irreconcilable paradoxes, such as the necessity of accepting that much suffering is inevitable against our duty to try to prevent or relieve it. Some of these difficulties were clearly a source of anxiety to most if not all of the participants. Despite long and deep discussion with the help of our guides in the fields of philosophy and theology we seemed often to have succeeded only in raising more questions rather than finding answers.

Our ambition at this year's meeting was to attempt to make some more positive progress towards building bridges between some of these irreconcilables.

The meeting was opened by Bishop Michael Hare Duke, who reminded us in his introduction of the consensus that had emerged at Scargill as to the necessity of fully engaging with the person in pain rather than standing back, even to the point of allowing ourselves to grapple with their (and our own) despair – acknowledging the stress which this entails and the consequent need for support.

Exploring an Interdisciplinary Approach to Pain: Building Bridges and Challenging Boundaries

Barbara Collier

Western science and scientific thought are considered to be an inheritance from the ancient Greeks starting from the 6th century BC and the work of Thales of Miletus.

In 1954 the physicist Erwin Schrödinger put forward two general principles as forming the basis of the "scientific method": the understandability of nature and the principle of observation. He considered both to originate in ancient Greek thought.

Scientific thought is a fundamental aspect of medical practice and an interesting historical link between philosophy and medicine can be found in the teaching of the 13th Century English divine and philosopher Robert Grosseteste and that of the 5th century BC Greek physician Hippocrates. Both men taught that only reasoning from *observation* could lead to understanding.

Robert Grosseteste became the first chancellor of Oxford University and was made Bishop of Lincoln. He lived at a time when Scholasticism was developing in Europe and the art of dialectic was dominant. Undue emphasis on verbal distinctions and subtleties meant there was a certain indifference to facts, but Grosseteste valued not only the use of words but also that of scientific method.

Hippocrates was born on the island of Cos where he later worked as physician and tutor at the Aesculepium. Among the many famous men living at the time were Plato

and Socrates, and Democritus who although better known as a philosopher associated with the atomic theory of Leucippus was also a physician and tutor to Hippocrates.

Hippocrates was the first doctor to insist that the art of healing should depend on scientific method and clinical observation. He introduced a rational system of enquiry into medicine by first rejecting the old “verbal therapy” and not concerning himself with the divine, the demonic or the soul. He considered that medicine should function independently of philosophical hypotheses and emphasised the rational interpretation of meticulous observation. Unfortunately no written work by Hippocrates is known to have survived but some 60 treatises written by others known as the “Hippocratic Corpus”, which were collected by Alexandrian scholars in the 3rd century BC, are considered to reflect his teaching. One, “The Nature of Man”, attributed to his son-in-law and successor Polybus, considered health to result from the proper proportion of the four Humours: Blood, Phlegm and Black and Yellow Bile. Opposing factors, particularly hot and cold, and wet and dry, were routinely noted and incorporated into treatment and these concepts persisted in Western medicine until the 18th century.

The author of the Hippocratic Oath is unknown. It starts with the words “I swear by Apollo the Healer and by Aesculapius, by health and all the powers of healing, and call to witness all the gods and goddesses that I may keep this oath and promise to the best of my ability and judgement”.

The mythological background to ancient Greek medicine, associated with Apollo the Healer and Aesculapius its founder, is of relevance to multidisciplinary medical practice today: We are introduced to those ancient times and the idea of “verbal therapy” by Homer, who (in chapter 15 of the Iliad) describes how “*Patroclus sat in the tent of brave Eurylyptus and was making him glad with talk, and on his cruel wound was laying herbs to medicate his dark pain*”; later Apollo allayed the pains of Glaucos “*by instilling courage into his spirit*”. The Greeks traced the origin of medicine back to the founder Aesculapius whose twin sons Machaon and Podalarius were mentioned by Homer as heroic physicians at the battle of Troy, dating them to the 11th or 12th centuries BC. One of several mythological accounts of the origin of Aesculapius describes him as the illegitimate son of Apollo and Coronis. He was exposed at a birth on Mount Titthian, famous for its medicinal plants. Here he learnt the arts of hunting and healing from Apollo and Cheiron the wise centaur. Athena took two phials of blood from the gorgon Medusa: that from the right she used to destroy life and bring war, and that from the left she gave to Aesculapius to save life and to heal. After Aesculapius had raised several people from the dead, Hades complained to Zeus that his subjects were being stolen from him and that Aesculapius was being bribed with gold, so Zeus killed him with a thunderbolt lest his art should unbalance world order. After being punished by Zeus for killing the Cyclops who made the thunderbolt, Apollo preached “moderation in all things,” and his watchwords “Know Thyself”, written over the gate of the temple at Delphi, resonate to this day.

Galen, in the 2nd century AD related that Aesculapius assigned to patients the task of composing odes, comic skits and songs to correct the disproportion in their souls. The ancient Greek culture respected the balanced proportion, the just mean, and the opposing forces within function. The “mean” in this context refers to the correct tension in a well-tuned string: “The doctrine of the mean should not tempt us to think that the Greek was one who was hardly aware of the passions, a safe, anaesthetic, middle-of-the-road man. On the contrary, he valued the man so highly that he was prone to extremes.....when he spoke of the mean the thought of the well-tuned string was never far from his mind. The mean did not imply the absence of tension

and lack of passion, but the correct tension which gives out the true and clear note” (Kitto, “the Greeks”, 1951)

What follows is a distillation of the more important points to emerge in discussion, but cannot quite convey the full value of the “sharing” which this format facilitated.

