

THE BRITISH PAIN SOCIETY

Special Interest Group for Philosophy and Ethics

The Power of Language

Burnout

Launde Abbey, 2nd to 5th July, 2018



Contents

Introduction	4
<i>Peter Wemyss-Gorman</i>	

The Power of Language

Speaking of suffering	6
<i>Michael Bavidge</i>	

Pain Signals and other Bad Language.....	17
<i>Betsan Corkhill</i>	

Burnout

The Problem	27
<i>Michael Platt</i>	

Why has medicine become such a miserable profession?.....	37
<i>Clare Gerada</i>	

The Raveled Sleeve of Care.....	52
<i>Michael Farquhar</i>	

Mindfulness for Burnout	70
<i>Sangram Patil</i>	

Bad doctors and graphic medicine.....	83
<i>Ian Williams</i>	

Creative writing.....	91
<i>Sara Booth</i>	

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Introduction

Peter Wemyss-Gorman

We debated two topics this year which although apparently unrelated, as will be seen do overlap in a very important way.

We have long recognised the inadequacy of language for describing the nature and intensity of pain or conveying the experience of suffering. Attempts to 'measure' pain have been largely abandoned and alternative methods of conveying pain and suffering such as art and drawing, though valuable, are of limited availability and practicality in the clinic. So words remain virtually indispensable in the intercourse between clinician and patient.

Language is of course a preoccupation for philosophers, and in his paper 'Speaking of Suffering' Michael Bavidge helped us to clarify our often confused thoughts on the subject. He argued that the criticisms of language are misplaced; they start in the wrong place and are the wrong sort of worry about the wrong things. "We express pain and suffering, before we describe them."

We are only too aware of the difficulty patients experience in expressing their suffering to clinicians but give little attention to the language which clinicians use to patients. In her powerful talk, Betsan Corkhill urged us to think much more carefully about our own words: we can become so used to the medical language we've always used that we cease to consider its effect on others. Words have a powerful potential either to set a person down a path of fear and catastrophisation or to start them on a journey to wellness and recovery.

Readers may wonder why the topic of burnout featured in a meeting of a group of clinicians dedicated to the exploration of philosophical and ethical issues arising from the practice of pain medicine. We have however tended over the years to have diverged further and further from matters to do with 'physical' pain into wider realms of suffering in general. Furthermore, the effects on our own mental health and wellbeing of working in an area of medicine which can often seem frustrating and unrewarding, with a patient population of whom many have severe psychological problems, have often featured in our discussions but we have never dedicated a whole session to this. The phenomenon of burnout seems to be becoming more and more prevalent, not only in our own speciality but throughout the medical profession, especially in General Practice, and indeed in other professions unrelated to medicine, with high rates of depression and even suicide. Our distinguished guest, Clare Gerada, (former president of the RCGP) described a vortex of problems resulting from escalating demands with diminishing resources, especially of time and staffing, aggravated by the failure of the traditional system of mutual support among health professionals which she called the 'medical matrix'.

Of the many vicious circles involved in this process, sleep deprivation and insomnia are major but neglected contributors to burnout. Michael Farquhar described his campaign to draw attention to this and address both personal and institutional measures needed to deal with it.

We were also treated to descriptions of novel ways of preventing and alleviating burnout, including Buddhist inspired courses in mindfulness meditation, comics and graphic novels, and creative writing.

As to the overlap between our two topics, which we did not directly address, it was tacitly evident from our discussions that many of us were aware of the effects of the language we use *to ourselves*, often critical and unforgiving when we ruminate about

our perceived inadequacies in providing the care we think we should be, or allow ourselves to dwell obsessively on a particular mistake or failure. There is an evident need for us to permit ourselves to use language to ourselves which is self-loving and forgiving.

Speaking of Suffering

Michael Bavidge

The Problem

There is supposed to be something wrong with language about pain and suffering. David Biro begins his book, *Listening to Pain*ⁱ, with a discussion about the failure of language to capture the experience of pain. To illustrate the point he draws on many sources – clinicians, patients, writers. ‘*Pain*,’ he says, ‘*is difficult to express. Language and pain seem as far apart as the opposite poles of an electric current. While language can capture much of the diverse range of human experience, it fails us in the case of pain*’. (Biro, p.11)¹

His anxiety is not confined to language and its limitations. He goes on to ask ‘*Can we really convey our subjective experiences to another person? Can other people ever understand how we feel?*’ These epistemic questions – what we can know and communicate - collapse into a final ominous metaphysical query: ‘*...are disconnection and isolation just facts of the human condition?*’ (Biro, p.19)

To be fair to him, he does not stop there with a series of sceptical questions expecting the answer ‘No’; nor with anxieties about the human predicament. In fact the whole book is designed ‘*to help sufferers recover their voice and to generate a rhetoric of pain*.’ (Biro, p.14)

In this talk I want to examine these claims about the failures of language and examine their philosophical roots. On the one hand, these criticisms of language seem strange. It is odd that we, the most communicative of animals, fail so abysmally to communicate such an intrusive aspect of our experience. If these failures really are endemic to language, then the best we can do is to guess on the basis of clues and contaminated evidence what is happening on the inside of other people’s experience. On the other hand, serious pain and suffering are dysfunctional and we feel isolated when we experience them.

So what to think? I am going to say that underlying these anxieties about the communicative failings of language there is a philosopher’s error: we misread personal isolation as the epistemic privacy of experiences, which leads to, and is bolstered by, a private semantics. The criticisms of language are misplaced. They start in the wrong place: they are the wrong sort of worry about the wrong things. We *express* pain and suffering, before we describe them. Through the dynamics of interpersonal expression we share our feelings and we disclose ourselves. Nevertheless, sometimes we fail to communicate. Some experiences intensify our feelings of isolation. Suffering can prevent us from communicating.

A passage from Italo Calvino gives me a way into my topic. He writes:

‘There are two different drives that will never attain complete fulfilment, one because “natural” languages always say something more than formalised languages can – natural languages always involve a certain amount of noise that impinges on the essentiality of the information – and the other because, in representing the density

and continuity of the world around us, language is revealed as defective and fragmentary, always saying something less with respect to the sum of what can be experienced.ⁱⁱ

A formalised language is a vehicle for transporting information; it is cut adrift from the density of human life so that it can be programmed into a machine and used as the basis of information transfer. Natural languages, particularly expressive forms of natural languages, arise out of our engagement with the world and our responses to it. The 'noise' of natural languages is not some interference; some crackle on the line. It is the tolerance, the play that language needs to convey our presence in the world and our presence to each other. It is a consequence of the fact that we live through language. Language is not some sort of perfectly engineered tool for completing a pre-defined goal.

If we experience the dislocation of language and world (and it is a professional requirement that philosophers experience that) we come to compare what is said to what is being talked about, the word to the object, the representation to the represented. David Biro comments on his own book *'Throughout this book our focus has shifted back and forth between the felt experience of pain and verbal representation of that experience.'* (Biro, p.137) If that is our focus – the contrast between experience and representations of experience in language or in any other form, then as Calvino says, the representation is always 'something less'.

We describe our experiences, even raw sensations like pain. But we do so on special occasions. A clinician asks us to describe the pain: how intense is it? Place it on a scale from 1 to 10. What sort of pain is it? Where is it? Whether a description is a good or a bad description depends upon the purpose for which it is designed. Descriptions are not attempts to duplicate in linguistic space the reality of the object described. One special feature of descriptions of sensations is that we get to them through the person who experiences them. Take, for example, questions about the location of pains. Pains have a location. That is one of the features that make pains so thing-like, more thing-like than love or resentment. We can say where the pain is - perhaps not always but often. It is in the second joint of my middle finger. But my pain is not 6 foot from the wall and six inches about the table, even if the second joint of my middle finger is 6 foot from the wall and 6 inches about the table. Pains are located but not in the way physical objects are located.

We complain about the wrong thing. The *'experience of pain and its verbal representation'* is the wrong contrast. If we think that is the problem and if we generalise it, we get a five-star philosophical problem: how can we put anything into words? How is our experience, how is the world, speak-able at all?

From Public to Social to Interactive

Private Language

My thoughts here are, as always, in large part, inspired by the later work of Wittgenstein. He began by focusing on language, but what he has to say applies to any communicative domain. He starts with the impossibility of a private language. The individual cannot inaugurate a language by mental acts of attending to his own experience and putting names on things. Whatever we say or think has to be rooted in public criteria which anchor what we mean and the truth of what we say. If we lose

the connection to the public world, then, as Wittgenstein puts it: *'whatever is going to seem right to me is right. And that only means that here we can't talk about "right"'*ⁱⁱⁱ This applies not just to talk about the world around us; it holds in relation to our own experience. Whether we are talking about tables and chairs or pains and anxieties, the meaning of what we say has to be publicly grounded.

Social Language

However that is just the start of it. It is not just that meaning, and therefore the possibility of truth-seeking, is a public affair dependent on criteria which are independent of any individual's say so. Making sense of the world is social. The individual on his own cannot initiate and maintain a language. Language, any domain of meaning, depends upon conventions and rules; we are required to think and act in this or that way; for example, we cannot but see this as 'a chair' or see that the hands on the clock tell a particular time. But those necessities cannot be explained by pointing to a rule written up on a wall, or for that matter in our minds. The issue is: how do words on the wall shape the way we think and feel? The rules involved in any understanding of the world, do not apply themselves; we have to apply them; and this involves interpretation: how do we take the rule? There's the arrow painted on the wall; but what makes it point in this direction, rather than that; or indeed in any direction. It seems we need another rule to tell us how to apply the first rule. But this in turn requires a further interpretation and so on. Wittgenstein argues that the threat of an endless appeal to one rule after another shows that *'... there is a way of grasping a rule which is not an interpretation, but which is exhibited in what we call "obeying the rule" and "going against it" in actual cases'*^{iv}. What grounds a rule is not another rule, not a super-rule which just hangs there and forces upon us its own application, as Plato might say. We have no *reason* which forces us to understand things in the way we do. In this sense, we *'obey the rule blindly'*^v. 'Blindly' does not mean 'arbitrarily', as if we just opted to think this way rather than that. We cannot choose how to think, in the way we might choose to play chess or draughts and so put ourselves under the relevant rules. In the case of our fundamental ways of thinking there is no place for us to stand to make a choice to play or not to play.

Interactive language

It is the actual interactive engagements with others which constitute the weight of the rule: we are called into the social world by other people. The vocative comes first; then we respond. The first *blind* steps into the meaningful world are taken in response to a call, and they are encouraged through endorsements and validations. These are not incentives or inducements - we don't bribe infants into language - but neither are they reasons – we do not argue children into language. They constitute the social underpinning that will eventually allow reasons to be given. Other people play a constitutive role in the establishing and maintaining of language and other forms of communication. The exchange of expression and response is the basis from which we go on to open up a gap between ourselves, other people and the world. Only then can we take the objective stance, report on the way things are and give our reports as reasons for action.

This is the line of thought: if we are to understand anything about the world, about other people and ourselves, we must be settled into a publicly accessible world; and not just a public, but a social environment. We are introduced by others into the world, through forms of life, culture, language and values of society. And not just a social environment, but into a community of interacting people who initiate us into, and maintain us in, an intelligible world. We are domiciled in the world before we

acquire information about it. And this community is woven out of expressions and responses, not out of an exchange of information.

The Magical Option

In his book *The World of Silence*, Max Picard comes out with a striking fantasy thought: '*Of his own accord, man could never have been able to create language out of silence. Speech is so completely different from silence that man himself would never have been able to make the leap from silence to speech.*' He is imagining a situation in which we, without resources, absolutely speechless, face a world absolutely un-talked about. He dramatizes the idea that description, reporting the facts, collecting information, cannot be what we do at the interface with the world.

Virginia Woolf imagines the same confrontation in relation to pain:

'The merest schoolgirl, when she falls in love, has Shakespeare or Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry. There is nothing ready made for him. He is forced to coin words himself, and, taking his pain in one hand, and a lump of pure sound in the other (as perhaps the people of Babel did in the beginning), so to crush them together that a brand new word in the end drops out.'^{vi}

This is a wonderful description of what Wittgenstein thinks can't happen. It is magical thinking to hope that a word can be precipitated out of mentally squeezing together something, anything, a pain or for that matter a carburettor, and a noise, and thereby generate a meaningful word.

Well, if it can't be done that way, how is it done? The feeling might be that pain is so insistent that it forces itself upon our attention - a carburettor can lie there on the shelf minding its own business, but a pain makes itself felt. Yes, but how does that attention generate meaning? How does the pain get into the conversation?

Expression

In the first place we express our feelings, we do not describe them. This is not a remark about a linguistic distinction between description and expression, relying on features of vocabulary or syntax - for example, we use special words and we speak in the vocative case. It is a remark about how we relate to experience, our own and other people's, and how our ways of speaking wrap round those engagements. We speak *out of* our experiences before we speak *about* them. Through expression we manifest our fundamental alignment to other people and through them to the world. It is through the whole dynamics of expression that our minds are on show.

How can expression bear this weight? What is it about expression that allows it to carry the heft of intimate personal communication? Expressing something to somebody has a different dynamic from telling somebody about something. Idiomatically we use the word 'expression' to cover all sorts of utterances, including expressions of opinion or belief; but we need a distinctive notion of expression when we talk of 'expressions of feeling' or of 'self-expression'. Expression is unmediated: we don't first become aware of our experience and then, if we so choose, give expression to it. That is the point of Wittgenstein's rhetoric question: '*... how can I go*

so far as to try to use language to get between pain and its expression?^{vii} First expression; then information.

Expressions are *modulated*. They acquire their communicative content in part through being more or less intense or hesitant or manipulative. The dynamics of expression are inseparable from its content. Expressions have a *mood*: we express ourselves enthusiastically or reluctantly or shamefully.

Expression is a type of *action*. An expression is *directed towards* someone, even if there is no-one there. An expression is a *disclosure*: confessions, confidences, apologies and declarations of love or regret are expressions. They are ways of putting ourselves on the line, of putting ourselves about a bit. Expression is a way of making our presence felt. When we express and talk about our feelings, there is an *integrity* requirement. As the great singer, Tony Bennett, said, the first thing a singer has to do is to *turn up*.

Expressive entry

It is through expression that we turn up. The location of expression is *entre nous*. We address each other. People have thresholds and margins; they have to be approached. The way we approach someone in pain is an integral part of understanding what their pain is like.

Here is a parable to illustrate the point. Imagine you are a townie, totally out of your comfort zone in the country. On holiday you wander into a remote Northumbrian farmyard. You see a pile of stones. You may wonder how they came to be there but there is little to go on. Next day you walk in and see an enormous machine. You have no idea what it is for. But you can tell from its gears and levers that it is machine: it is for something. It has intentionality built into it. The following day the farm dog is there. A dog whisperer will know what the dog is up to. But, being a townie, you are nervous. You know there is more to a dog than meets the eye. But you don't know whether this one sees you as a threat, a soft-touch, or a new companion. On your final visit, the farmer is at the door, with his gun over his arm.

Stones, machine, animal, person - how we approach them reveals our commitment to what sort of thing they are. Our deportment is crucial; before we say a word the negotiation has begun. If you are looking for trouble, you might say, 'From the start the personal is political'. We turn to other people; we appeal for companionship. We reach for ways of keeping company. We see this at its most spontaneous in the way the infant reaches for its mother. Later in life this spontaneous turning towards each other and reaching for each other comes less easily and is shaped by, perhaps distorted by, the social and institutional structures within which we live. In pain and suffering it becomes difficult; at worst it becomes impossible. But whether it comes easily or with difficulty, at all phases of life, what we want is trust and confidence in each other; we neither need nor want certainty.