Discussion

Barbara Collier had suggested “observation” (and measurement) as a theme for discussion following her presentation. Agreement was universal regarding the importance and value of these in the context of pain management, but much difficulty expressed as to their application, especially as regards measurement. We all try to observe non-verbal as well as expressed clues as to pain intensity and distress, but these may be misleading or confusing (the patient who smiles as they relate intense pain) The effect of observer on that observed is well recognised: the patient’s perception of the practitioner as concerned and interested may “free him up” to better express his feelings, (but the overly concerned doctor may make him worry more!) Levels of consciousness and “focus” will effect reported pain – pain remembered and imagined may not be the same as pain “felt”. Measurements of non-quantifiable entities have well-recognised drawbacks but may be of value in validating subjective judgements, especially with incommunicative patients. It is clearly necessary (but difficult) when assessing the results of intervention or surgery. Measurement of disruption of activity may be better, and perhaps more important (eg in post-operative pain impairment of the ability to cough) than that of pain intensity,

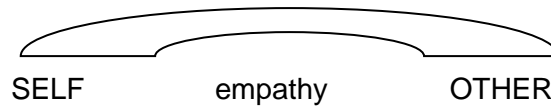
The effect that patients may have on us was acknowledged: (“countertransference” as the psychoanalysts term it), as was the possibility that (at least for pain doctors) too much empathy and involvement may effect our objective judgement as to what is best for the patient. The compulsion to “do something” even against our better judgement may be overwhelming if we share too much of his distress. But it was allowed that the process of consultation, involving reassurance, education and recommendation (even not to treat) may be of as much healing value as any intervention – perhaps evoking the healing potential of “the doctor within” .

One group found themselves sharing experiences of their difficulties in communicating such different ways of looking at things with their colleagues in other disciplines. Patients who are naturally fixated on the “physical” aspects of their problems often find it particularly difficult to accept referral to a psychologist and even more so where it is felt advisable to involve a psychiatrist (This provoking lively but inconclusive discussion of the role of psychiatry in pain management).

BUILDING BRIDGES – HONESTY AND EMPATHY

ANDY GRAYDON

Reaching out to another person – be it patient, colleague, manager, friend or spouse – involves building a bridge between you. This bridge is constructed from empathy, and is connected to the other by acceptance, which must be non-judgemental.



First, however, if the bridge is to be solid and stable you have to be sure that the self at your end is genuinely you. This involves honesty, or perhaps better, sincerity. The word sincere is derived from the Latin *sine* (without) and *cera wax*, (referring to the custom of covering up broken statues with wax and selling them as intact – hence *sine cera* = “genuine” , without pretence)

There seem to be two kinds of sincerity: outer (or intellectual) and inner (or emotional). Outer sincerity, sincerity of the head, is about intellectual integrity: doing the right, acceptable things, following rules and laws, and usually has moral connotations. Divergence from this is insincerity. We hate and despise a liar, and easily and intuitively recognise one. Lying in this context consists in expressing something you do not think, pretending to believe something you do not in fact accept. This might be termed negative insincerity. But there is more to honesty than refraining from lying. When we fail to express what we do believe or think to someone when it would be to their advantage to know, we are guilty of positive insincerity.

Inner sincerity, the sincerity of the heart, is both more important and more difficult. It is perhaps best defined by its obverse, insincerity, which once again can be negative or positive. We are guilty of negative insincerity when we to express a feeling, such as love, which we do not in fact feel, and of positive emotional insincerity when we fail to express what we feel to a person when it might make a real difference to them. True inner sincerity is much more difficult to achieve than we imagine. In contrast to outer insincerity which although sometimes excused, such as when it is used to protect someone, is never commended, emotional insincerity is regarded almost as a duty; concealment of feelings or pretence to emotions not felt is even encouraged as a social virtue.

This however is much more dangerous. When we pretend with our feelings we are at risk of losing the capacity to distinguish between truth and falsehood and so deceive *ourselves* about what we believe. If we cheat others about our feelings we may soon become unable to know what we really feel. For instance if we tell ourselves that we love someone when we do not we may believe this but end up by unconsciously hating them. Such loss of emotional integrity, and consequent emotional insensitivity, do nothing to fit us for task of reaching out to others.

But even if we achieve sincerity in this sense, there remains the necessity for empathy to build the bridge, and the importance of reaching out to another person

and listening to their feelings in a non-judgemental way – in sum accepting them as they are. Referring to patients as “good” and “bad” is a notorious (but very tempting) way of judging people rather than accepting them. Quantum theory suggests that even “solid” inanimate objects, such as a chair, may be perceived differently by each observer. We may accept this but still too readily prejudge and stereotype people according to what has gone before, rather than encountering them in their present moment.

It was suggested from the audience that it was not easy to be non-judgemental – indeed we have to make judgements all the time - and that keeping a degree of “therapeutic space” between practitioner and client might perhaps facilitate this.

Father Andy proposed an exercise to help clarify our thinking on judgement, which involved discussion of the following fable:

“Once upon a time a couple who were deeply in love and wanted only to be together were separated by a deep fast flowing river, which could only be crossed by a ferry. The woman approached the ferryman to take her to her lover but had to confess that she had no money for the fare, so the ferryman refused. A stranger overhearing this offered to give her the fare if she would make love to him. She agreed to this, earned the fare and was reunited with her lover. They would have lived happily ever after had not a friend told the lover what the ferryman had recounted of the events of the day before, whereupon he confronted the woman and rejected her for ever”.

Who behaved the best in this situation, and who the worst? This was discussed in the groups with notable lack of consensus! It was agreed, however, that each character behaved both well and badly by different standards: some (eg the friend) did right for the wrong reason, and others (eg the woman) did wrong for the right reasons. Perhaps if the woman had been honest about her action her lover might have accepted her motivation and a bridge built between them. The important point however was that each believed they were doing the right thing for the right reason; the morality appeared different from the perspective of each participant. Being non-judgmental always demands that we accept that the other believes, however mistakenly, that they are doing the right thing for the right reasons.

ALCOHOLISM, DRUG ADDICTION AND SPIRITUAL PAIN

PAUL BIBBY

Consultant Nurse in Pain Management.

As increasing numbers of patients with drug or alcohol addiction problems find their way into various clinical areas, difficult to control pain has become an increasingly common problem among this group.

The administration of appropriate amount of opioids is the usual difficulty, for which trusts are beginning to develop guidelines.

When called to these patients I have noticed that they have been labelled in such a way that interactions between them and staff have often been a bit of a shambles.