Inhibition

So expression is the way we communicate our inner lives, and we are very good at it. But being very good at it does not mean that it always comes easily. Some difficulties are dysfunctional, shyness for example. They get in the way of communication. But some difficulties are internal to the communication itself: inhibitions, restraint, discretion are part of the content. Some things can only be said with difficulty. Wittgenstein gives a nice example: *'In this way I should like to say the words "Oh let*

him come!" are charged with my desire, And words can be wrung from us, - like a cry. Words can be hard to say: such, for example, as are used to effect a renunciation, or to confess a weakness'.^{viii} We recently watched with some discomfort the evidence given by the Fire Officer, Mr Dowden, at the [Grenfell](#) Inquiry. What he had to say could not be retained within the bounds of normal protocols.

What we withhold and what inhibits us, as well as what we make explicit, allows us to understand and misunderstand each other. Unrestrained venting of feeling can be as uncommunicative as sullen withdrawal. Road rage is expressive, but not of the enraged person's feelings about the traffic incident, but of their hysteria.

Our attempts to control our expressions of pain are part of the expression of pain. They reveal the ways in which people take or try to take their experience. Even silences are sometimes deeply significant: the pauses between question and answer, reticence when chat seems natural, a generous action made without comment, dumb insolence.

The key of suffering

The difficulties we have in speaking about suffering does not just affect individual words or phrases, or particular utterances, they can affect the whole of language, putting it in a new key. Virginia Woolf describes in her essay, 'On Illness', how our relation to language takes on a strange quality when we are ill:

In illness words seem to possess a mystic quality. We grasp what is beyond their surface meaning, gather instinctively this, that, and the other—a sound, a colour, here a stress, there a pause—which the poet, knowing words to be meagre in comparison with ideas, has strewn about his page to evoke, when collected, a state of mind which neither words can express nor the reason explain.

Incomprehensibility has an enormous power over us in illness, more legitimately perhaps than the upright will allow. In health meaning has encroached upon sound. Our intelligence domineers over our senses. But in illness, with the police off duty, we creep beneath some obscure poem by Mallarmé or Donne, some phrase in Latin or Greek, and the words give out their scent and distil their flavour, and then, if at last we grasp the meaning, it is all the richer for having come to us sensually first, by way of the palate and the nostrils, like some queer odour.

Being Virginia, she takes examples from fine literature, Mallarmé and Donne, but what she is describing occurs in everyday experience – for example,, the sound of a mother's voice to a sick child. In illness we become aware of the buzz around words. Humphrey Bogart says in the *Barefoot Contessa*, 'There's more to talking than just words'. Particularly when we are ill, we become aware that we gather from the words more than the words. The dislocation of words and meaning leaves us in a half-life. Normal rules do not apply. We experience both a heightened sensuous awareness of the physical and an oceanic feeling adrift from ordinary life. The hectic pulsing of the fevered body merges with out-of-body experiences. At its extreme, illness engulfs us: our experience becomes incomprehensible, unsurveyable.

We should not assume that the way we talk and what we talk about always link up in the same sober way. Is there a comparison between the language of delirium and the language of dreams? Dreams are a sort of after-image of experience and the language of dreams is an after-image of language. When we recount our dreams we are aware of them slipping away as we speak. But this is not a failure of memory in the usual sense. The difficulty is not the difficulty of recalling the objects on the conveyor belt in *The Generation Game* - the matching luggage, the steak knives and the cuddly toy. When we awake from a vivid dream we start to narrate it, then we begin to lose confidence. We try to carry language across the divide between sleeping and waking. We give up in frustration or we cheat by forcing the well-ordered language of everyday onto the dream experience. We are unsure whether language fails because the dream slips away or the dream slips away because the language won't stay stable.

We cross and re-cross thresholds as we wake and fall asleep. Normally we move easily between these worlds. Transmigration seems to be a permanent feature of the human soul. But sometimes, particularly in childhood, nightmares mark the transitions from one state of consciousness to another. Something similar, but less dramatic, happens when we snap out of a daydream or when the lights go up at the cinema.

The language of suffering

Again something similar happens in relation to suffering and living with pain. The bereaved, the depressed are incorporated into the world in distinctive ways. Suffering can engulf us. If communication becomes difficult it is not a failure of vocabulary or an inability to find a powerful metaphor. Acquiring a language is to be taken up into a conversation, to acquire a form of life; not a means of managing a task already defined and understood. And there are many ways of living a human life and we go through many phases in the course of a lifetime. It does not seem possible to live a human life on one storey.

You could have found the moral of all this in a Christmas cracker: we should look after each other and language will look after itself.

Discussion

It's not just words – if you are suffering you are going to look like someone suffering; and yet there is this idea of empathy – of picking up their emotions. Communication is not just about words - it's all the other signals you pick up in the process of it.

You're right ... but I have always been a bit leery about empathy. There is one sense in which empathy is indispensable; health carers have got to have empathy, that goes without saying. However, when I first started thinking about this I looked at some books on psychiatry: one talks about empathy as a solution to the same problem ... a kind of bridge between you and me. I don't like that because I am trying to argue for a much more direct form of personal knowledge than that suggests. But we shouldn't depreciate the value of empathy and perhaps some academic conversation does that.

This business of asking someone to rate their pain on a scale of 1 -10: ... whose 1-10? Someone who has a very high pain threshold – their 3 is going to be someone else's 10. I've never got that. I agree with Mike: empathy is a quite subjective word tuning in to all the signals that come from a person: how do they look, what colour is their face, how are they sitting – all of those things that need to be studied so much more in terms of being able to work out what someone is actually dealing with and how bad their pain is.

Yes - this is very interesting. Again in quoting Wittgenstein ... I don't want to sound as if I were thinking of God but in his early work he does lay down the law as if he were God almighty ... one of the difficulties in reading his later work is all this exploratory and suggestive stuff. He's got a nice point about this: he says, "look, dammit all, I've got a pain, I know how bad it is;" he doesn't like saying I know I'm in pain, but now he is talking about ... "I'm the only one who knows how bad my pain is. You may know from reading the signs that I'm in pain but I'm the only one who knows how bad it is". That's like saying I'm the one who knows how tall I am, I'm this tall. I also I know where I am – I'm here These are totally unimportant things. But it's not just that – it's subjective – as you were saying your 1-10 may be quite different from mine. What do doctors use that one to ten thing to do? It seems to be as much way of handling pain as of reporting it. I have a friend who worked as a clinical psychologist; when the Metro first opened in Newcastle, a number of people were experiencing claustrophobic anxiety and he used to get them to use a rating scale. He said the point was that when he asked where were they on the scale they immediately began to feel less anxious. There could be things like that, although objectively, as it were from an epistemological point of view, as Wittgenstein says, whatever seems to you to be right will be right, and therefore there is no point in talking about it being right. Nonetheless that doesn't mean it has no purpose; that would be too strong a conclusion. There may be a good clinical purpose in asking people to rate their pain

The 1-10 is it supposed to be your scale - how bad is it compared to the worst pain you have ever had?

There are too many numbers, which patients find confusing. It came from the Visual Analogue Scale where you place your pain on a ten centimetre line, originally used in research. We use pictures of four faces from a smile to a grimace which patients have to identify with and they seem to understand this a lot better.

The 1-10 is an 'intellectual' measure. When you try to measure something you have to step away from it. The other side of dealing with pain is using metaphor: people are instantaneously able to come up with really elaborate figurative descriptions like boiling oil, stabbing - and you ask what colour it is. or what is the texture like, rough or smooth, hard or soft etc. And then you can say "I wonder what it would be like if it was shifting from red to another less painful colour ... People can do that. We don't tap into peoples' creative minds; we're fixed so much into intellectual measuring which as clinicians we have been trained to do, but there is this other universe. Betsan was talking yesterday about a lady who could turn down her pain on a dial.

You talked about being drawn into the social world of other people. I'm a paediatrician and we see lots of kids coming to our clinic with a diagnosis of autism, some low-functioning and some high functioning within the spectrum. Many young people with autism seem to have a different threshold for pain, which often seems to be higher. Do you think that is related to the ways in which they construct ideas of pain due to the way they interact socially with the world?

Oh gosh - you tell me!! I have a tiny bit of experience because I do RDA (Riding for the Disabled) and I find that there is a big spread in the way people relate. I think your suggestion is very plausible. These two points are related in a way. The sort of accounts of pain we have just been talking about don't look like a description of the pain. They look like relating the pain to a much broader context of their experience of their lives. Of course that can count as a description, but it's not that I have this inner goings on which I'm immediately aware of and know what it's like and I am going to tell you what it's like ... when I say it's orange or this instead of the other, I'm giving some sort of account of how it relates to my world or my imagined world.

I told this story at a previous meeting . When my then five year old my son Colin was stung on the lip by a wasp he screamed and screamed until my brother who is a doctor got his attention: he agreed with him that it really, really hurt, but he pointed to the mantelpiece clock and told him that every time the big hand pointed to a quarter of an hour it would hurt less ,and when it gets to the top it would stop hurting. He stopped crying and went out to play, coming in every few minutes to check where the minute hand had got to - and on the hour it had gone! The point of the story was that he had to look at the clock to check how bad his pain was. This seems to me to be a parallel to what you were saying.

Our acute pain team was called by ward staff to see a senior army officer who appeared to be in pain but was denying it. When I asked him how his pain was he replied abruptly "I have no pain!" So I asked: "if you were a civilian, what would your pain be?" ... "Eight!"

The first time we measure pain is not that important in itself, but I tell the patient that we will compare the first number you give me with what you say the next time I come. So if the first is 20 and the next 12 - OK! - we are on the right track. So there is some use in measuring pain.

We assume because it is a number it is precise, and we can do things with it. Perhaps dishonest is too strong a word but ... I remember when I started I was taught by somebody who should have spent at least another week at empathy school ... We used to use the Magill Pain Questionnaire which has 24 words and people have to circle the ones that apply to their pain. There was one patient who only circled two or three words the first time but when he came to do it again he marked 13, because he now understood what some of them meant: some of them were affective and had a crushing or the torturing quality to them instead of being purely descriptive. And I liked your division between expression and description. But I sometimes think we use our numbers and our questionnaires to 'sanitise', because we give our words to the patients instead of listening to their stories and hearing how they are affected. I often cannot change someone's pain, but hearing them express it may help them to cope better if they feel they are being supported ... held almost ... it's how much we want to engage ...

That's a very good example of detachment which I think is a real cultural clash in our society at the moment: the encroachment of scientific ways of thinking into areas where they are not doing good and may even be harmful. It's a big issue for philosophers. I won't argue - if I'm doing epistemology – for saying that their personal knowledge – our knowledge of ourselves and of each other – has got structural differences from objective knowledge of the world. We distort either side if we merge them. In the past the distortion tended to be that we anthropomorphised the natural world, but now there is another error which is to depersonalise the personal world – which is a real pain in the neck! – and has bad effects in how we behave. This applies to intellectual problems as well: a lot of the rows that

philosophers have about artificial intelligence and so on are just symptoms of this problem.

And the medication we use can impact that. Sometimes I think it's like putting a wet blanket over somebody. I remember when I was on an antidepressant the world just went grey. What was going on inside was less disruptive but it was also somehow less satisfying.

fMRI scans of pain show that the same areas light up whether the pain is physical or mental; they overlap in the limbic area. You can't subtract emotion from pain. It was said that Henry Cooper never felt pain; everyone has a different sensitivity to pain.

Being empathic with a patient can reduce their pain. You might not have a quick fix but just coming into the practice and talking about it to someone empathically listening is very powerful. There have been some studies on the relationship between the patient and the breast surgeon which has shown that if there is good connection and they get on in an interpersonal way the patient will have more benefit from the surgery and even live longer.

There were two things in the news this week; first about AI GP consultations but the other was about a study that showed if you have the same practitioner throughout your lifetime your outcomes were much better. That's common sense – there are things AI is never going to be able to do.

I think they are telling us that their life hurts?

... Their life is pain...

....It's not just emotional pain, it's loneliness, poor housing ...

... a cascade of misery

People who for example have had very abusive childhoods will often have greater pain. There was a study which showed that people who had been sexually abused had more unnecessary operations. I do think that the amount of emotional pain is very directly connected to the amount of physical pain, and it is almost impossible to divide between the two. .

But is there an amount of pain?

That's a good question. There was a fascinating comment about pain as a thing. Where it is, etc. – a wonderful concept in this context.

Have you read A Monster Calls by Patrick Ness? It's about a boy whose mother is dying of a terminal illness, and he manifests his emotional pain as a physical monster. It gets across the way in which people externalise emotional pain so they feel they have some control

Another aspect of the numbers is what the managers do with them. They love outcome measures: "Are you cost effective in terms of reduction of pain?" etc. – when we are only interested in making their lives better.

Can I make a comment about metaphor to be more sympathetic to it and against the emphasis that David Biro and others put on it: I think in a way the problem goes deeper. Metaphor has been looked on by various scholars as the main way in which

we expand the language. It's not just saying 'my pain is sharp' because it's like the point of a needle; that's not what we mean by a metaphor in that sense, but that we take a language which may be quite restrictive and compartmentalised, and we open the world out by using those words and expand our way of talking to embrace it. In that way language develops and broadens out. I'm struggling to say something sensible about life pain but it seems that language ... seeing everything as a symptom of suffering – that is language in a different key. It's not extending metaphors in the ordinary sense

We are seeing a 12-year-old child, and he and his mother both have sickle cell disease. We couldn't understand what was going on but it turns out that when his mother has a crisis, he gets pain. It seems that he can't distinguish between his mother's condition and his own. The psychologists have been having great difficulty with the situation. I gave him a TNS machine and that seems to have turned him round. But that interaction is fascinating.

You will be aware of the fMRI studies showing that the same areas light up in the partner of someone in pain ...

...and primitive tribes whose men noisily suffer labour pains while their wives quietly get on with it!

Can you comment in the context of this discussion; when we use terms like physical pain and emotional pain in the context of chronic pain, which is a product of our brain and consciousness (which is another problem) and define pain as a physical or potential threat, are we introducing a dualistic argument?

We could go down that route. The philosophical conditions that lie at the back of it are attempts to accommodate the fact that we have at least two – indeed many ways of talking about things that matter to us. Perhaps we already make a mistake if when we try to boil the ways of speaking down to just two, we set up a kind of metaphysical dualism. The problem which rears its head is the distinction between pain and suffering. If I am asked to define suffering I find it very difficult...

... you gave a very good paper on the subject here a few years ago! ...

... it's got to be something more structural. To make it simple I would like the home territory of pain to be episodic and localised and that sort of thing but of course that is going to expand. Suffering is more structural in human life; it veers towards mood, as it were, or disposition as opposed to episode and sensation ...

Is that a difference? Are you saying about people whose life hurts that they are suffering rather than being in pain? Things like arthritis create physical pain but people with it might not necessarily consider their life to be in pain; they don't necessarily show the pain and they may have found ways not to suffer

¹ David Biro, *Listening to Pain*, W. W. Norton & Company, 2010.

² Italo Calvino, *Six Memos for the Next Millennium*, Jonathan Cape, 1992, p.74-5.

³ Ludwig Wittgenstein, *Philosophical Investigations*, Basil Blackwell, Oxford, 1958, §258

⁴ Op. cit. §202.

⁵ Op. cit. §219

⁶ Virginia Woolf, 'On Illness', <http://www.gutenberg.net.au/ebooks15/1500221h.html#ch3>

⁷ Op. cit. §245.

⁸ Op. cit. §546.

Pain signals and Other Bad Language!

Time to start weighing up your words

Betsan Corkhill

Our topics this year, 'Burnout' and 'Skilful Use of Language' are important and current topics, that are also linked. I am going to talk about the language used in healthcare with a focus on pain. My aim is to encourage you to think deeply about the language you use, consider alternative options and to begin changing. I hope you will want to encourage others to think about language. I will also reflect on the ways in which language and burnout may be linked and challenge organisations that continue to use outdated or factually incorrect language.

We can become so used to the words we've always used and our medical language that we cease to consider their effect on others. Words can set a person down a path of fear and catastrophisation or start them on a journey to wellness and recovery. I am convinced that for outcomes to change the language we use needs to change. People living with pain rely on us to help them to understand their symptoms. As 'patients' within the patient/ clinician role, they are more vulnerable to the words we use. They get an expectation of what their future holds from these words. These expectations have a real impact on their health, wellbeing and outcomes. Language shapes ideas and changes the way we perceive our world. Those perceptions change the solutions that people choose and the outcomes achieved.

Creating Expectations

It's time to think deeply about how the words we use affect people's expectations, their biology and your own. I want you to think about this not just in your spoken language but in all your communications, from the letters you send to the messages left on answer phone machines. People often bring me hospital letters to 'translate' and it comes as no surprise that 50% of patients don't understand what their doctor has told them. Given the purpose of communication and language is to be understood, it's important we use plain English, everyday words that are factually correct. You can inadvertently distance yourself from those you treat by using complex language. It's not just words that create expectations but the way you present them. Many letters are poorly written, have spelling or other errors that, at best give a poor first impression and at worst create an expectation of incompetence. If your department sends out automated letters, take a look at the templates. What does the heading say? I once received an appointment for a blood test on headed paper that said HAEMATOLOGY ONCOLOGY DEPARTMENT. It scared me.

Think too about the letters you send to GPs where copies are sent to patients. Have you told your patient everything that's in it? Do they understand? I am frequently asked to explain words that people have no idea of the meaning. Last year, my husband had heart surgery to repair a mitral valve. There were a few post-op complications. The discharge letter to the GP said he was in heart failure, something the hospital had omitted to tell us. You can imagine our shock when we read this. Communications set the stage and create an expectation. They can improve confidence and promote a sense of safety... *or not*. The way we communicate has a direct impact on a person's health, wellbeing and outcomes. I believe it's time to start using language, and our presentation of it, not just to eliminate bad or factually incorrect language but to take it a step further. We need to

start using words to deliberately create positive expectations; to change perceptions; to purposely promote recovery and healing and to actively promote health, wellbeing and active recovery. Those who use hypnosis already know the benefit of this approach and the power of words.

Words in Pain

“What you hear goes straight into your imagination.”

Gillian Reynolds, Radio Critic

Two years ago I was offered the opportunity to run my own ‘pain management’ programme outside the NHS. I started by thinking about what kind of information I would like if I had ongoing pain. That led to taking a detailed look at the language I was routinely and automatically using. We’ll look at this later alongside suggestions for change. “Sticks and stones may break our bones but words will never hurt us.” ...? I think we all recognise now that words can cause significant harm and, if chosen with care, significant help. Words get into your subconscious, they permeate your thoughts, become your ideas, your story. They affect your perception, understanding, expectations and can become so routine and familiar that we stop thinking about their effect. Words can change the very nature of pain and our understanding of it.

The following words were said to patients or overheard by clinicians listening to colleagues.

“Now what is it that makes you feel the need to be unwell... my dear?”

- said to a lady with ME. Are those with ME/Chronic Fatigue/Fibromyalgia more likely to hear this type of language because we don’t understand their condition?

“I don’t know why you’re so worried. You already have a wheelchair.”

- said to a lady with ongoing pain who had broken her ankle and was concerned it wasn’t healing as it should.

“Dress for your disease... my dear.”

- said to a lady with Rheumatoid Arthritis.

“Basically, your father’s head is falling off.”

- said to the daughter of a man with severe dementia who was no longer able to hold his head up. (I’m happy to say, good physio remedied this.)

Then you have the more subtle such as:

“You have to stop gardening.”

Again I’m happy to say this lady is now back gardening and enjoying it.

“You’ll end up in a wheelchair.”

- said to a man with newly diagnosed Psoriatic Arthritis. Based on this comment, he resigned from work so he and his wife could enjoy what was left of his 'walking years'. There's a good chance that he may not end up in a wheelchair.

"Rest until it calms down."

I once met a lady who had been in bed for 40 years following a minor back injury at 18. She was still waiting for it to calm down.

"You no longer fit our criteria."

How soul destroying is this to get in a letter? Yet it's being used increasingly as services struggle.

Words have a greater effect when they come from 'the expert'. When the expert uses bad language it makes it even more difficult to convince people otherwise. Just recently I was having a conversation with a lady about the benefits of movement. Her reply was "Aaah, but that doesn't apply to me because my consultant told me I have two vertebrae out of line crushing my nerve." These words create powerful images in our minds. What kind of message did she take away from that? "If I move, it may damage my spinal cord." "I have to protect my spinal cord at all costs." When she gets pain in the future will she think her vertebrae have moved again? She is in a state of constant vigilance and stress. People change their lifestyles based on what we tell them. Words can, and do, change people's futures. I'll come back to specific language like this later.

Words of War

I'd like to focus now on the widespread use of warmongering language in society when talking about health issues. Imagine for a moment that you are a soldier going into battle against an enemy you can't see or hear. One that can creep up on you in the middle of the night, or suddenly jump out at you. It thrives on making you suffer. Worst of all, it is invisible to others and you cannot describe it with words. In fact your friends are so sick of you trying to explain, they've deserted. Others think they know what it feels like, but no one really does. You feel very alone. You set out to fight this enemy and are determined to beat it with an ever expanding arsenal of pain-killing weaponry but the harder you fight, the harder it fights back. Pain is the enemy you live with every day... every hour... every moment of your life. It disables you, stabs you, crushes and pinches your nerves, burns you, shoots down your legs, blinds you with headaches so severe they make you sick. Even those rare moments without your enemy you have to be vigilant, waiting for it to return. It has a nasty habit of flaring up and getting angry. It loves to visit in the middle of the night in your darkest hour when you feel most vulnerable and alone. In fact, it is so evil it makes a point of attacking you when you are at your weakest – stressed, ill, low, depressed, anxious – you have to be alert at all times. Hypervigilant. You start to predict, to anticipate when your enemy will strike and avoid those situations. This enemy is out to damage you, degenerate you, harm you, and has powerful friends it can call on to inflame your body and mind and fatigue your very being. When you have an enemy like this you can never relax, never sleep, never have fun. Your body becomes a battleground and you lose touch with the you that is you. Nothing and nowhere feels safe. You lose hope, feel defeated, but you soldier on, barely surviving, always searching for that magic bullet. Life is so exhausting when pain is your enemy.

Widespread use of warmongering language is ironic given our goal is to alleviate suffering, to save lives, treat injury, help people recover and heal. The use of

warmongering language prepares people to fight, run, freeze, flop. How does this encourage healing and recovery? How can turning your body into a war zone lead to increased wellbeing and improved health? War links pain to suffering, it generates fear, worry, anxiety, hopelessness, despair. The more threatening we perceive our world to be the more we look out for threat, the more likely we are to come to catastrophic conclusions. We see less of the good things. We become vigilant and sensitive to symptoms. War leads to chaos, destruction and uncertainty. A place where there is little safety, increased stress, tension and pain. You can't begin a journey towards recovery and healing like this. Having this viewpoint of disease might bias researchers by narrowing their focus, closing off alternative options.

Do pharmaceutical companies have a vested interest in promoting warmongering words where drugs – pain killers – are seen as weapons? Viewing drugs as weapons invites us to try one more drug, a new weapon, to fight until the bitter end, try every treatment: every weapon at our disposal. This can lead to over treatment and medicalisation. It encourages a scenario where the doctor becomes ‘the commanding officer’. An individual doesn't lose a battle with disease. *It's not about winning or losing.* That sets an expectation of recovery based on how hard you fight. It's not about using medicine as a battle against disease and death. If you die it doesn't mean you've failed or that you haven't fought hard enough. It becomes a battle that no one can win because we all die eventually.

This can have a detrimental effect on clinicians as well as the people we treat, and I think it contributes to clinician burnout because it can make everyone feel like failures. Always being ready to run or fight suppresses healing in both patients and clinicians.

You have to suppress emotions when you are constantly at war. You have to appear strong, to hide any weakness – an enemy will pounce on weakness. It can mean you miss out on the things that make life worthwhile, it leaves no room for fun, play, laughter, curiosity or healing in either the person with pain or those treating them. When we view a person's body as a battlefield it can prevent us caring for the person behind the label. It comes as no surprise that women with breast cancer who ‘ascribed negative meaning of illness with choices such as ‘enemy’, ‘loss’ or ‘punishment’ had significantly higher levels of depression and anxiety and poorer quality of life than women who indicated a more positive meaning’.

Words of war make good headlines. They can motivate angry people. Warmongering language is so ingrained that it's become natural to want to fight or battle disease. It's so ingrained it's become difficult to come up with alternatives. Moving from words of war to words of healing and recovery is difficult. Changing this language will mean changing the way society views disease: changing our views on healthcare so as to focus on health and recovery, and changing medicine and the approach of pharmaceutical companies. Healing words that focus on recovery can seem a bit ‘bland’ or ‘airy fairy’ in contrast. Yet they should carry more power than destruction. Words of healing and recovery should surely carry more power than fighting and killing. Our goal should be to enable the people we treat to use words that work for them within the context of recovery.

Another Perspective

The Welsh word for pain is poen, from the Latin poena meaning punishment, retribution or penalty, but we have a different word for pain following exercise. ‘Scrwb’ (scroob) is a word that carries no danger and is often said with a shrug of the shoulders, “It's just a bit of scrwb.” That shrug of the shoulders is really important. It attributes insignificance. Perhaps we need to find different English words for pain?

It's difficult to change the words people use so perhaps we need to find new ways of presenting our words to change their impact. Advertisers have understood the power of words within the context of presentation, the fonts and colours used, for a long time. I think we could learn valuable lessons from the way they influence expectations in order to purposely create different expectations to actively promote health, wellbeing and recovery. We have already moved from the language of war to one of care and healing in the field of HIV. A similar process is starting to happen with Type 2 Diabetes. It is being recognised as a curable condition if you focus on improving health. Those who are reversing their Type 2 Diabetes aren't battling or fighting their disease. They are not making a battleground of their bodies. They are doing the opposite. They are focusing on improving lifestyles, wellbeing and health. It's time to start asking: do we want to kill and destroy, or recover and heal? - and begin to create an environment of safety and compassion within which this can happen.

De-humanising Words

Another problem we have is the use of de-humanising language such as 'pain patients', "How's the back?", "I saw a difficult knee today", 'frequent flyers', 'bed blockers', 'bed 6', 'fibro patients', 'migraineurs'. People give themselves labels too. Many are unhelpful for aiding recovery and healing. Terms such as 'Fibro warriors' or 'Mesh injured patients' do little to promote health, wellbeing or hope.. The use of this type of language stops us seeing the person and encourages us to identify them by disease. Used alongside automated, impersonal letters that no human sees it can send a powerful message that we don't really care about the person behind the label. Human beings need to feel connected and cared for. Nurturing compassion in our language and communications is good for everyone.

The Language of Pain

The language we use, and the conversations we have with people can intensify and prolong their pain experience... or not. When I started looking at the language I was routinely using, my first conclusion was that if I had ongoing pain, I wouldn't want to just 'manage' it. I would want to learn how I could still live well. I called my course a 'Wellbeing for People in Pain' programme, but soon changed to 'Wellbeing for People with Pain' because if you are in pain it implies that pain is bigger than you – it's not. Pain is in you. I wanted to focus on an individual's capacity to create health, to improve wellbeing and to focus on their ability to change.

But pain is still there. It has to be because without pain we wouldn't survive. Recovery isn't about eliminating pain. I believe everyone can make changes whatever their starting position.

The big problem with pain is that words can't describe it. As a result, we resort to warmongering and mechanistic language (wires and gates) or isolate pain to a symptom or sign. But pain is about a lot more. Let's think now about the type of expectations we create with the language we use. The following are examples of two different pain programmes. The first is called a 'Pain Management Programme'. Within the introductory words the course leader says, "We're not here to fix your pain. We will be teaching you coping skills to manage your pain, learning about self-management." This overview covers 'learning to live with pain', and the importance of

'pacing'. The second programme is a 'Pain Education Programme'. The course leader uses slides and images as I do. Participants enter the room to a slide that says HOPE in large letters. In this introductory session the course leader says "I expect your pain to improve." "I expect your mobility to improve." It takes a lot of confidence to say this type of thing doesn't it? It takes confidence, energy and most importantly a healthy practitioner. I'm going to suggest this now: Pain is what we say it is within the context within which we experience pain. The language we, and our patients use, creates and can change context. I spoke earlier about what happens if we regard pain as the enemy. Pain evolved to protect us and it can change context significantly when we start slowly and steadily introducing 'protective' language, gently moving people away from pain as the enemy. I always find it helps to go back to evolution. I talk a lot about evolution on my programme. Pain evolved to stop us putting our hand in a hot fire or walking on a broken leg. With this as a foundation, you can introduce the idea of a system that becomes over sensitive like a car or fire alarm that goes off when it doesn't need to. In this case we wouldn't focus our efforts on putting out the fire. We would focus them on re-setting the system. Introducing ways of calming the system down takes the focus away from a linear, biomechanical viewpoint.

X-rays and Scans

The way we describe X-rays and scans can significantly influence the context within which people feel pain and what they do about it. It changes outcomes. Words such as 'wear and tear', 'bone on bone', 'damage', 'entrapment', 'degeneration', 'unstable', 'crumbling', 'twisted', 'crushed', 'slipped disc', 'soft', 'pinched nerve', 'vertebrae out of line', are still routinely and widely used. I'm sure you could add to this list. Why are we so surprised when people don't move?

What would happen if instead we said something like this – "I can see there are normal changes due to getting older, but these are nothing to worry about. Your joint may have become extra sensitive and feel painful but you won't do it any harm to move. In fact, moving will help to strengthen and lubricate your joints and muscles... and you're pretty good at healing – just think back to when you last cut your finger. There is a lot of repair going on too."