In searching for ways in which clinical staff can be educated in the care of this group I came to the conclusion that these patients could be said to be suffering from “spiritual pain” , and that their addiction is a form of self medicated analgesia taken in the attempt to make life more bearable. Relief from their pain over-rides anything else, to the point of losing relationships, employment, status, freedom, and self-respect, even life itself

Spiritual pain can be distinguished from emotional pain (“my feelings are hurt due to loss or bereavement”), and psychological pain (“I am now becoming more deeply troubled by that loss. I am depressed and not sleeping”), in that the sufferer feels that “ I am so unable to appreciate my separateness from this loss that I need to sate my feelings” , or that “I am so unable to accept the truth about myself as a person that I need to alter my perception of reality”

Spiritual pain arises when life is so difficult and painful for an individual that they have a constant need for “analgesia” ,which usually results in the destruction of their unique essence in the very pursuit of that relief from the pain of life.

As with any form of pain relief, tolerance to the drug and the need for greater doses builds up; changing the drug may help but often only for a while. Work or other “feelings-avoidance” behaviours may be successfully substituted leading to the conclusion that “drugs and alcohol weren’t the problem – I’ve got off them” . Again this only works for a while as they are indeed right – it is not the drug that is the problem, but the pain that goes with them everywhere.

Addiction (which may be to many other things besides drugs such as gambling , sex and work) has biological, social and psychological roots: there is evidence of genetic predisposition, it is most severe in surroundings of sociological hopelessness, and sometimes follows bereavement, severe stress and depression. But regarding its spiritual roots, it has been suggested that addicts are living with an exaggerated desire to return to the comfort and security of Eden, and that sense of oneness with God’s creation which has been lost. But we cannot go *back* to Eden – the only way home is *forwards*, through the painful desert. Addicts must acknowledge their pain to be free of it.

The challenge for us is to free our clinical thinking from similar misapprehensions: that there is a simple “fix” for anything that hurts, be it physical, psychological or indeed spiritual.

While we strive to relieve patients from their pain by ever improved forms of analgesia the solution for these groups of people appears to be in ‘putting down their drug of choice’. Facing their ‘pain’ rather than relief from it seems to provide the key to recovery from addiction.

It is not being suggested that physical pain relief should be withheld from such patients, or that addiction can be resolved during an in-patient stay. However, our mind-set may well be a contributory factor in aggravating an already difficult to manage situation.

Perhaps the most appropriate approach is that taken by Alcoholics Anonymous and Narcotics Anonymous, which is fundamentally spiritual. They insist that:

There is an admission of personal defeat.
There is an acceptance of the need for help.

This help is needed from a power greater than self – or else self would have been strong enough to sort out the problem.

This help is also needed from others: hence the greater power can be the AA group – not necessarily God. This also creates community and breaks down isolation.

The success of this and similar approaches suggest that there is a lesson in this for us if we are to become truly effective in working with addicts and alcoholics.

The Dynamics of Relating through Pain.

Dr. Kate Maguire.

Kate Maguire described herself as a social anthropologist and psychotherapist who having survived nine years in the NHS now works with survivors of torture, field workers returning from crisis areas traumatised by their experiences, and with anorexia (also a condition of pain), and who lectures at London University on adult survivors of sexual abuse. She had in the past worked in refugee camps in the Middle East. She felt that the motivation for a life spent working with pain stemmed from a childhood experience of seeing a picture of a concentration camp prisoner having his own stomach burnt in front of him, and a lifelong desire to prevent this sort of thing happening to anyone else. Much of this time had been spent trying to look at authority dynamics, power, and the source of abuse in society today.

“Hermeneutics is not about developing a procedure of understanding but clarifying the conditions in which understanding takes place” (Gadamer)

Hermeneutics originally meant the study of the interpretation of Scripture but now encompasses the study of meaning in general. The word derives from the name of Hermes, the god who acted as interpreter between the gods and men. There have been other gods who filled this role of bridging this gulf in understanding, and in some ways the role of the pain practitioner mirrors this: pain is very alienating, isolating, and splitting, and the pain practitioner can act as interpreter and link for the sufferer. A basic tenet of hermeneutics is that there is no making sense at a distance and one must always work out an internal connection with what one seeks to understand. Sometimes we think we understand but often we do not and there is an enormous gulf. “Whoever among us has learnt from experience what pain and anxiety really are must ensure that those who are in bodily need obtain the help for which they came to him; he belongs no more to himself”. (Schweitzer) This will no doubt resonate with all working in pain – you cannot walk away from it once you discover it and it becomes part of you.

Dr Maguire wished then to bring us some of her work with the victims of torture in the hope that looking at this extreme instance would enable us to make some connections with our work. First, though, she reminded us that all therapeutic encounters involve awareness of your own “process” – your own identity – and your relationship to the other, and seeking out the process of the other in reflection. It was necessary to turn Christ’s injunction to “love God.....and your neighbour as

yourself” back to front: first it is necessary to love, accept and have compassion for yourself, then your neighbour, and then you may find God, whatever your concept of God may be.

Torture has been described as a process of *demolition* : “there comes a moment when the pain moves away from aggression to the physical body of the subject to a more destructive experience of dereliction. This moment occurs after a time of imprisonment and torture which varies according to the individual and the context of the situation. It can be a few hours, days or months. Starting with the intensity of the physical pain, sensory deprivation, obscurity, blindfolding, the breaking of affective and effective links with the personal world which was loved, the subject finally arrives at the constant presence of the painful body, hurting , broken, totally at the mercy of the torturer. All other perceptions of the world which are not centred on the present experiences cease to exist. We call this moment the demolition.”

Those who work with the survivors of torture need to try to put the demolished pieces back together because torture is not just physical but emotional, psychological, existential and indeed spiritual. What can we learn from this extreme example about the whole spectrum of pain and to help us in its management? Pain is sometimes beyond words, and very difficult to describe in all its complexity and confusion. We have to find a way to help the sufferer to interpret it both for themselves and between us.

Maslow’s hierarchy of needs are very relevant here as the whole of torture is based on deprivation of those needs. Maslow categorised them as:

Primary needs:

Physiological eg. food, water and sleep

Safety and security needs – the need to feel physically safe from physical danger and emotionally secure.