Painful Words

Let's take the term 'pudendal nerve entrapment'. It's enough to make anyone's pelvic floor spasm. What kind of image does this fill your mind with? A nerve that's trapped gets stretched in all ways when you move. David Butler and Lorimer Moseley say "Pinching a nerve is like trying to pick up a lychee with chopsticks." It's actually difficult, they're slippery, slidey, elastic. Yes they can become very sensitive to movement but rarely, truly crushed, entrapped or pinched. People who improve from sciatica often do so without any change in their MRI findings. Let's take a further look now at some of the words routinely used in the world of pain. 'Self-management' – The term implies limitation to me. Would we get further if we started talking about 'self-nurture' or 'self-nourishment'? – which suggest growth and healing. 'Goal setting' – you may be surprised to see this on my list of potentially problematic terms, but I'm talking about blinkered goal setting. You can become so focused on reaching the end goal that you miss out on life – all those little things that make life good and special. You can stop enjoying the process and that process is your life. I prefer to use flexible goal setting as a means of setting direction whilst also focusing on increasing enjoyment of life now. One lady on my programme said "I've realised I don't have to be miserable. I can have fun". It's about learning to go with the flow of life but having your direction mapped out; recognising that life events, unforeseen

circumstances and opportunities can change that direction. Focusing on flexibility because nothing in life is linear: pain, wellbeing, life itself, none of these are linear events. Within this less driven viewpoint you can better cultivate compassion for yourself and others. 'Pacing' – What does 'pacing' say to you? To me it says 'limiting' and I certainly wouldn't want to pace my life forever. It would be a depressing thought. What about using the term 'activity planning' instead? I've opted for 'baselining'. It's a term I got from project management in business and means finding your baseline of activity from where you can begin to improve. A baseline is a point of reference. It involves making a plan to set your direction (goals) while taking into account all your available resources. These can include financial, social, your support networks or knowledge, so enabling your plan to 'fit' your specific needs, into real life. That's what I love about it. You agree to stick to this baseline and keep at it, regularly checking the viability of your plan in the recognition that circumstances may, and do, change. Does it still fit in with real life? When circumstances change the baseline can be reset. That's OK. It's about finding a steady platform or foundation from where you can begin to live again. It changes the focus from one of symptoms limiting life to one of moving forward. 'Let pain be your guide' – when I trained as a physio we learned to say 'let pain be your guide'. We now know that if someone stops every time they feel pain we're training people to move less. We're training their brains to make more pain with less activity. We were unwittingly training them to be less mobile. 'Chronic pain' – It's good to see a move away from the term 'chronic pain' because it means different things to different people and can mean 'intense' to some. But have you thought about the replacements – 'long-term' or 'persistent'. What do these 'say' to you? If I had to choose I would use long-term because 'persistent' says, to me, going on and on and on and on without a break. I prefer to use the term 'ongoing pain' because it offers a small chink of hope, because there is hope. 'Exercise' – is another word that causes problems. Words can get caught up in pain maps and trigger pain. Exercise is one of these. You can see people visibly tense when they hear it. The word alone can trigger pain. I'm pleased to see the Chartered Society of Physiotherapy's recent campaign to stop using the word exercise and instead talk about increasing levels of 'activity'. 'Activity' is a much safer word isn't it? It has more chance of fitting into real life too.

Simplicity versus complexity – complexity can bring hope

Sometimes in an attempt to explain pain we can over simplify it. I'm a firm believer that those living with ongoing pain need to understand the complexity of pain. When they 'get' this they understand why one approach or pill can't 'fix' the issue. It helps to move them from a linear, biomechanical viewpoint to an understanding that pain is made, or not, as the result of everything going on within you, around you, your culture and past experience. Everything goes into the mix of this conversation including what Lorimer Moseley calls, "All the things you know but that you don't know that you know". Even words can bias this conversation towards making pain... or not. We can make the complexity work for us. The fact that everything goes into the mix of this conversation gives us many avenues in to change the conversation. The complexity gives hope. There is always something you *can* do to improve the situation. Something you can make changes in. Understanding this complexity means you begin to understand that pain isn't an accurate measure of what's going on in the body.

This takes me to the issue of 'pain signals'.

“Anyone who talks about pain signals is talking neurobollocks.”

Mick Thacker

These nerves aren't carrying pain in some sort of package of pain. As far back as 1986 Patrick Wall and Steve McMahon said,

“The labelling of nociceptors as pain fibres was not an admirable simplification but an unfortunate trivialisation”

That was 32 years ago! Talking of pain as a signal reduces it to simple mechanics. Understanding that nociception or alarm signals are NOT pain is at the core of understanding pain. Understanding that pain, the feeling, the experience and the injury or condition are separate issues is at the very core of understanding pain. Pain is a conscious experience. Nociception is an unconscious process. They are different. Nociception is happening all the time and is only part of the complex conversation. It is still present in people under general anaesthetic whereas pain is not. If you don't feel pain, it doesn't exist whereas nociception does. It's hugely powerful to realise that when you're not feeling pain it doesn't exist. If nociception resulted in pain every time, we would all be in pain every moment of every day. So it is really important not to use the term pain signals and vital that the people we treat get consistent, factually correct information.

Brain scans and X-rays don't show pain. A scan can't show a feeling, an experience. In fact they probably don't mean much at all unless you know that person's social background, past history, current state of mind, culture, home environment, level of knowledge. They might mean a bit more than that. So there are no pain signals, pain pathways or pain fibres. When you look at this conversation, it also becomes clear there is no pain centre either. The issues that contribute to this conversation will be different for everyone, so you begin to get an understanding of how each person's pain is unique. You can also talk about those downward signals. These are of increasing interest in current research. The fact that our thoughts, beliefs, experiences, environment and state of mind can change these downward signals to modulate those alarm signals is hugely powerful. It gives hope. Instead of using words of war we can talk about making changes to this conversation and to bias it towards not making pain. Focusing on wellbeing enables people to look forward.

Life's a Journey

We can talk about going on a journey of change. I'm aware that some people don't like the metaphor of 'going on a journey' but it works in so many ways. It focuses on where you are going. You can talk about potholes, pits, signposts, and occasional road blocks along the way. Sometimes there is a need to take a different direction. Your goals set your direction but you can choose to take an alternative, more scenic route if you wish. As Winnie-the Pooh says "Life's a journey to be experienced, not a problem to be solved". There are no winners, losers or failures on a journey. Some will carry heavier burdens while others get fatigued more easily but that's all OK. The clinician moves from being the commanding officer to a trusted guide exploring different avenues and directions. Importantly it provides an opportunity for the traveller to travel unaided only calling on guidance when the road gets rough. In war you are dependent on a good commander whereas a traveller can undertake a journey by themselves with perhaps the occasional input from a guide. They're not

dependent on the clinical guide and, as they learn from experiences along the way, there is potential to become less so. And that's what we want to achieve isn't it?

Pictures and Quotes

Don't be afraid to use powerful images in your programmes. They can say a lot more than words. I use an image of a person standing on a tall post situated on top of the tallest building in Hong Kong to illustrate how our thoughts influence our biology, our physiology. We visualise balancing there, feeling the wind buffeting us because we are so high up. We feel our bodies sway slightly as we watch the tiny cars below moving along the crowded streets. We feel our heart rate and anxiety levels rising as we visualise this scenario. Then we focus on an idyllic beach with its blue sky and gently lapping waves and we feel an instant change in the way our bodies respond. In these scenarios our bodies are responding to our thoughts about these images – and they're just images. The experience is far more powerful than any words. I also use popular quotes – they're easy to read. People like and remember them.

“When a flower doesn't bloom, fix the environment in which it grows, not the flower.”

Alexander den Heijer

“You won't have any ladybirds in your garden if you don't have aphids.”

Gardener's Question Time

“Supposing a tree fell down, Pooh, when we are underneath it” said Piglet. “Supposing it didn't” said Pooh after careful thought. Piglet was comforted. “It's more fun to talk with someone who doesn't use long difficult words, but rather, short easy words.”

Winnie-the-Pooh

It's quite fitting that such safe, wise little characters were created at a time when AA Milne was suffering from PTSD and the trauma of World War I.

Burnout and Words

Focusing on improving wellbeing has a lot of benefits for the patient but also you, the clinician. It opens lots of avenues through which you can help the people you treat. Changing our language changes the context within which a person experiences pain and the context of our consultations. Helping those you treat to understand the complexity of pain and its emergent nature means there is always something they can do to improve and always something you can do to guide them. The use of warmongering language means you are fighting a battle you can never win. It can lead to mental defeat in you and those you treat. Add this lack of achievement to the pressures the system poses on you and you could well be accelerating your path to burnout. Moving from “I can't make a difference” to “I can make a difference” is good for your health too. Think too about how you talk to yourself. Do you talk to yourself as you would talk to a friend you care for? Do you nurture you? It matters because everything goes into the mix of life, health and wellbeing. You are listening to your own self-chat. It's time to start cultivating compassion and self-nurturing for everyone, including ourselves.

Just think if speaking kindly to plants helps them grow, imagine what speaking kindly to humans can do? And if you think you can't make a difference you absolutely can. As the Dalai Lama once said, "If you think you're too small to make an impact, try sleeping on a mosquito."

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Discussion

One of the slides you showed – I think it was the one about 'fibro-warriors' - had words on it doctors use about patients, and I fear that many of us are guilty sometimes of talking about patients in a way we would never actually talk to them with the sort of assumption that it doesn't matter. But I wonder how true that is? – does the way we talk about patients influence the way we behave towards them when we actually see them?

I would think it does. People get identified by labels like these

That was a brilliant talk but I am constantly irritated by the implication that it's all one way: that patients are the passive victims and doctors and nurses are the perpetrators of evil. You mentioned the Facebook pages ... my husband did work on chronic fatigue and he gets hate mail and called names like Mengele and is constantly harassed. Patients aren't passive victims. My son is a social worker who has just started work in Southwark in child protection. He came home the other day and said "I saved a child from going into care today". "That's brilliant" I replied ; "what did the parents say?" "They told me to fuck off!" That sort of resonated with me in the consulting room because although what you said makes absolute sense, when I say to a patient – "look, this is going to get better ... this doesn't need treatment" they say things like "you're the doctor – why are you saying that?" There is the sense that health literacy in this country is so bad that you can't ... but I don't think patients should be let off the hook as regards their language, which is sometimes quite appalling.

Patients come to a clinic with a language they have picked up from a culture ... a society... [inaudible]

[Unfortunately the recorder was inadvertently not switched on for the remainder of the lively discussion]

Burnout: the problem

A discussion led by Michael Platt

Our subject is burnout in the caring professions but the impression is growing that it is much more widespread. The problem affects other professions: 'The clergy are falling apart' (headline in the Telegraph). In 2000 the Church Times reported that the number of clergy retiring early due to stress and ill health has doubled in the last ten years. The lawyers are another profession in trouble. A large percentage would not choose the profession if they could start again. Drop-out rates have risen and more than 30% qualify for mental health intervention, with nearly quadruple the incidence of depression of the average occupation although they have never wielded more economic and political power than they do today, and are the wealthiest profession in the world. Teachers are dropping out much faster than they can be replaced. Schools are facing cuts and rising costs and see no way of improving matters for their staff. Many of those dropping out blame increasing bureaucracy designed to measure pupil progress. Teachers report lack of support and overwork: a typical remark was "I work 60 hours a week and still don't feel I am doing a good enough job. I am too tired to have any life outside work". All the teachers at one primary school in Bristol not on sick leave quit at the end of the school year in 2017. Can we in medicine do that? Accountants are not immune: one survey revealed that 74% acknowledge that poor wellbeing is having a negative effect on their concentration. I have quoted evidence from the professions but there is no reason to believe that burnout does not afflict the whole of society.

Doctors, in common with the other professions, are not valued. We feel we are just cogs in a big machine. Poor wellbeing and moderate to high levels of burnout are associated, in the majorities of studies reviewed, with poor patient safety outcomes such as medical errors. However the lack of prospective studies reduces the ability to determine causality.

Countless health care professionals suffer from anxiety, depression and addiction. Estimates from Public Health England put the cost of staff absence due to poor health as £2.4 bn. a year excluding the cost of agency staff to cover the gaps and the cost of treatment. Clare Gerada explains that "as a doctor or a nurse you are trained to put patients first and to put their needs above your own". I think it's more than training – it's part of vocation as well. I teach nurses and I still think their attitude is vocational even today, because I don't think they would stick out what they are being asked to do otherwise.

In one study, of respondents who were classified as burnt out and made redundant, 72% admitted to stress. 85% said their job intruded on their personal life. 67% considered switching careers. 42% had lost sleep due to overwork. Factors contributing to burnout include workload, lack of sleep, poor work/life balance, lack of coaching or feedback or recognition and loss of meaning.

About 15 years ago there was a Japanese scholar who studied the reasons why certain industries did better than others. His prediction was that those which valued their workers and looked after them properly would do far better than those that didn't. Does the NHS value your labour? How many of you ever see your CEO?

The ICD-10 ((the WHO international Classification of Diseases) definition of burnout states that it is “a state of ‘vital’ - emotional, mental and physical – exhaustion caused by prolonged stress.” Burnout occurs when you feel overwhelmed, emotionally drained, and unable to meet constant demands. As the stress continues, you begin to lose the interest and motivation that led you to take on a certain role in the first place. Burnout reduces productivity and saps your energy, leaving you feeling increasingly helpless, hopeless, cynical, and resentful. Eventually, you may feel like you have nothing more to give. The negative effects of burnout spill over into every area of life—including your home, work, and social life. Burnout can also cause long-term changes to your body that make you vulnerable to illnesses like colds and flu. Because of its many consequences, it is imperative that we start to deal with burnout as an urgent priority. Our occupational health department told me a few months ago that they had never seen so many doctors off work with burnout. Some never return to their training post.

Discussion: Why is no-one doing anything about it?

I think there is a fear particularly among older professionals that if you complain you might finish up with no job – how will I support my family? There are very young people coming into the professions who are saying ‘enough’ and are refusing to do more than they should.

Last year there were a huge number of medical graduates that didn’t even go into their houseman year. They went into Big Pharma who hoovered them up.

Bullying is another problem - from management and all the way down. ...

...it becomes cultural ...

Managers apply sticking plasters, like downgrading jobs. The survivors are expected to do more and more; some of them are very capable of doing that but many are overstretched. They are not supervised because the people that should be supervising them are not there or are themselves overstretched. When I was the medical representative on the trust governing body and a major finance cut was announced just before Christmas I said what I thought the consequences would be. Before the New Year I was visited by the Finance Director, the Chair and the Chief Executive together to ‘appraise me of the situation’!

People being bullied have no-one to go to for support.

Back in the 80’s we supported each other ... we met in the pub. In the 90’s when I became a senior lecturer I was conscious of the formation of deaneries; we began to lose control of our education and our self-regulation.

It is very similar in the universities. The atmosphere changed - a little later than in medicine – when under the rubric of the QAA ([The Quality Assurance Agency for Higher Education](#)) you were ruled in. The difference was that although we were used to being almost permanently assessed by senior academics we were now being assessed by managers, and people were terrified. I remember asking why we were so chicken about this when we had to prepare a whole new way of presenting ourselves; mainly paper based and a terrible waste of time.

This sort of thing hasn’t increased productivity – indeed it is worse.

What is depressing is that when doctors go over on to the dark side they turn on you

Why doesn't the profession stand up for itself?

It's a bit like putting a frog in a pan of hot water, when it will jump out, but if you put it in cold water and heat it slowly it will stay there until it dies. Things are happening in incremental ways so people don't react.

When rats were stressed in a laboratory by putting too many of them into a small environment they ate each other. At the moment we are being cut in half ... but who is going to get through that door to sit in one of the few chairs on the other side.