Secondary needs:

Love and belonging needs – for friendship, love and ability to relate to and identify with other people.

Self-esteem needs – for a positive self concept and respect from others, and recognition of one’s own separate identity.

Self-actualising needs – to develop one’s innate talents and potential, and to respond to challenge.

Maslow believed that satisfaction of these needs was necessary to develop an effective personality, and function effectively within the community.

Modern methods of torture are accordingly planned:

To deprive the victim of basic physiological needs – food clothing etc

To deprive the victim of safety and security by beatings, humiliation, darkness and sensory deprivation.

To deprive the victim of love and sense of belonging by solitary confinement, torture of family, telling lies about the family and allowing no communication.

Depriving the victim of self-esteem by physical, psychological and sexual humiliation including buggery and rape

To deprive the victim of self-actualisation needs – paralysis, despair, ego distortion and confusion, lack of worth, self-doubt, shame and guilt. These feelings come about as a result of the systematic destruction of the other four.

The ultimate aim of the torturer is to achieve fragmentation of the victim in such a way as to make it impossible ever to function normally again in society or family (the affects on children often testifying to the latter.)

One can begin now to see parallels in several of these effects of torture with the effects of any chronic severe pain in “deconstructing” the individual, his ability to function usefully and the way he feels about himself. As with those suffering physical and spiritual pain, victims of torture often turn to substance abuse to deal with fragmentation.

A very helpful concept in the management both of chronic pain and the survivors of torture is that of locus of control, internalised by the belief that one can have an influence on the environment’s response to oneself, and that one can change oneself and the world, and externalised by the belief that everything is in the hands of authority, or God, and that one is powerless to change anything – in other words states of empowerment and disempowerment. One of the most important things to be done for survivor and patient alike is to restore empowerment and an internal locus of control.

Next to consider was the question of authority dynamics. These were studied in Professor Milgram’s famous experiments in which the subject was ordered by an authority figure to give a victim apparently progressively more unpleasant, dangerous and ultimately lethal electric shocks (in ignorance of the fact that the “victim” was an actor and the no electricity was delivered.) The subject was persuaded that the experiment was in the “noble cause “ of establishing whether punishment had a positive effect on the learning process. Only 22% gave less than 300v , despite the victim’s apparent severe distress, and over 60% obeyed to the end at 450v although the victim appeared to be unconscious or possibly dead. These were ordinary people, not pathological sadists. This demonstrated the power of authority and our conditioning to respond to authority out of different kinds of fear such as embarrassment at spoiling the experiment, fear of being different, and of repercussions and out of an abnegation of personal responsibility, to obey authority rather than not hurt another person. These are exactly the means (including the fear of themselves becoming the victim) by which torturers are recruited and trained (and dehumanised) – the “noble cause” in this case being the security of the state, the religion etc. As well as authority, torturer and victim, an important passive role is adopted by the “silent others” – those who chose to turn a blind eye to torture (or the abuse of children, bullying , indeed any preventable distress – the parallels are obvious)

Because there is no contact between authority and victim, the latter assumes that the torturer is acting alone and that the authority would help him if he only could make contact. The same authority dynamic operates in any large organisation, including the NHS! It also affects the relationship between practitioner and patient, typically when the latter’s disappointed expectations of the former can be blamed (fairly or

unfairly) on "the administrators" – and can be used by the practitioner to mitigate his sense of failure, or even to excuse his disinclination to help a patient he dislikes. Conversely, it is up to us to challenge authority if we cannot fulfil our role as healers due to the restrictions laid on us - ignoring if necessary the "noble cause" of avoiding overspending etc. The alternative is collusion as culpable as that of the torturer.

Another application of an "internal" authority dynamic might be seen in the patient's perception of his pain and you, the practitioner: in this the "authority" is whatever or whoever caused the pain; the "torturer" is the pain itself; and the "victim" is the patient. He may see you as a benign authority who can take away the pain but if you fail you may be perceived as part of the malign authority or even the torturer. Your task is restore the power this perception denies him, perhaps using metaphoric processes but above all by being the communicative bridge between patient/victim and pain/torturer, through an open and listening relationship. His pain may still endure but need no longer be all-consuming and invasive of his whole identity and life.

Another important aspect of torture is called "disappearing". This has two meanings in this context: firstly physical disappearance, as in the thousands in Chile and other parts of South America who have simply never been heard of again, and secondly hooding of victims, depriving them of contact with anyone, of the possibility of recognising or being recognised, of identity – in short dehumanising them. (In contrast with mediaeval depictions of torture where it is always the *torturer* who is hooded and unidentifiable.) Of course we "disappear" people all the time –especially children! ("*go to your room! ...but Mummy... Mummynot now I'm busy.*") Many patients who come to us are saying in effect not that "I have pain" but that "I am pain", and have in a sense disappeared.

Even removing the hood after a long period can be traumatic as revealed in a poem by a South American prisoner which starts:

"Today they took off my hood
How can I cry now?
Just at this moment I so feel like crying
Where would I hide the tears now?
Now they have taken off my hood

We must be careful when as practitioners we want to help someone "reappear" to go gently and not rip the hood off.

Dr Maguire gave us an illustration of a young man who had been captured and tortured by the Khmer Rouge and after several suicide attempts had been seen by a psychiatrist who labelled him as having a "personality disorder" - never having encountered him as person - and in effect "disappeared" him. Harrowing extracts from his diaries revealing what he had been through, and the source of his incredible pain, changed the psychiatrist's whole attitude to such patients – sadly after the suicide of this young man.

Working with this level of pain on has to ask oneself several questions: how does one speak about pain; how does one receive the communication of it: how can subjective pain be conveyed to an external other person; how can mind and body be joined again when the pain has separated them and made them mistrustful of each other (In the torture situation the body made be almost dead but the mind says "keep

going....keep going” ; or the person may want to die but some doctor is keeping him alive.)

What language can we use to convey these things? That of religion and mythology? (Prometheus was tortured because he had compassion for cold human beings and gave them fire. Christ too was tortured because of his compassion for mankind) Of poetry, metaphor and allegory? Metaphor in particular is very important for the expression of extreme pain. Metaphors are interpretative bridges, symbolic and profound means of communication which bypass the explicit cognitive reasoning gates allowing one to understand and experience one kind of thing in terms of another. Among many valuable benefits they allow people to speak of the unspeakable with less trauma to speaker and listener, integrate the cognitive and the emotions, help to unlock defences from the inside, to safely retrieve images of trauma and provide the client with a means of self-help beyond the counselling room. Dreams and nightmares are important metaphoric processes; the client must be taught to regard nightmares not as the enemy but part of the process of healing.

Discussion was mainly around the relationship dynamic between patient and clinician, about power and authority in this context and the notion of powerless in the patient and in the clinician. It was widely felt that the clinicians present were not overstressed by feelings of powerlessness engendered by their work with patients so much as by the authority on top of them. Awareness of the authority dynamic might enable them to avoid transferring these feelings to patients through clinical detachment, irritation, referring on, overprescribing etc - acknowledging that this sort of response from a clinician only intensifies the patient's already existing powerlessness caused by his pain, and contributes to his becoming entrenched in a position of hopelessness, anger and not being heard, impacting on any success of outcome.

Almighty Love and Ills Unlimited

Bishop Michael Hare Duke

So far in this meeting we seem to have mainly been in two areas of discourse: firstly the practical issues of workload and finance, and secondly the issues of how we survive emotionally, and cope with the expectations of patients and society. I want now to address the question of what makes sense, how do we put it together in a framework of understanding which takes into account the tradition we have inherited as doctors and from other sources.

The title of this reflection is stolen from Austin Farrer, an Oxford theologian and philosopher. His academic and intellectual framework of belief assured him of a loving God who cared for all his children but his life experience was to be the father of an only daughter who was autistic. The pain for him and his wife Catherine was that with all their teaching and perceptive ability, with all their Christian devotion, they could not communicate at any emotional level with the child they so desperately wanted to cherish. As they watched her grow encased in the shell of her self-absorbed world, they experienced the dilemma that gave the title to the book which he wrote to explore their family distress.

The painful dilemma is a perennial one. It appeared in a Broadway play, called JB, a modern version of the Book of Job. The core theme was summed up:

"I heard upon the dry dung heap
that man cry out who could not sleep
'If God is god, he is not good,
if God is good, he is not god'"

God cannot be Almighty Love, if Ills are unlimited. If he were loving how could he let this happen to me? If he is good, he cannot be what we assume by the title 'God'. If on the other hand he has all the power of the Creator, then he is a cosmic sadist.

The dilemma was not so succinctly put, but the same question dogged me when I was I was a hospital chaplain. Patients would reflect on their histories, and contrast their pattern of respectable family life, moderate enjoyment, avoidance of excess with the opposite indulgence that they had observed in their neighbours. They themselves were in hospital whereas the others were flourishing. The objection was always 'Where is the justice in this?' or more simply 'It is not fair!'

As pain consultants you are more aware than most of the pressure of suffering in our society and of its random nature. Yet there is a widespread sense of grievance about it in popular thinking. How are you able to hold on to the notion of the love of God for yourselves or what comfort can you offer to sufferers or relatives? Do you see that as part of your role, or is that your cue to send for the chaplain? Interestingly the Scottish Executive recently set up a Working Party to report on Spirituality in the NHS. The work began with a discussion of administrative questions about the responsibility of Trusts for funding Chaplains but ended with an examination of the nature of spirituality and the responsibility of all staff to respond as best they could to the questions of their fellow human beings. This was in addition to ensuring that at every level attention was paid to specific religious needs – spirituality was not counted among these.

Traditionally Christianity has answered the questions about suffering and justice by looking at the suffering of God, seeing Christ crucified as identified with the world in its pain. This, it has been said, is God's action to acknowledge responsibility for the suffering that is inherent in his act of creation, rather as a parent will see how family life is potentially the source of suffering as well as joy and take responsibility for the areas where it has gone wrong.

Thus much is theory, addressing the issue of Theodicy, a subject first given its name by the 18th century German philosopher Leibnitz. Long before his day however people were suffering and asked how the pain could be understood and how it could be combated. One solution was to find a source of wrong doing which had incurred God's displeasure and brought punishment on the individual or the community. The history of the Black Death is instructive; sometimes a group was sought to be the scapegoats for what was seen as the direct punishment of God: sometimes a natural cause was sought and pogroms were instigated against the Jews who were accused of poisoning wells as the common water supply.

The alternative solution involved a shift in theology. The One God was replaced by two rival forces at work in the world. The Good Creator was matched by an opponent, responsible for all evil, including pain. This is Dualism which understands the created world as a battlefield between Good and Evil, Dark and Light, God and the Devil. The healers, enlisted on the side of Life, eventually evolved into two complimentary professions of doctors and priest/pastors. Their equipment emerged

progressively through magic, autosuggestion, to scientific diagnosis and treatment with an increasing insight into the dynamics of the mind/body interaction. I believe that the time has now come when increasing efforts are required to bring together the two groups of practitioners who have on occasions been seen as rivals. In the worst cases clergy or 'pastors' have wanted to magnify their status by advocating 'spiritual healing' over against the medical remedies, the medical world has repudiated the 'mumbo jumbo' of religion or even the language of human relations. This however is to institutionalise the Mind/Body split that characterised the Cartesian world-view. It may rather be argued that for a priest to anoint a patient before an operation or to administer Communion may introduce a positive dimension which makes its own contribution to healing, adding to the surgeon's skills, not vying with them. Unless this partnership is properly acknowledged, there is a danger that when scientific medicine has come to an end of its resources patients or relatives will be tempted to resort to magical remedies 'just in case'.

This however to import the split to the area of the sickbed, pitting the priest/magician against the doctor/scientist. The healthier option is to look again at the make up of the human person as an interacting system of body, mind and spirit; and try to discern which part lies behind any particular set of symptoms and then see what the appropriate response might be.