Signs of Burnout

This features regularly in the literature:

Maslach Burnout Inventory

- Emotional exhaustion (EE) – feelings of being emotionally overextended by one's work; no longer able to give of themselves at a psychological level
- Depersonalization (DP) – unfeeling and impersonal response toward recipients of one's service, care, treatment, or instruction; negative, cynical attitudes and feelings about one's clients; dehumanizing perception of others that can result in viewing clients as somehow deserving of their troubles
- Personal accomplishment (PA) – feelings of competence and successful achievement in one's work with people

3

The signs of burnout include the feeling that every day is a bad day, caring about your work or home life seems like a total waste of energy, and you're exhausted all the time. The majority of your day is spent on tasks you find either mind-numbingly dull or overwhelming and you feel like nothing you do makes a difference or is appreciated. Physical signs and symptoms include feeling tired and drained most of the time, lowered immunity, getting sick a lot, frequent headaches or muscle pain and change in appetite or sleep habits. Emotional signs and symptoms include a sense of failure and self-doubt, helplessness, feeling trapped, defeated, detached and alone in the world. These are accompanied by loss of motivation, an increasingly cynical and negative outlook, and decreased satisfaction and sense of accomplishment. Burnout may also manifest itself as withdrawing from responsibilities, isolating yourself from others, procrastinating, taking longer to get things done, using food, drugs or alcohol to cope, taking out your frustrations on others as well as skipping work or coming in late and leaving early.

The differences between stress and burnout are summarised in the table below:

Stress	Burnout
Characterized by overengagement	Characterized by disengagement
Emotions are overreactive	Emotions are blunted
Produces urgency and hyperactivity	Produces helplessness and hopelessness
Loss of energy	Loss of motivation, ideals, and hope
Leads to anxiety disorders	Leads to detachment and depression
Primary damage is physical	Primary damage is emotional
May kill you prematurely	May make life seem not worth living

Further discussion

Do you make a distinction between good and bad stress? I think I perform rather better under a certain amount of stress ...

If it keeps mounting there comes a point where you can't cope

Health and safety are trying to change the term stress. Employers are using as an excuse that you need a certain amount of stress to perform at your optimum so what they are trying to do is change the wording to pressure - we all need a certain amount of pressure to perform at our optimum ...

That may be true in management terms when it's about clearing your waiting room but you need to spend time with patients ...

Loss of control – when you can't see your way out – that's bad stress

Positive stress is involved in situations that are opportunities to which you adapt positively with a good outcome. Negative stress is associated lack of control... the breakdown ... think of it like training: the purpose of stressing yourself in a training exercise is that you become fitter and fitter but if you overdo it you go over the cliff – that's quite a good analogy.

It's difficult to make a distinction between burnout and depression...

...depression is often a feature but burnout is more than that ...

...depression can have many causes but this is depression from a particular source of precipitating factors ...

If you recognize that you are becoming overstressed ... that's where how you have learnt to deal with stuff in your life comes in. If you have, for some other reason not to do with your work, had this driver that makes you carry on in spite of everything, that is when you are going to get to burnout

People can function with burnout for long periods but they are emotionally blunted – they're not stuck in their beds, they come in, do their job and go home, but they're running on empty without the emotional intelligence they need to do their job...

... 'presenteeism' (as opposed to absenteeism) ...

It's important to remember that these distinctions are quite fuzzy; everybody has different: different ways of coping, different attitudes, even different mental illnesses.

People come to us (GPs) for whom burnout has been a long time coming and say "I don't know what's wrong with me but I need some time off work; could you give me a certificate for a week and then I'll be better". You know immediately that they aren't going to be back for some time; they are often professionals. I usually say I'll give you a week and then come back and we'll have a chat about it. After a couple of weeks they begin to realise how stressed (and depressed and anxious) they are; one feature seems to be that they gradually improve but relapse is triggered by any thought about or any contact with work.

Which is probably why 70% people in that situation change their jobs or their careers.

I say to patients: "of course you feel like this - you've been in a toxic workplace" – so instead of feeling they are useless, hopeless and a failure they realise that they were just in the wrong environment.

There was an article in the Guardian about two people who suffered burnout: one was a pharmacist who loved he job but got burn out; she recognised this and took time off and now does something completely different, but had to go through a bereavement period after abandoning her career. The other was a very high-achieving businessman. He is still getting over the bereavement after ten years.

I had to leave Intensive Care due to burnout and I still miss it – it's like recovering from an addiction ... it's where I feel I belong ... I understand that feeling of bereavement ... going through the five stages of grief ...

... shame ... and loss of status...

It's also an issue with retirement

Work-related causes of burnout include feeling like you have little or no control over your work, lack of recognition or reward for good work, unclear or overly demanding job expectations, doing work that's monotonous or unchallenging and working in a chaotic or high-pressure environment. You can see all of those in the NHS.

Lack of recognition ... used as a tactic can have the opposite effect

That's a major one for teachers who get nothing but criticism and outright opposition from parents.

Doctors are no longer trusted ... many more complaints ...

We no longer meet managers socially. I chair the medical staff committee but no-one attends meetings – there's no interest. Consultants come in, do their jobs and keep their heads down and go home... there's no socialising, no community spirit ...

... no formal peer review group ..

There are similar problems with General Practice support groups. So many GP's all are basically burnt out and fully functioning GP's so few that becomes self-perpetuating. How can we change the environment to make it better for them? ...

A recent development is that young consultants won't go for permanent jobs; they prefer to travel around taking locums

We have struggled to fill permanent posts; recently when we did the individual had to take a chunk of maternity leave and is now negotiating to come back part time. We are not sure we want to go along with it but we are required to consider the request and if there is no reason why we can't agree with it we have to offer them a contract adapted to their needs. Then other people, including locums considering permanent jobs, will think if it works for her it can work for me. Unless you make that first step to provide tangible and visible proof that things can change then nothing changes.

It's the same in Brighton in General Practice: nobody wants to be a partner.

...emails ... sparks a fire ... may be misread because there is no nuance to it ...

... can be forwarded and finish up on front page of newspaper ...

The Emotional Resilience Toolkit provides practical guidance in promoting the resilience of young people as part of an integrated health and wellbeing programme and is available online. There is a study where they invited all these big companies like Astra Zeneca and asked them what they would do if you were to introduce a wellbeing programme. Some of them produced free fruit and encouraged walks at lunchtime but most were a bit resistant. But the ones who did found that across the board all the measurements of job satisfaction improved and profits went up. But the important thing was the perception that the big guys at the top recognised that you were there. It doesn't take much ...

... companies like Google that give their employees a day without targets etc to work as they want, encourage creativity.

... you feel so much like a child when you have gone through medical school and through the ranks and have colleagues telling you how helpful you are, then some idiot from above tries to push you about and say you can't do this or that; your colleagues try to support you loyally but feebly but they can't stop you from being treated like a naughty schoolgirl ...

This is why the trade union movement started, to resist dominance by people who want to control you.

We in the Royal College of Nursing have been trying to engage our members to vote and participate ... when you challenge politicians as a union they ask how many of your membership have voted for this. It's pitiful when less than 20% of the membership will engage by pressing a button on a survey monkey type voting thing. It's been a real eye-opener ...

I was amazed in the Junior doctors' strike in 2016 how much support they got from nurses and doctors with consultants working double to cover for juniors.

Lifestyle and Burnout

Lifestyle causes of burnout include working too much without enough time for socializing or relaxing, lack of close, supportive relationships, taking on too many responsibilities, without enough help from others and not getting enough sleep.

This is very individual but a lot of it stems from systemic problems that make an individual behave in this way.

If you are burning out and you try to get out of the situation by changing your job or your hours or getting out of medicine altogether there is a subtle pressure from people around you: colleagues, parents and others. When I initially cut down to part time work and relinquished my partnership my parents who are quite old and proud that I am a doctor – they come from a working class background - found it very hard that I was giving up. I kind of knew that because they didn't tell other people about it for about a year. I found it very difficult; they are nice people and generally very supportive. It's still slightly problematic; I didn't do general practice for a couple of years; I've gone back to it and although they are proud of the comic side of it they still, now I'm doing two days as a GP and the rest on comics, say "have you been at work today?" -when I've just done 12 hours!

My previous (romantic) partner was also a GP in North Wales and burnt herself out and now works as a gardener with the National Trust. A lot of former colleagues were quite judgemental.

Two thirds of trainees are now women and Clare [Gerada] mentioned that suicide rates among young women are higher. A lot of these things come into play; there is an expectation that they will have children; girls are brought up nowadays to believe that they can do anything a man can do – and then they find that it's not that easy because your body clock is working against you: you want to have children before you are 40. It's true for nurses and others as well as doctors who have ambitions as well as wanting to raise a family. But you can't change the fact that if we do have children we are never going to be able to work full time. That is a big problem for employers. It makes it very difficult for a practice to allow patients to see the same doctor over time.

As we have said, everybody is different and personality traits can contribute to burnout. People with perfectionist tendencies for whom nothing is ever good enough are particularly vulnerable, as are those with a pessimistic view of themselves and the world. The need to be in control and reluctant to delegate to others is a frequently seen predisposing factor. Burnout is particularly like to afflict people with high-achieving, type A personalities.

I have a colleague who is a brilliant scientist but also does clinical pain work and is totally 'in his head'. It's very difficult to communicate with him: he thinks he is telling you everything but it's all inside his head.

Dealing with Burnout: the '3-R' approach

- Recognize: watch for the warning signs of burnout
- Reverse: undo the damage by seeking support and managing stress
- Resilience: build your resilience to stress by taking care of your physical and emotional health

There is usually good support to be had from occupational health, but I'm worried about 'building' resilience. You tell people to be more resilient but what does it mean? Taking care of yourself includes removing yourself from the stressful situation.

Isn't it true that your basic resilience is built into the first three years of your life? If you put babies into child care facilities that aren't properly manned the child is on high alert. Cortisol levels go up and stay up; you upset the child's biochemistry and there are alarm bells going off continually - in other words you are Hypervigilant. So if you have that sort of background you can only be resilient up to a point and you are much more vulnerable.

There are things you cannot change

Of the different versions of advice on dealing with burnout only two mention resilience so it is very controversial.

Is it a new concept? In [? ...] a book about highly successful people, one of the chapters uses the metaphor of taking time to sharpen a saw – otherwise it will go blunt.

People who are perceived to be weaker than their colleagues are told to increase their resilience, and they may take that very negatively.

A few years ago people who weren't coping were told to take a time management course.

The bottom line is that if you are getting stressed out to recognise this within yourself and then manage it. I see a lot of people who don't

Doctors should have supervision. They should be fighting for that . Going back to learning hypervigilance when you are small: looking at that sort of thing and how we are made can give us more ability to work out how we can manage it. Once you start to recognise the way that you are it can make a huge difference to the way you handle whatever is going on.

Self awareness can be difficult. I didn't think I was particularly stressed – I knew I was busy, but it wasn't until I found the car keys in the fridge ...

GPs have a shelf life. We all know that even if they start out enthusiastic within about ten years they are burning out, by which time their kids are at private school, they are married to a certain level of income and they are terrified of cutting this and losing their social standing so they carry on for another 20 or 25 years. The model of doing the same job you started with until you retire or die is a hangover from the industrial revolution.

I think that is going away now. The younger doctors I see don't want to do that. They are going to move around more. Everyone has a shelf life which varies. Not everyone will want to stick around until they are 65 or 70.

... the same applies to nurses ... can retire in their mid 50's

My colleagues who have retired are so happy!

Why is there so much burnout?

Burnout is a symptom of an ailing organization, rather than a sick individual. Blame is indicative of the problem in the first place. There can be an atmosphere and a system which is supportive of collaboration, sharing out the stress of the team and creating a sense of shared purpose and healthy interaction, or there can be one that leads to blame and people reaching a point where they can't carry on.

What happens in a hospital when so many people are off or retiring early? How does a service carry on? There seems to be a point when it can't do what it is supposed to.

I have become an expert in rota gaps. We don't know how many there are in our trust at any one time. The remaining people have to cover so work intensity goes up. We are on the edge of a cliff.

I am coming across more people who are doing home schooling - the schools are in a mess ...

...teachers are inundated with paperwork and form-filling ...

Burnout is a condition of our times. Society itself seems to be burning out with austerity and rising poverty compounded by the uncertainty caused by Brexit. We see cuts to services, social care and the voluntary sector, affecting projects around domestic violence, for parents and for older people. All these things make it harder for people to cope.

... "twentieth century syndrome ... people can't cope with advances in technology ...

... people were complaining about this in Victorian times! ...

... is this a condition of our time and associated with a huge pace of change – or has it been happening throughout history?

We have a government that don't seem to care about the poor and disposed and an opposition that don't seem to understand what is going on.

The leader of the opposition gives some inspirational talks; he has a lot to say and to offer but he is never covered by the media unless he utters one phrase that can be made to sound stupid

We have been talking most of the time about the individual causes of burnout but we haven't done much on organisational and social factors. We are faced with this vicious spiral – a vortex of different elements, for instance people taking early retirement aggravating the shortage of numbers of doctors to do the job. So are there any reasons at all for optimism? We have talked about blame and it's very easy to blame 'them' – the government, managers etc. ...

... The problem is that people simply don't know how to get out of this - so what do you do?

That's what I'm asking!

I really don't have an answer to cover everything but factors that protect a workplace from burnout include a sense of purpose and of belonging, and a management style

that finds a balance between clarity and presence, but also offer people autonomy to allow them to get on with what they need to get on with. A boss should say: “we recognise you’re having a tough time; what can we do to help you?”

There is an interesting video on YouTube by Daniel Pink on RSA (Royal Society of Arts) Animate - Drive. It demonstrates that traditional motivators: carrots and sticks – have been shown not to work and may even be counterproductive as rewards often destroy creative drive. Three things: autonomy – letting people do what they want, mastery, where you can practice your profession and get better and better at it, and the perception of meaning and purpose in your work, have been shown to be effective in improving performance (and company profits)

Why has medicine become such a miserable profession?

The impact of personal, professional and institutional stigmata on doctors in need of treatment.

Clare Gerada

Today is the 70th birthday of the NHS! And including helping in my father's practice on Saturdays I have been working in it for some 40 years.

Although I am focussing on doctors and their mental illness, the ideas are relevant to any group (for example, teachers, the clergy and psychotherapists) which has a strong personal and professional identity, with all its attendant privileges and problems.

Introduction

It seems that everywhere we look across the world doctors are demoralised, depressed and dejected. Rates of burn out, depression and anxiety are all increasing. Doctors have suicide rates up to 4 times that in the general population. The rates of suicide are particularly high for women, and increasingly so. Proxy measures of distress such as sickness absence, early retirement, bullying and complaints all point to a profession in distress, and it appears to be getting worse.

This isn't just a problem in the NHS. It is a world-wide phenomenon. Wherever you look, whether they are in a publicly or privately funded health system, whatever their age, gender or speciality, whatever level of training, you will find distressed doctors.

Some specialities have reported rates of burnout between 50% and 70%.

Me and PHP

I have been at the forefront of trying to address the pain in our profession. For a decade I have been a doctor's doctor running a confidential, self-referral service for doctors with mental illness and addiction, called the Practitioner Health Programme.

The catalyst for setting up the service up was the tragic death through suicide of a young talented psychiatrist, Daksha Emson. She also killed her 3-month-old baby. Daksha suffered from bipolar affective disorder and was well known to treatment services. When she wanted to get pregnant, with permission of her doctors, she stopped all of her medication. Three months after the birth of her daughter, she developed a relapse.