Here in one sense we are operating with a three way division. Pain presents initially as a bodily symptom and diagnosis begins with a search for the physical cause. Fast on the heels of this comes the question of the contribution of the mind, either in enhancing or reducing the severity of the pain. As a stage further in this complex is the belief system within which the sufferer lives and uses to interpret experience. Is life for him or her a series of random events. This begins with the accident of birth, the lottery of education, the right job turns up, a suitable partner is acquired, an illness strikes. All these may appear to have a mixture of chance, choice and ability but is there behind them all either an overall plan or another dimension from which help may be sought or derived. This is a world into which we make our entry by supernatural or non-scientific means, which can be described as magical or spiritual. These however are quite distinct ways of operating. Magic is about manipulating objects, events or people by a spell – a secret power that is at the command of the practitioner. The spiritual way is primarily through prayer which brings some kind of influence to bear on a person or situation but in a non-prescriptive form. This is not always understood. I remember at a Mothers Union Retreat a powerful Enrolling Member approaching me to say "Bishop: at the intercessions tomorrow will you pray for x's son, that he may come to his senses and give up the dreadful relationship he is in with a most unsuitable girl". I could only answer, "I will pray for the boy, but what he ought to do and how he should order his life is his affair. All that we can do is wish him the freedom to make a good decision." I suspect that the lady thought that I was not very Christian, but I still believe that one of the most important insights of the New Testament is "Where the Spirit of the Lord is, there is liberty"

In practical terms, when we have treated a patient to the best of our ability, when we have thought about his internal dynamics to consider whether there is any resistance to getting well and sought to help him to explore this, then there remains the power of prayer that does not dictate any specific outcome to an illness, or the pain of a relationship, but simply lets the distressful situation come to rest with a Wisdom that is way beyond our own and can discern outcomes that we could never imagine, but at the same time will empower us to make apparently impossible choices. Rather than prayer (as it is commonly understood) on the lines of "Lord, make her rheumatism better" we should seek simply to move her into the light.

What does become important is to have confidence that 'all shall be well' , and this can be a vital resource for all concerned with the management of a situation, patient, physician, family, pastor, friends and carers. It may be that it is the role of one member of the team to help others sustain such a stance. It comes out of the personal faith of an individual but also from the culture of a religious belief. It starts perhaps with the assumption which we all share that propensity towards healing is part of the human condition. Wounds heal, broken bones mend, we grow through some forms of mental illness, forgiveness is an expected outcome of conflict. It does not always work, but there is a bias towards a good outcome. The Christian Church has an iconography that chimes in with this. Traditionally it has looked to the prayers of the Saints to back up our own, it has written of the ministry of angels. Such language is not now much in vogue, indeed in a secular environment it can be frankly off putting. What it represents however is a sense that in the struggle with pain, physical or mental, the individual practitioners or their various groups are not alone, they are on the side of a total system that carries a bias towards restoration.

A quotation from Jung to the effect that he had had 'clinical experience of Angels' is the kind of remark that I treasure because it does not come from a religious stable but is the reflection of a man who had looked into the human mind and was not going to be fooled by a neurotic search for fantasy reassurance.

As our various professions seek to bring hope and confidence to the work in which we are engaged we have a right to find signs of a transcendent world around. Its existence was the theme of a book by Peter Berger, a sociologist, entitled 'A Rumour of Angels'. In it he draws on the experience of a mother comforting a child crying in the night with "its all right.....it's all right" – suggesting a sense that the universe is on our side, and that beyond her love its lots of other love. He cites other evidences of transcendence such the human ability to play even in the midst of tragedy, the gift of humour, and the gift of moral outrage. Through all these aspect of human experience he argues for the existence of a world that is supernatural. These are his rumours of angels. And these are the signposts by which it is possible to discern a bridge between the two poles of a loving God and a world of pain. It is not an argument to be won in favour of this side or that. It is instead a way of finding the golden thread which runs through the total human history and makes it possible to hold together the contradiction. This is not simply an argument to be savoured and evaluated intellectually. It is something lived out in the hope, the tenderness and the dedication of all healers of body, mind or spirit. We keep on doing our jobs in spite of tiredness, stress and failure because of the sense that it is worth doing and that we are on the side of something bigger than ourselves. We are the witnesses by our practice, holding on against the temptation to give up, entering into the pain of others, believing in them when they have ceased to believe in themselves. Maybe few of your patients would use the language, but on the ward rounds on in the consulting room you are for others an icon of the supernatural world, concrete messages of the love of God. "If he or she is around, I too can hold on". It is an awesome responsibility.

Discussion

How can such challenging concepts be put over to intellectually unsophisticated people?

People have always said "I will pray for you" – or they may only have said "I'll be thinking of you" – or they may simply have held a hand. We seem to find it ever more

difficult to touch people and holding a hand may be all that is needed to communicate our humanity and our belief in their humanity and the courage not to be frightened – no words are needed.

What do you say to people when they ask “why me?”

I tell them that God doesn't decide to make things happen to people – we live in a world where lots of random things happen, but he is around and beside them when they do happen .

Are you saying that salvation doesn't lie in self-fulfilment – not something you do but something you receive?

Perhaps one of the most important things for people to discover is that they are not in charge – that they are sustained: that they are part of a whole company of people and rely on their mates. This reliance can be seen as spiritual.

Prayer can be very under-rated and can often bring peace in place of anguish in a very wonderful way, but in spite of the trend towards holism in recent years there are often situations where the spiritual need is apparent but one cannot help in this way without being asked as one cannot (indeed one is not permitted to) push one's beliefs. It could be argued that we are not assessing patients adequately if we fail to assess their spiritual needs.

Sometimes all we need to say is “it's all right – I'm here for you”. Maybe God was saying through Jesus the same thing “it's all right – I'm here for you.”

Are we talking about divine answer to prayer or simply the effect of the act of praying?

There have been double-blinded studies of prayer, which have apparently demonstrated a “therapeutic” effect of prayer even when the recipient was unaware of it. Bishop Michael related the story of a Tibetan monk (now Abbot of the Buddhist monastery in Scotland) who, when he first came to England, found a job as a hospital porter. A surgeon, on learning of his background, invited him in to the operating theatre, where he sat and directed his meditation towards the patient and the surgeon . It was noticed that the surgeon's results seemed to get noticeably better during this time

It doesn't matter what the patient believes if you believe that you are the hands, ears and eyes of Christ, and you are responding to Christ in the stranger, the poor, hungry etc. You can hold them in prayer without telling them what you are doing.

But you can still offer empathy, compassion etc independently of your religious beliefs – although they may be inter-related.

There are often restrictions put on you if you wish to use prayer in your work and sometimes outright opposition from one's colleagues – but they must learn at least to respect other people's beliefs.

One can – indeed one should – never force one's religious beliefs on anyone but access to “spiritual” help (be it only non-verbal) should always be available. This is particularly important in a multi-ethnic, multi-faith setting.

There rarely seems time in the outpatient setting to explore a patient's

spiritual needs, although one might occasionally be intuitively aware of them (and should always be open and sensitive enough to pick them up) Should we have spiritual assessment tools as well as physical and psychological ones? Is spiritual pain and need a diagnostic category? Of course all these aspects have to be addressed but in practice you can't take them all at once – or you can tell the patient at the outset that all pain has these dimensions and that they all need to be attended to.

We need to find each person's metaphor, be it religious or otherwise (poetry an art come into it here) For people with no religious beliefs, and are frightened or despairing, one must try to find some sort of well of hope in them to draw reassurance from.

Pain practitioners shouldn't try to play the role of the priest? – OK, if the patient needs someone to talk to them in religious language, one needs to involve a professional, but what we have been talking about mostly this morning is a spiritual attitude rather than religious language – but there are things best left to those who are professionally trained to deal with them. And we should be aware of the difference between person and role – some chaplains are not particularly good at this sort of thing, while some nurses and others who clearly are. Perhaps all clinics should have a chaplain or priest as a member of the team – where this is the case, it gives the message that the possibility of a spiritual dimension is at least recognised. This is partly an institutional matter. There aren't enough chaplains to go round, and their training isn't always necessarily appropriate.

What resources do we have in our present culture for dealing with pain? Although Christian theology generated all sorts of questions with regard to suffering, it also provided some of the answers. What, in a so called post- Christian era, can we rely on for our patients or ourselves, or to illuminate dilemmas such as euthanasia? The situation might seem a little bleak, and perhaps it is more useful for practitioners to concentrate on doing the best for each patient as they come than asking what might be seen as a useless question.

Art to Express Pain

Joanna Zakrzewska

The setting for the work on which this talk is based is the Trigeminal Neuralgia clinic at the Royal Free which is held in a room dominated by an enormous dental chair, which seems to symbolise the difficulty in accepting a biosocial concept of pain in place of a biomedical one shared by both specialists and patients.

The sort of pain my patients experience is vividly portrayed in a poem written by one of them:

Hey Dr Edmonds I'm back again today
Won't you please do something and make this pain go away?
It has hurt all night , it has hurt all day.....

For years this has been my story
Each time I go it's the same

Yes, that tooth, no, that tooth
They all hurt just the same
Now take these pills ,puree your food
And pray the pain goes away

Oh the horror of this pain
The ice pick stabs again
The quickness of this pain
Has come and gone again
Sometimes it lasts for ever
And I think that I might die.....
Sometimes it is just a burning.....
It may feel like Novocaine
that is beginning to wear off.....

Now it is time to eat
And brush these teeth
Here comes great fear again.....
Oh please not this pain

Then comes the worst of all
Pain like this I never knew existed.....
The blade of the knife is carving
The pain is so fierce
And now I see my face
As one of Jack-O-Lantern.....
I just want to die
the tears flow down my face
In my heart I ask
Please let this pain pass.¹

And another:

What colour is pain?
White-hot, sizzling
Blood red where it rends
He senses, tearing
Shredding,
Then drips crimson
As it pulls back, plunging
Knife-like again
The colour of a scream
Torn from the pit of being,
Echoing in the mind, throat,
Ears, seen with eyes
Clanked shut like teeth.
The colour of a moan, a wail
Drawn up from the very cells
Within
Colour of darkness – no

Not black.
Darkness curled up, folded over,
Binding, Blinding.
Held fast in this womb
Of pain
The colour of skyrocket
Touched off in this
Small enclosure of one cheek,
Shards of fire,
Rending,
Clawing,
Tearing.
The colour of an invasion.
And I,
The prisoner, bound.

Other patients have attempted to express their pain in pictures.

Trigeminal neuralgia is in several ways different from other pains; as well as being difficult to describe it cannot be measured in terms of disability; it is particularly socially isolating as although the sufferer doesn't appear ill, (and has a condition most people haven't heard of) he or she is very reluctant to go out, for instance for a meal, or any activity which might provoke the pain.

One of the things that patients find crucial the support of other sufferers and a support group – The UK Trigeminal Neuralgia Support Group has been set up. The value of the support of a loving partner, and the sense of impotence experienced by the partner, are poignantly expressed in another poem:

I see your pain
In your face.....
Never knowing.....when the next pain will come
I feel so helpless.....
Want to help
but don't know how
Afraid to touch
Your cheek or brow

If I could take
your pain away
I'd d it now..
This very day!

Just know I care..
Though I can't feel
The pain you have
I know is real!

And another:

.....I could endure the pain
but couldn't be without

His standing by me, his love devout
Alone with aches it's hard to bear,
He's there with me, he really does care.....

The theme of overcoming pain by is taken up in this poem:

The Serpent comes
Fork tongued and unctuous ,
It slithers down the ganglion,
Fang flickering, nerve licking, where and when to strike?

Can we be friends?
Can I make peace with you?.....

Some poems relate a story with a happier ending:

It was such a relief when you first found out
Your pain really did have a name.....

Then lo and behold, a support group you found,
With people that all shared your pain

Information was learned, medications you shared
And the tic you started to tame

Things improved for a while, you started to smile
Then back with a vengeance it came.....