In her diary at the time she wrote of her shame at not being a good enough mother and of her concerns that others might find out how seriously ill she was. The subsequent inquiry into her and her daughter's deaths highlighted the way in which the system treats doctors with mental illness differently. How, for example, she relied on corridor conversations – snippets of care of outside the normal consulting room. The report was the only one I have read which instead of apportioning individual blame blamed the system and the way doctors with mental illness are treated differently. Her doctors did not want to share information with other health professionals through fears of breaching confidentiality, so the health visitor didn't talk to the GP and the GP didn't talk to the consultants. She was treated differently just because she was a doctor; for example she was told by the health visitor that as

she was a psychiatrist she should be able to care for herself. In sum, the enquiry revealed how stigmata - personal, professional and institutional - created the toxic mix which contributed to her and her baby's deaths.

It took a further 10 years before the money was found to set up PHP. Initially it was only for doctors and dentists living in London but since Jan 2017 it has been expanded across the whole of England and includes GPs from ST1 to 1-year post retirement. Now there are around 85,000 doctors who can access this confidential service, and around 1000 per year do so. We are just celebrating (if that is the word) our 10th anniversary.

GPs make up around half of all our referrals but we have seen every speciality. Psychiatrists and paediatricians are overrepresented; surgeons are underrepresented – they don't get depressed, they get divorced instead, and have in fact have the highest divorce rate of the medical profession. It seems that their pain is being projected into their marriages. Anaesthetists, while having low rates of mental illness, nevertheless have high rates of death through accidental or deliberate overdose. Sadly, they know now to obtain and use dangerous opiates.

Of our 5000 patients around 80% have mental health problems, mainly depression, anxiety, and symptoms indistinguishable from PTSD, and between 10 and 20% have problems with addiction, mainly to alcohol, though we also have doctors who have used drugs ranging from over the counter medication to cocaine, amphetamines, and even street heroin. (You can get anything on the Dark Web using Bitcoin)

We have over 100 doctors with bipolar disorder and a small number with undiagnosed paranoid schizophrenia.

We have even created a new diagnosis we call 'NHS-it is'. Over the decade we have seen an exponential rise in the numbers presenting for care, with a massive spike in 2016, possibly linked to the distress caused by the junior doctor industrial action. I had thought that it might be less, thanks to the camaraderie and sense of belonging, but it seemed to be the opposite, I think because of the cognitive dissonance involved in withdrawing your labour when your every instinct drives you to want to work.

The average age of doctors coming to us has dropped from 50 to 38 years old. The proportion of female doctors has increased. The proportion with addiction has dropped, but overwhelmingly the number of doctors presenting for care has increased year on year. And wherever you look all over the world you see the same pattern emerging. I think this is a real increase and not a reporting artefact.

Causes of distress

But before we look at the causes let's just look back. Distressed doctors are not new.

Dr Vikenty Veressayev, a doctor practicing in the late 19th Century wrote the book *Confessions of a physician* which was published in 1901 and traced his life from medical school through to his early resident house jobs in Russia. (the equivalent of Rachel Clarke's recent book *Your Life in My Hands*). It was very badly received by the medical establishment in Britain because it exposed doctors. He described the life of a doctor as being made up of:

“moments of terrible nervous tension... a sudden turn for the worse in a recovering patient, an incurable who cries for relief, the

impending death of a patient, the ever-present possibility of an untoward accident or mistake”.

Whilst the illnesses and problems he encountered might have changed over the intervening century, what hasn't changed is the general discontent. Dr Veressayev complains about the stress of his job, of his disillusionment with working as a doctor and of the high rates of depression and suicide amongst his colleagues. (10% of his classmates) He blames this on the unrealistic expectations of the patients as to “*the scope of the powers vested in the physician*”. He also complains about the pay and conditions, the culture of complaints and litigation and the unrelenting work load.

Though he doesn't use the term 'burn out' (it took another 70 or so more years before this word was used) he certainly had many features of it and gave what must be the first description of burn out in the published literature,

“ . . . there are times . . . when you are seized with such depression that only one thought remains — to turn your back on it all and flee far from the madding crowd and feel, if only for a time, free and at peace^x.”

In the mid 19th century another doctor called medicine “*the most despised of all the professions for educated men*.” Doctors found it difficult to earn a living and in 1913, the American Medical Association estimated that no more than 10 percent of physicians were able to earn a comfortable living.

Things were no better in the UK. Victor Horsley, a great Victorian doctor, (who was named after Queen Victoria) fought hard for general practitioners to get paid at all – at the time they relied on charity from their patients and most were poverty stricken. Doctors were even discouraging their children from becoming doctors. Battan, writing in the BMJ, reported that

“In a profession one of whose chief glories was what the Minister called “in -breeding”, fathers are now discouraging their sons from following in their footsteps.....^x.”

In 1976, again in the BMJ, Heimbeck^{xi} wrote that

“medicine is a demanding mistress. Any doctor who is unable to make the commitment necessary for the patient whenever he is needed is better off in some other field of endeavour”.

And of course, he has a case. No matter what safeguards are put in place medicine is a tough job. Hours are long, expectations high and the emotional demands unrelenting.

Lessons learnt during medical school do not necessarily translate easily to the real-life environment. Patients do not follow the rules; they become ill on public holidays and at night. They do not always get better and the pattern of their illness doesn't fit the neat descriptions in the text book. Medical crises can occur unexpectedly. Patients scream, shout and complain. They die.

So, medicine is a tough job, but it has always been thus and this doesn't explain why rates of mental illness are rising. As I said, the rise in mental illness does not only of course involve doctors. We find the same in teachers, social workers, judges and police, indeed across all professions.

But the problem is worse in medicine, so, let's ask why this should be.

1. The individual: the doctor

Has the business of becoming a doctor changed? Has the sort of young person who chooses medicine changed?

Let's start with the individual – the doctor. The vogue at the moment is around improving the resilience of doctors. We see compulsory resilience training - a few sessions of mindfulness to whole courses on how to improve your resilience. There is also a vogue for trying to select people with personality traits which foster resilience.

The Chair of the GMC has opined that doctors should learn from those fighting in Afghanistan to put our psychological and physical armour on. But being a doctor is not the same as being a soldier. We are not trained to kill.

There is no evidence that this generation is more or less resilient than previous ones.

Doctors have always been required to be adaptable and flexible and able to move between different clinical settings, work stressors and teams. As such, medical professionals are perhaps some of the most resilient individuals in the work force. (As has been seen with doctors undergoing basic training in the army). They work long hours, have to move between an intensely traumatic event such as the death of a child to a more mundane and routine task and have to show leadership in the most difficult times. They even have resilient bladders and can go long periods without a bathroom break!

Resilience is a process, not a personality trait, and is dependent on an interplay between the individual, their environment and wider socio-cultural milieu. Resilience is always contextual. Given enough environmental pressure, everyone has their breaking point, beyond which they can go no further.

To give an example: I am a very, very good GP. I can clear a room of 50 people. But I recently had to work at the front end in A&E and I couldn't use the IT system, I didn't know who the different categories of staff were, the patients were different – everything was different. I went home crying and said to my husband "I don't want to risk my registration working there any more." Fortunately as a very senior doctor I was able to do that before I became a gibbering wreck.

2: The job

And it is the working environment, not doctors personalities or psychological make up which has changed considerably over the decades, especially in my own profession of general practice, where work load, intensity and patient complexity have magnified in the last few years. I have sat in the same place, in the same practice and seen more or less the same patients for 27 years. I have always started at 8am. In the old days I worked from 8-11am when we had what we called call over where we dished out the visits; I would do mine and be back in time to pick up the children from nursery, feed them, go to a meeting, go back to work by 4pm, do my evening surgery and be home by 6.30pm.

A generation before, my father would do his morning surgery, come home for a large lunch with half a bottle of wine followed by a siesta and still be home by 7pm.

Now, I am lucky to finish my morning surgery before my evening surgery is due to start.

Patients are more complex and more litigious. The scrutiny we are under by organisations such as CQC were non-existent in the days when I started. What has also changed in the intervening years is how the system cares for today's doctors. I was taught by the surgeon Harold Ellis who qualified in the 1940's, (pre-NHS) and is still alive and probably the oldest doctor still working (as a trainer). Writing in the

BMJ he boasts of the hard work he had to do including working a one-in-one, always on call for 6 months on the trot. But he also talks about being woken each morning with tea and toast and his shoes polished overnight.

Even in my day we had free accommodation on site, with hot food day and night.

But now the work is unrelenting. The hours maybe shorter but they are more intense.

The Medical Matrix

But where the job has changed most, and what I think is contributing to the rise in mental illness is not the work load or its intensity. Although this has a part I actually think that the worst thing is the loss of connections between each other. Medicine is a relational activity, between doctor and patient and between doctor and doctor, doctor and nurse and so on. It is not isolated. To survive a life time in medicine we need each other. I talk of the matrix of medicine. Matrix is a concept I have taken from Group analysis, brought in by SH Foulkes, who came here as a refugee from Nazi Germany and set up groups for distressed soldiers at Northfields – probably the first therapy group in the world.

The matrix consists of unconscious connections and a hypothetical web of communication which link us together past, present and even into the future. The medical matrix is made real for doctors through shared education, and our cultural, social and lingual experiences. It is reinforced by the collective spaces which doctors inhabit, e.g. medical schools, hospitals and doctors' messes. The matrix, with its unconscious connections, means doctors, as if by radar, can find each other across a crowded room and when together, even medical strangers find points of intimate connection. Hidden from sight, the medical matrix is defined by its values, ways of behaving, culture and most importantly, its defences. It determines the way doctors behave and creates their group norms, including the tacit assumption that doctors do not become unwell and do not show their vulnerabilities; hence the propensity to turn up for work even when impaired or unwell.

To survive a lifetime so close to distress and to carry out their tasks of selflessly serving others, doctors have to develop collective defences, which include depersonalisation, sublimation, humour, and, importantly, denial of vulnerability. I have to believe I am invincible. The defences used by doctors were described in the 1950s by Isabel Mynzies-Lyth in her seminal work on nurses and their collective unconscious social defences against anxieties (Menzies-Lyth, 1992). In fact, the defences she described are a quintessential part of the medical matrix and part of the unconsciousness processes permeating it. These defences centre on a doctor's ability to detach themselves from their patients – a necessary psychological requirement for ensuring that they control their feelings, refrain from excessive involvement and do not over-identify with their patients. They are vital for survival. Without them doctors could not do their job.

The Medical Self

While the matrix creates a doctors group identity, it is reinforced by changes to a doctor's individual identity as, during training, the professional and the personal merge to form a single identity, which could be thought of as 'the medical self.'

I was exposed to the medical matrix early on in my life. My father was a single-handed GP.

His surgery was our front room and our home was surrounded by the trappings of the matrix: books, equipment, even a full skeleton. I learnt the rules of the matrix: how to behave in public, how not to tell secrets, and how to belong to 'group' that was medicine.

And the group of course welcomed me .

Here is an example that explains the medical matrix in a real, tangible way. My husband [Professor Sir Simon Wessely] was recently awarded a Regius chair, the first psychiatrist in history to be so awarded by the Queen. He was giving the inaugural lecture to an audience which included some of the giants of medicine from all over Europe. Just before he started a young friend came in and whispered in my ear that she had just qualified as a doctor. I went up and told Simon, and before he started his lecture he announced that Jessie had just qualified. The whole audience stood up and clapped. She had joined the matrix.

But it is also the self that changes. During my early life, as well as my group identity, I also changed how I felt about myself. My father taught me that the power of medicine lay not just in the pills and potions he dispensed but also in the ability to listen, engage and be part of the groups that he served, not distant from them but 'being with' and part of their group.

However, my father was different from his community. He stood out as the local GP, priest-like in the reverence he received from patients and the local community. So too did I stand out. As patients entered my personal space, I separated from them and became and felt different. Unconsciously I defined myself as 'the doctor's daughter.' My personal identity began to incorporate those of other doctors. I answered the phone with authority, abandoning my name and instead giving myself the title of 'Dr Gerada's daughter'.

So even before arriving at medical school, as with other medical students, either implicitly or explicitly I saw myself as different from others.

Doctors' long and arduous training does nothing to disabuse this view. Doctors are set apart from their peers. At medical school they have longer and more structured training. They become 'bilingual', learning a scientific 'language' of clinical terms and vocabulary.

They develop 'new' mannerisms, such as the medical gaze, a slight tilt of the head and downward look. Most succinctly of all, the new identity is finalised through the acquisition of a new name: 'Doctor', institutionalising their sense of being special.

All of these factors create a deep-rooted and stable personal identity. The medical self gives doctors the confidence to move from a traumatic event, such as the death of a child, to a more mundane one, such as ordering blood tests. It allows us to present ourselves to the world

The medical self – in fact any 'self' is made up of our several identities e.g. mother, doctor, patient, spouse. But also engrained is the identity of healer' that is the medical self which doctors 'present' to the world, and which guides them throughout their career.

It is all-pervading such that a doctor is never 'off-duty', they are expected to inhabit the medical role at all times as the Good Samaritan, ready to leap into action, irrespective of the situation whenever the unwelcomed call goes out for a doctor in the house. Doctors cannot leave their identity behind at the hospital gate or consulting room door. Their responsibilities permeate all aspects of life, similarly to a religious vocation, and they are constantly compelled to define themselves by their work.

As a doctor, I can no more take the doctor out of me than an artist can take their creativity out of themselves. Being a doctor is therefore not just a job that you go to but is something that you are. It is this medical self, located within the medical matrix,

which acts during work to mask the doctor's suffering, and protects them from subjective feelings of guilt, fear and hopelessness. It gives identity and certainty.

The total doctor and their patients

The identity of the doctor is therefore both individual (as the medical self) and collective (the medical matrix). The individual has embodied 'certainty', 'authority', 'objectiveness', and these are reinforced through the dynamic process of interactions and relationships with their colleagues, and juxtaposed against the 'radical Other', namely patients.

Doctors and patients are distinct but interdependent, and the 'whole' is founded on the co-existence of these parts, as doctors need patients to formulate themselves as 'doctors'.

In the medical literature, this phenomenon is perhaps best illustrated by Dr John Sassall, the protagonist in the John Berger's 1967 work *A Fortunate Man: The Story of a Country Doctor* (Berger & Mohr, 1997), a non-fiction, fly-on-the-wall description of a GP, who lived and worked in a remote and deprived community in the Forest of Dean. Sassall was the well-loved family doctor who, according to the author, 'is accepted by his patients' who think of Sassall as 'belonging' to their community. Yet, as Berger goes on to say, he was not equal to them. He was described as being privileged, not in terms of his income (this was very modest), or his house or car but with "the way he thinks and talks, due to his education and his medical training". As Berger wrote, "whilst he was trusted because he lived with them, his way of thinking could only have been acquired elsewhere." No matter how much Sassall wanted to blend in, he could not. Even though Sassall drank, ate, lived, played and worshipped with his community, he stood out as being different and this difference was principally in his way of thinking, (described in the book as self-indulgent, imaginative, intuitive, inquisitive and magical); his way of being: able to bear witness to suffering and self-controlled; and his way of living: always on call and available to his patients. Sassall had tremendous power, not just over his patients but over the entire community. Both patient and doctor benefited from this arrangement. For patients, the medical matrix means they can split off their fear of death and the fantasy that death can be prevented through the actions of doctors. That is why this is so important: it's not just one way. Patients need to think their doctors are different.

There is a need to create a subgroup. Society uses 'chosen subgroups' to delegate certain unpalatable tasks, such, as those described by Ballatt and Campling (2010) in their work on compassion in the NHS, *Intelligent Kindness*:

"it is easy to forget the appalling nature of some of the jobs carried out by NHS staff day in, day out—the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products".

It is the subgroup which processes this unpalatable material, which is then made socially unconscious, hidden from sight within the medical matrix. It is a necessary function of the subgroup. If we start talking about equality between doctors and patients, think what we might be giving up.

This calls to mind Thomas Main (1975) who established therapeutic communities, when he described the defensive interplay of projections between care-givers and patients and the 'phantastic' collusion which occurs between the two. This collusion is a major feature of the medical matrix. It allows patients to project their fears of death into doctors, who have to process and contain them and defend against them.

Collapse of the Medical Matrix

So the matrix acts to protect doctors in their work and create the characteristics which constitute 'good doctors' such as conscientiousness, perfectionism and altruism. The rules instil a drive to do well and bind them to their job, ensuring, as in the first line of the Geneva Declaration (recited by doctors on graduation), that 'they dedicate themselves to the service of humanity.'

I believe the principal cause of the massive distress amongst doctors is the collapse of the matrix, which is under threat as the structures within medicine where doctors train, work and play are rapidly changing.

The training of doctors now has a multi-professional focus, and their working lives are spent in non medically led hierarchies. The private spaces such as doctors' dining rooms where doctors traditionally met and relaxed together and formed those important connections, enabling the medical self to be contained and strengthened, have long disappeared both for practical reasons (space) and for the perception that they fostered elitism. This is threatening the fragile ecosystem which has, for centuries, protected doctors from the emotional burden of their work and contributing to the current worldwide epidemic of depression, anxiety, burnout and suicide amongst doctors.

The sociologist Zigmunt Bauman (2000) has spoken of a crisis of identity in 'postmodern' society where individuals exist in a flux of uncertainty and rapidly changing social positions, which he called 'liquid modernity'; I believe the current training for and practice of medicine fulfils his vision of a liquid society.

Doctors now have fragmented lives. Their training no longer involves long attachments to a single unit. Doctors in training now have short rotations with frequent changes of wards and even hospital, usually many miles apart, often with very short notice of the need to change location. Shift-working gives little opportunity for collective 'down time' meaning that the informal spaces where doctors come together have largely disappeared. Learning and reflection is done in the anonymous setting of the 'online' space as virtual classrooms and e-portfolios have replaced the face-to-face contact with peers and teachers.

For medical school and medicine, to institutionalise a single 'self' in this world of liquid modernity creates tensions and anxiety, especially in a world where medicine itself is changing. The hierarchy between patients and doctors is rapidly disappearing. Doctors are now encouraged to share decision-making with patients, be less authoritative and make less claim to have 'total' knowledge. The concept of medical schools as 'total institutions' creating the 'total professional' of the doctor, set on a pedestal of medicine's own construction, is rapidly disappearing.

Doctors across the world are traumatised by repeated and ever faster re-structuring. They are having to move away from their idealised past as a vocation undertaken by white-collar professionals to a job done by blue-collar workers; from the consulting room to the factory floor. Doctors are less confident of their role in society; the 'self' constructed during medical school does not fit the reality of the working world. This creates blurred matrices: rather than coming together in their own matrices, doctors are at risk of becoming psychological singletons, only capable of defending their own psychological skin (Turquet, 1975).

John Sassall (that saintly GP described by John Berger) had inadequate defences to sustain him following the death of his wife. He had no peer group (his work partner had long since retired), no safe space to talk about the burden of his work which became too much to bear as he could not contain the suffering of his patients; he

had no matrix, and his medical self, with the illusion of invincibility, prevented him from seeking help. And he killed himself.

This I believe is the process happening amongst members of the medical profession today.

Recreating the Matrix

We cannot turn the clock back to an idealized past, but we can take steps to understand it. For doctors, the past allowed much closer identification with each other and with their community of medics.

For the last decade part of the treatment offered by my service is the opportunity to join groups. These vary widely: support groups, therapy groups run on group analytic grounds, Balint groups, reflective practice groups; large, medium and small groups. There are groups for doctors who have had their practicing rights removed (either through suspension or erasure) and for doctors who have chemical or behavioural addiction. Groups help doctors to share experiences and difficulties in a safe and supportive environment. In the fragmented and increasingly isolated world of medicine they act as a focal point to reduce professional loneliness and improve wellbeing and to restore a sense of identity to self and group.

This identification, as I have argued, is necessary for the creation of the social and personal defences which are vital to avoid experiences of anxiety, doubt, guilt and uncertainty (emotions which are just below the surface of most doctors). One reason is that

the practice of medicine is largely an illusion. Doctors reassure patients that their symptoms are not due to cancer or a serious illness, not because they know for certain (we never can) but because their training has given them the authority and power to offer this certainty and for the patient to trust that doctors are right. This, I believe underpins the phantastic collusion which Main talks about.

But these defences are fragile and can be easily shattered following something as simple as a minor complaint or error at work. This can only lead to anxious doctors and over-investigated patients.

For doctors to do the jobs demanded of them by their patients they must recreate those spaces and connections to 'be together' as a profession and create their defences.

Of course, I am not so naïve as to assume that just by restoring the medical matrix the problems of doctors' morale will be completely solved. There are many other issues which have to be addressed – such as the marketisation of the health system and the destructive influence of inspection, monitoring and regulatory systems. Nor am I arguing for doctors to be on their pedestal and others in their place, but rather that if we expect doctors to give their all to others then the quid pro quo is that we have to protect them and their groups of belonging, the spaces where they can learn, play, cry and suffer together and in so doing, build the necessary defences to care effectively for their patients, and importantly, remain mentally healthy.

Discussion

Do you think the rise in mental illness among female medics is because there are more of them? [nearly 70% of the profession]

It is and it isn't. They certainly are over-represented but the rise in female medics is non-factorial. A woman in her mid-thirties is putting down roots; she is creating a family and having her second or third child. But a woman in her mid-thirties in medicine (the peak age is 29-30) is treated like an adolescent. At an age when her biological clock - her whole being - is urging her to settle, she is on the move. Many of our young female doctors find that rotations are designed to give no choice; they have to follow a run through training lasting seven years which may take them 70 miles in opposite directions. It doesn't seem to be anything to do with lack of resilience.

[Partly inaudible after interruption in recording] ... Doctors coming off the production line are taught about medicine and quite rightly so but they haven't been taught how to get into the swampy lowlands ... doctors in the pain clinic are getting there. ...

We've lost the doctors' mess and dining rooms; we used to meet in the pub after work and that's gone. Doctors come in, keep their heads down and go home ...

It's not just doctors ... We're very lucky in having a post-grad education centre from which patients and relatives are excluded where when you have a break you can nip down, grab a coffee and chat without being overheard - you can't talk in the eating area.

My argument is that it cannot be like that, because what we do is not just technical ... it is illusionary; For example an anaesthetist telling someone the needle is not going to hurt and that they will be comfortable when they wake up.

This is why I think the current vogue for reflective practice is wrong: reflection should take place in groups or teams of peers, not in an isolated portfolio . It should be entirely private. We can't just allow things to be processed by the individual; we can't let something destroy an individual, for instance making a young doctor go and write in their portfolio that they've had a complaint. This is absolutely the wrong thing to do. I'm working with a group trying to change the law about complaints and the way in which doctors and nurses and everyone in the system are managed when they get a complaint. We lost a 26-year-old paediatrician who had an absolutely trivial complaint but for her it proved catastrophic and she killed herself. We have to understand that the health of the staff is important We have a complaints process that is destroying people and we have to change it.

There is massive fear in this

Yes - complaints kill. The more biddable, the more perfectionist, the younger, the nicer you are they are more likely to kill you. If I have a complaint my reaction is "f *** off! but it can be the most painful at the beginning or the end of your career.

A number of my colleagues have retired in the last five years and every single one of them has had the most spiteful and difficult complaint just as their career was drawing to a close. It's a real pattern and makes me quite miserable.

I have noticed that I am slightly more abrupt with patients that are annoying me - slightly less sympathetic ... that happens towards the end of one's career.

Perhaps if GP's were allowed more than 10 minutes per patient the pressure wouldn't be so great. Maybe that is wishful thinking.

We can only contain a certain amount of pain. If somebody said you can only see 60 souls a week that would make a lot of sense. There are only a certain number of

souls you can contain in you heart across your career ... I'm not saying ... but towards the end of your career perhaps you become a bit more fragile?

If you make a mistake or forget something when you are young it's down to inexperience. If you make the same mistake when you are middle-aged it's just ... life – but if you make the same mistake when you are old it's because you are old and shouldn't be practicing, and there are pressures on you to stop. The same mistake is seen so differently.

There is a furore in my department at the moment about whether an older colleague should be allowed to come off the on call, which would give them a better quality of life. I recognise that in my early 40's 7 nights a month may not be something I can continue. When we are considering safety why are we so bad at thinking of ourselves? Perhaps we should be spending more time with patients and seeing fewer because if we don't our careers may end badly.

Junior doctors are losing the matrix because they spend four months with us and rotate to another hospital.

When I was a junior at York County hospital the pub across the road had an extension from the hospital switchboard!

Social media are going to be a big thing for young doctors - they can be a potential antidote to isolation

There is one called 'Tea and Sympathy' which is a support group for doctors. It can feel like a suicide prevention service. It isn't moderated formally but several of us go in and pluck out distressed people

Doctors don't have supervision. Supervision is compulsory for psychotherapists

I'm trying to get a code of conduct involving compulsory one-to one supervision for all doctors.

We tried to bring in mentoring in the North East but it was focussed on those who had problems, so the implication was that if you are going to a mentoring group you must have a problem. As opposed to: this is normal and expected and will help you to realise your potential and nourish you.

The other system is 'grandparents and parents'; every member of staff is allocated two grandparents and two parents whom they can have throughout their training. It is this is non judgemental, but 'Doctors in distress' and 'support groups' have titles which imply that you are damaged.

[inaudible as several people talking at once] ... Balint groups ... [A Balint group 'is a group of clinicians who meet regularly and present cases to each other to discuss. The aim is a group process of exploration and for the medical participants to transform uncertainty and difficulty in the doctor-patient relationship into a greater understanding and meaning that nurtures a more therapeutic alliance between clinician and patient'.]

...which are similar to Schwartz rounds. Schwartz was a barrister doctor who was dying of cancer – he was only in his 40's and realised the effect his dying was having on the staff; he made money available in his will for these to be provided . [Schwartz Rounds 'provide a structured forum where all staff, clinical and non-

clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.’ They follow a similar format to Balint Groups in terms of their reflective nature and focus on emotional impact, but the latter are only open to certain members of clinical staff. Schwartz Rounds appear to have been more widely adopted in the UK]

Such groups do work – as in a recent case of a maternal death in our hospital where they provided a safe space - but I wonder if they work with larger numbers?

They do work, but the idea is the whole team should take part and what I have found increasingly is that the senior members of staff don't go because they don't want to be vulnerable in front of the juniors and the juniors feel embarrassed.

The medical matrix was very good on some levels but it also involved the superhero and very male dominated behaviour. OK, you can't go back - society has changed - but how can we instil in people the sense of their own authority and competence which they need to treat patients without their becoming a superhero or a patriarchal figure ...

I think we can do it again. We can create spaces without creating full matrices. We can look after staff when they are vulnerable. But we can't let patients off the hook; they want authority without accountability but they can't have one without the other. They can't say: I want this and then expect ... when it all goes wrong ...
... the virtual environment we work in might change and recreate some of these linkages.

Five years ago my mother died in hospital after a catalogue of mistakes. These largely happened because hospitals in west Wales are stretched beyond the possible with newly qualified doctors in charge of the whole hospital at night with no access to any senior advice. The cardiologist was not available. I kept a diary and I wrote out a story and sent it to the hospital management. I said I want you to learn from it but I don't want it to be a complaint because the staff are under enough stress as it is. The answer I got was that it had to go in as a complaint which I didn't want. The medical director agreed to meet me and he was wonderful, and we agreed between ourselves that they could do as I asked and learn from it, but he actually said the only way he could get the department to eliminate the problems would be to close it...the problem is they just can't get the staff.

There are two things to focus on: one is the pain of what you had to go through, and the second is what we call the human factors in an organisation. There is a current consultation and I would urge you to send your story in to the [Healthcare Safety Investigation Branch \(HSIB\)](#)

If you have an aeroplane with two pilots and they encounter rough weather there isn't an absolute definite way of landing that plane but the pilot chooses to land it one way, The co-pilot may disagree but after they have just about landed safely the co-pilot may say: "now talk me through why you decided to do it that way" and "I would have done it this way" and they would both go and report themselves to the air accident investigation body; and they would both be invited for a non-judgemental, non-threatening discussion, so useful lessons could be learnt for the next time this situation arises. We have no equivalent; we are not even able to learn from mistakes and this is what the HSIB is trying to introduce so the Trust would be mandated to provide a safe space to discuss that issue, and why your mother died, in a safe way so that they can learn.

We discussed this subject at one of our earliest meetings in 2001 or 2, particularly in the context of lone pain consultants of whom there were a lot at the time, and we drafted a proposal to the Pain Society for some sort of support or mentoring system. The Council discussed it and said it was a good idea but they didn't have the resources etc. I wonder if this is something the BPS should be considering again?

There is a big fear of prosecution. I have a lot of people who come [for psychotherapy] and all they want when a mistake has been made is for someone to say 'I'm sorry'. But people dare not say they are sorry because they think this will make them open to being prosecuted. So people get very angry when all they wanted was an apology and someone to listen to them. I don't know what should be done about that.

The HSIB are creating a safe space where things can be discussed in a way that blame doesn't get attributed. If someone has broken the law that is different. I think if enough noise is made by everybody working in the system we may well end up getting a change – but it's the usual collusion of anonymity – nobody wants to take responsibility ...

I remember many years ago hearing a talk by the then president of the GMC about a change in the culture so it was OK to complain and OK to say I'm sorry and there were all these systems set up ... and 30 years later nothing has changed.

I heard a talk at the Canadian Anaesthetic Society back in 1971 from an American medically qualified lawyer who specialised in medicolegal cases, in which he said that by far the commonest reason for people suing doctors was not the hope of financial gain or the desire to punish them but the perception that they were being lied to or at least not being told the whole truth. He said that even in the US, where doctors even then were terrified of litigation, if you were open and honest with people about mistakes you would rarely get sued.

When I started medical practice in Australia all the emphasis was on never commit yourself, never say you are sorry, because you are laying yourself open. It has completely changed now: our Medical Defence Union encourages us to always tell the truth, always say you are sorry, always be prepared to negotiate, and always to say that we will have learnt from this.

I would say the first thing you do when you get a complaint is not to apologise unless you are apologising existentially. Recently we had a death which was on the front page of the BMJ. Existentially, I apologised; we were all to blame because if a young man dies who has seen 15 doctors clearly something must have gone wrong. But personally I am not responsible for his death. And so you get a defence: if you went out and crashed your car and killed someone you wouldn't go 'I'm sorry', you would say 'let me get legal advice'. The problem with what we are doing now is that we have pushed it far too far. Doctors in the throes of an error will admit to anything. My doctors will admit to starting a third world war because they are so ashamed. I think they are wrong. You must protect yourself. The first thing you must do – of course you can apologise existentially: I am sorry this has happened - but not say that I am sorry that I may have failed you and that is how you've lost your leg. But that is what they are asking us to do. But the first thing you must do is to seek legal advice. Junior doctors have been told to write a statement of reflective practice and sign it. But even in a police cell you would be given access to a lawyer and you'd be told your rights.