.....So to the hospital you came.....
When you woke, a big headache you had,
but behold ,no tic did remain.
The journey was long, your problem was solved
And now you have life back again.

So much for Trigeminal Neuralgia, which terrible as it is, is at least quite often gratifying to treat on a biomedical model. The other condition seen in the clinic, Atypical Facial Pain or Chronic Idiopathic Pain has no cure , and seems to be much more stress and tension related. Patients coming to what appears to be a dental clinic do not expect an holistic approach are frequently puzzled by and even resentful about being asked about emotional and social aspects of their lives. An attempt had been made to explain the relationship of emotional factors and pain with reference to the Gate Theory, put in such a form as to be comprehensible to the average patient. This involved designing a diagram [which was presented for discussion and suggested improvement by the groups. This proved an interesting and stimulating exercise, but furnished perhaps too many good ideas to achieve consensus! Many different designs were suggested but it often seemed that those which had practical advantages conveyed the wrong impression symbolically – and this was different for different people]

1. A philosopher's viewpoint

Michael Bavidge

What is a philosopher's viewpoint? All philosophy is simply a reflection on the way we live, and on the assumptions that underlie the way we live. Those assumptions take the form of concepts and beliefs, and ideas and key words which capture them. (Beliefs can be true or false, but concepts are just useful or not.) By underlying the way we live I mean what we know or think we know, or what we value or think we value. All the talks and discussions at this meeting have challenged us by asking these two questions: what do we know and what do we think we know, how much do we know and how do we know it; and what do we value and how do we behave and choose our objectives as a consequence.

In discussion over dinner about what distinguishes this conference from other pain meetings, having rejected "non-scientific" or "anti-scientific", someone came up with the suggestion of "the no easy solution conference". This has seemed peculiarly apposite although it's not so much a question of "easy" versus difficult as "simple" versus "complex". There has been a clear understanding that pain is complex and people in pain are complex, and the approach to them necessarily complex: it must be multidisciplinary and modest in its expectations (avoiding the hubris - overweening pride - portrayed in Geek mythology). Scientists from Newton to Crick and Watson have often found it possible to come up with beautifully simple solutions to apparently overwhelmingly complex problems, but it would seem that no-one here believes that to be a reasonable expectation when dealing with the person in pain.

Since I first started studying philosophy I have always by inclination been anti-reductionist. I believe that reductionism is wrong both epistemologically and methodologically; it is only credible because the view of the world it gives is a shadow of your own methodology - you think the world has to be this way because you are wedded to this way of looking at it. In general this conference has rejected this approach although we have been reminded that "the devil's in the detail", and that observation and measurement remain as necessary in therapy as in science. Adding to the complexity of the scene is the whole set of problems which spin around the notions of subjectivity and objectivity. The word subjective is often heard in a pejorative sense as "illusory" or "idiosyncratic". It is used in a cognate sense but also means simply the view point of the subject: the participant or the observer. If a group of highly intelligent aliens, passing over while taking an inventory of the world, were to look down on this room what would they have to see? Even if they have a completely different conceptual structure they would have to see *us* and notice that we are waving. They would have to realise that we are not just data to be observed and entered into a theory, but subjects, people who are going to make demands on anyone who is going to deal with us. So you can treat my brain and nervous system as just another object to be studied, but if you are going to treat me as a person who has subjective states and who has a certain take on the world, there is only one way of getting at me, and that is a participative relationship.

I know that you want a patient to participate at every level in his own treatment, and I really want an answer to a question I posed earlier: what makes a good patient? As I get older it is probably inevitable that I shall one day become a patient and I really want to be a good one, not just one who doesn't make a fuss etc. It's not a bad thing to be a patient; we seem to have lost the ability to explain what is good, even fine about being on the receiving end of other people's attention (Illness is not good but

being a patient is.) Is it to be a better consumer? I'm a very bad consumer; I never complain in restaurants and would much rather be killed by a surgeon than suggest he doesn't know what he is doing!

Finally I want to comment on the two models of communication we have been presented with: one a bridge and one a room. The former has useful for some purposes but when it is set up we have two individual boxes and I prefer a model by which (as Heidegger put it) you open up a clearing between people and invite them onto that common ground. Meaning is then generated in that public space. The two outstanding figures of 20th century philosophy, Heidegger and Wittgenstein both moved from a concern with meaning and significance being rooted in the individual mind to rooting them socially. The image of a room (as suggested by Kate Maguire) sounded like a space that has been made significant by the objects that are donated by the patients and the carers as well – so it is a significant space – not just an empty area – and people are invited onto it. They become part of a community which is concerned with pain, acknowledges pain, and tries to do something about it – and perhaps most of all it is a community in which everyone and everything is “all right” .

(2) A theologian's Viewpoint

Michael Hare Duke

Through out our conference two questions have emerged, the boundaries of human compassion and the measure of divine indifference. How do we square a Love which Almighty with the unlimited ills that are your medical stock in trade? What limits do you set to your engagement with the distress that you encounter in your practice? We have attempted answers that have been sometimes practical and sometimes theoretical.

From a theological point of view the issue of 'theodicy', the justification of God in the events of history, has never reached a tidy conclusion but its resolution may lie in the experience of your professional work. We look in vain for a neat equation between divine mercy and justice, perhaps your contribution provides the missing term.

I am reminded of two verses by A E Housman, the Cambridge classical don and poet, from "An Epitaph on an Army of Mercenaries"

These in the day when heaven was falling,
The hour when earth's foundations fled,
Followed their mercenary calling
And took their wages and are dead.

Their shoulders held the sky suspended,
They stood and earth's foundations stay;
What God abandoned, these defended
And saved the sum of things for pay.

Your task in medicine is to care for those who may well feel abandoned in their pain. The attention that you give them is a professional duty but communicates their value as human beings. Beyond your conscious intention you are the way that God's

concern can be understood. In this I want to exalt your professions, claiming that in your clinics and wards people find a reassurance beyond your diagnostic and treatment skills, they discover their human worth. Is this just good practice or a theological communication?