I think we are doing it to ourselves. We are forgetting that we too should have rights.

As health workers we are told by our organisations about our duty of candour, but there is no duty of candour for managers for failure to provide although it's OK for the clinician to carry the can

I find it difficult to reflect but I find it very easy to discuss things with my colleagues. I gain a lot of benefit from that. But on my own I have no touchstone to endorse what is and what isn't reasonable - just my own inbuilt mood at the time and I may or may not be aware of whether I being extremely negative ...

I am trying to get individual reflection banned, or at least not making it mandatory. Reflection mustn't be confused with rumination. If you are depressed or anxious you ruminate - it goes round and round and round, and this is what happened to the young girl who killed herself. It is against every human fibre to reflect on your own. There is a fantastic author called John Launer who is himself a doctor and has written a book called *How not to be a good doctor*.

All you have to put in your portfolio is *I have reflected* – full stop. You reflect in your diary because it is personal ... I am actually asking: why don't they ask us about our dreams? You can't reflect in that concrete sterile way. But the idea of writing a reflection that someone else can read like a confessional ...

...we are required [by our organisation] to provide reflection for revalidation according to the template they give us. If you are smart that is just a series of factual ...

But the young ones are being sanctioned – punished – for not putting their emotional feelings ... the other naughty expression that is coming in is lack of insight. So we have two words coming together now, reflection and insight, which constitute a toxic combination.

In our area they tend to be 'can we refer to tertiary centres like pain clinics' rather than 'how does that handicapped child make you feel'. A lot of them are process meetings. My sense is that all mandatory training should be abolished ... it is my ambition before I die.

This meeting is fantastic- this is where learning happens

Who came up with these ideas about reflection? - who is driving it?

That's a very good question. It came quite widely out of the medical profession thinking that we need to discuss the emotional aspects of our lives. We then got Shipman and appraisal came in and the two hit together. Then it became part of the mandatory process and now part of the management process and nobody has challenged it. At the moment there is a consultation going out from the GMC on reflection. I'm on the BMA so I got this and I said "we shouldn't be consulting on this: there is no evidence at all that this works". What they are trying to do is make it an issue and then make it better. Nobody is actually saying we should scrap the whole thing, so I refuse to comment on this document until we review the whole process because the whole thing is nonsense. It's like the fire training that requires you to know the colour of fire extinguishers for different kinds of fires. All these intelligent people have to do mandatory annual fire training...

... It's a waste of time ...

... so why do it ...

... it's mandatory ...

...just say no!

In the old days your training was determined by your learning needs ... assessing these and realising the bits you didn't know. I hated learning about diabetes and I had to force myself to go on a course about it, but that's how we should learn as adults.

It's part of a wider issue ... the patients shouldn't be passive, but society shouldn't be passive in this either.

I'm very struck by both the similarities and dissimilarities between your account of the situation in the medical professions and academic life in general. For example the senior common room used to be a very important place in universities when I was first appointed (to Newcastle University) 30 years ago. Now either there isn't one at all or it's just a canteen and there is no social life centred around it. I did a lot of interviewing as a lay member on panels for the medical school and there I saw some of the best and worst of people. I saw some of the most arrogant people I've ever met among senior male medical academics; I got the impression that they had never been challenged for the last thirty years and they were quite hard to take. I think things have changed, but at that time when the medical students they came into medical school they were lectured by the Dean of Medicine and told that they were a cut above everybody else in the University and that is how they should think about themselves, and not even move in the same circles as other students in the canteen.

The other thing is the matter of litigation. This was never mentioned when I was first appointed. Now people are getting very worried about it for both good and bad reasons. Managers fear litigation every minute. Because the students are paying fees their parents are getting much more concerned about what they are getting for their money. We have some practices that in a law court wouldn't last two minutes. For example, (in the humanities) the marking procedures. We have double marking and the guy who does that is called the moderator. My last marking was of 80 essays of 2000 words each to deal with in less than a fortnight and he had to moderate them in an even shorter time. I asked them how he did it and he replied that they sat on the left hand side of his desk for two days and then he moved them to the right! I had one student who came and complained about the mark I had given her; she wasn't a difficult student, a very nice straightforward person, but she had been told by an uncle who was a lecturer at another university that it was obviously a 2:1, and she wanted to know why I hadn't given her one. Now in court, with some hard nosed QC, I wouldn't have lasted a second.

Do you shred all the papers when finished? I'm told this is a way round this.

I don't know

i Veressayev VV. The memoirs of a physician. Page 246

ii Batten Re COLLINS REPORT

iii Heimbeck D. Why the clinical clerkship: a statement to students. *Pharoes* 1976; 39:103-5

The Raveled Sleeve of Care

Michael Farquhar

You asked me to talk about sleep today in the context of burnout because of my work around the importance of sleep for healthcare professionals. We don't talk enough about the importance of sleep in the context of the care we give our patients. The average medical student gets about ten minutes teaching on sleep in a five year curriculum. I hope to persuade you that sleep is absolutely fundamental to every aspect of your physical and mental health and that if we spend about a third of our lives asleep and very little time talking about it in the context of healthcare we are missing an obvious trick. Equally we don't talk about the fact that when we are asking people, within healthcare to work 24 hours a day for 365 days a year to provide care that is acute and essential we don't think about the impact of that. There is a big impact on fatigue, there is a big impact of sleep deprivation and in particular, if we are thinking about people who work at night, there is the additional problem of working against our body clock when our brains should be asleep. The reasons why I started doing this work will become apparent as I talk, but in the last few years the intersection between the work that I do and the work that has been done by other people around the concept of burnout reveals very much overlap. Inadequate sleep is not only a significant contributing factor that makes healthcare professionals more vulnerable to burnout, but also part of its presenting symptomatology.

When we start thinking about sleep in the context of healthcare we go back to the 19th century when the concept of sleep was such that if there was something wrong with you then your sleep would be affected; poor sleep was seen very much as a symptom. We have now got to the point where we are turning that around, and while we still acknowledge that poor sleep is a feature of many health conditions, even more importantly we recognise that sleep is the foundation, the bedrock, and if you are not sleeping as you should do the risk of having other physical and mental health problems increases and your ability to cope with these or recover from them is impaired. You will all know that when people are sleep deprived their perception of pain changes and they become more sensitive to painful stimuli and if you have chronic pain that will affect the quality of your sleep. So most conditions have this very complex relationship with sleep where poor sleep both potentiates the problem and can become part of the symptomatology. As is often the case, Shakespeare had a lot to say about sleep and actually got it right long before the psychiatrists got into the area:

Methought I heard a voice cry "Sleep no more!
Macbeth does murder sleep"—the innocent sleep,
Sleep that knits up the raveled sleeve of care,
The death of each day's life, sore labour's bath,
Balm of hurt minds, great nature's second course,
Chief nourisher in life's feast ...

– the idea that sleep is a protective thing that soothes us when we are hurt. It underpins everything about our physical and mental health. The other thing about sleep in this context is the interrelationship between science and stories. A lot of peoples' experience of sleep and sleep difficulty is driven by social and cultural understanding. That space that Michael (Bavidge) was talking about between dreams

and waking is a special place where all sorts of weird and wonderful things can happen. For some people that can be a very positive and pleasurable experience, but for others it can be scary or even terrifying. But it has this kind of ephemeral quality; something we feel we are not really capturing properly.

If we look at a historical context the idea that when sleep problems occurred and how they were interpreted: a common sleep problem is sleep paralysis where you wake up and feel you can't move any part of your body which can be very frightening. You may have an impression of a weight pressing on your chest or a band round you as part of that. It is explicable in terms of sleep physiology: you are paralysed when you are dreaming to stop you acting out your dreams, and occasionally that paralysis can persist if you wake too quickly. But if you experience this when you wake you feel scared. Your diaphragm is still working but your accessory muscles of respiration are paralysed; you try to take a big breath in and you can't which your brain interprets as a tight band as it tries to create an explanation for the sensation. I can explain that on a physiological basis, but if you go back to the Middle Ages it was explained as incubi or succubi - demons coming in the night and sitting on your chest. This sensation is often associated with a persistence of dream imagery called hypnagogic hallucination which can also be terrifying. The way people talked about this then was in these kind of terms, which drove a lot of the language about demons and tempting things coming in the night. It might be an explanation for alien abduction stories: the quality of many of peoples' experiences is consistent with sleep paralysis. But we don't interpret things in such an illogical perspective in the 21st century; we tend to put more of a sci-fi twist on it. So alien abductions are more common now than in the middle ages. We interpret these phenomena in an individual way.

There are positive aspects of that space between dreams and wakefulness, as in the story of Kekulé the chemist who was the first person to make the intellectual leap required to describe the structure of benzene, which is a hydrocarbon with an unusual non-linear structure. He was trying and failing to make sense of his laboratory findings and he went to sleep and dreamt about the great serpent Ouroboros, that bites its own tail. As he woke up he realised that that was the key: it was a circle, not a line. That came from the creative space when we dream and process the day's thoughts and emotions; the brain can sometimes make those intuitive leaps during sleep.

One of the lovely things about sleep is that we don't really know a lot about the real functions of it yet. Dreams probably do have a purpose in their own right. On one level they are probably an interpretation of all that shuffling and processing of all that information that the brain is doing. We put stories to that, and we hope the stories are pleasant, but in dealing with daytime stresses and worries, dream sleep can be one of the places that can manifest. So although nightmares are a common experience of childhood, repetitive and intrusive nightmares can often be a sign that there is something else going on, and may give a clue to what that might be.

That relationship between sleep and peoples' narrative experience of the world is something that everybody has on a personal level, but it is not something people have thought about in great depth.

Language and sleep

Every now and again I get kids in my clinic who are terrified of going to sleep and when we track it back we find stories like: 'Grandad went to sleep' ... 'we took the dog to the vet to put it to sleep'. Using language loosely can drive a lot of fears and worries. You would be amazed ... I think we are often very guilty, particularly when we talk to children, of thinking we are doing them a kindness by talking in euphemisms and indirect ways about difficult experiences. Kids aren't stupid and

often we do them a disservice by not talking to them in honest and clear terms - yes, we have to tailor it to their level of understanding - but we may only create confusion and often drive fear by not doing so. Anaesthetists and I often fall out: anaesthesia is not sleep and fuzzy language about it can sometimes be a problem .

The consequences of inadequate sleep

So that's a bit of a backdrop about the kind of fuzzy nebulous elements in sleep, and the ways in which we think about it and construct ideas around and which underpin it. My work involves thinking about what happens when sleep is not going well in healthcare, on the background of much deeper understanding over the last 20 or 30 years of the consequences of sleep deprivation. You all know instinctively that if we don't get enough sleep we don't feel great and the less sleep we have the less able we are to go on. But increasingly we are understanding that even mild and moderate sleep deprivation is actually a very significant lifetime risk factor for a number of serious illnesses like Type 2 diabetes, obesity and Alzheimer's disease, at both a personal and a population level. From my perspective as a paediatrician, we have been looking at the cardiovascular effects of interrupted sleep in children. A lot of children have obstructive sleep apnoea. This is something they normally grow out of; it is all to do with the size of the adenoids and tonsils and as they get bigger it usually gets better by itself. But we are increasingly understanding that if we just let them do that, the children who have those symptoms in childhood are at lifetime risk of cardiovascular disease: hypertension stroke and MI. So at a population level it makes sense to do something about it.

Our new College president has said that we have two epidemics facing children in Britain today: obesity and mental health. Sleep underpins both. If we get sleep right we can help to modify these kinds of things. The idea that we ought to be thinking about sleep on a population level as well as individual is beginning to take traction.

There are some books out there at the moment that are really good at getting understanding of sleep across at a basic, popular science level. Matt Walker is a research scientist from California who has written a great book which summarises the current evidence about what sleep is for and why it is important. Ariana Huffington, a high-powered American business-woman who founded the Washington Post among other things had a significant breakdown several years ago and realised that the pressure of what she was pushing herself to do had got to the point where she couldn't sustain it any longer. She took time out to re-examine her life and one of the things she recognised was that she had got sleep all wrong. She came back and remains very successful, and insists that sleep is very important for all her employees as well as herself, as we all work more efficiently when we are not sleep deprived or fatigued, and has written the book *The Sleep Revolution*. She is beginning to change the culture in her world of high pressure business. Not only will people be nicer and get on better but the company will make more money.

What I think about sleep is this: it is the missing piece of the jigsaw puzzle that nobody thinks about or talks about. I have an open challenge for any clinician in my hospital that I can find a way of coming to talk to their team about why they should be thinking more about it. I haven't found anybody who can refute that. We can always find a way that in thinking about sleep we can help people to improve the care they can deliver and do something for themselves.

Having said that, one of the challenges about sleep is that we don't really know the answer to the question: why do we sleep? – what is the function of sleep? The likely candidates are:

1 Repair

There is a physical role for sleep. This is the oldest idea - that we just need to switch off and recharge your batteries. Children grow during sleep. Lots of our body processes are linked to a normal sleep pattern. Deep sleep, the most physically restorative part, is when we produce growth hormone, so children who don't get enough sleep don't grow. But for all of us sleep is reparative. We think this is the physiological underpinning for an increased risk of some cancers

2 'Rebooting' the brain

There is a very definite cognitive element in sleep, and it plays a vital role in learning. If you have been learning things over the course of this day's conference, you will not retain the knowledge, or integrate understanding into that knowledge, unless your sleep is good. If you slept poorly last night, your ability to take in new information today is impaired. If you have rubbish sleep tonight the information you have learnt today will be less well integrated, processed and remembered. It's a key point we make with secondary school children: it's no good staying up to midnight cramming; you need sleep. We see it with people doing membership exams who think if they burn the midnight oil they will get better results, but actually it's probably the converse. The correlate of that is emotional processing. If you don't get sleep you are probably going to be a more unpleasant person the next day. There are good studies of interpersonal relationships in couples that show that when they are both sleep deprived there is a lot more fighting.

One of the common fallacies about sleep is that it is a passive process—a relaxation away from the world. But for most of the time it is actually a very active process, particularly during dream sleep when we are as physiologically active as we are when awake. Sleep has a role in almost anything you can think of. An important one is the function of the immune system during sleep. If you are exposed to the common cold virus and you are not sleep deprived you are much less likely to become symptomatic but if you are, the risk increases three times. If you get the flu vaccination when you are sleep deprived and we test your titres on day ten they will be 50% less than in someone who had the right amount of sleep. We spend a lot of time persuading people to get their flu jab but none at all making sure that our staff get the right amount of sleep.

When you get ill you increase your sleep time. Thinking of hospitals: they are rubbish places to sleep although there are data to show that you get better quickly with the right amount. There are data from neonatal intensive care units which are run with bright lights 24 hours a day compared with those that have a natural light/dark pattern, and long-term babies in the latter are discharged on average 15 days earlier. Truly terrifying statistics. The median amount of time someone in an ICU sleeps before they are woken up is *three minutes!* That would be torture in Guantanamo Bay but in intensive care it is normal practice.

So, sleep is restorative and if we get it wrong it is harmful.

When I was doing my O-levels I decided to experiment by taking a tape of my history stuff and leave it running while I was asleep and I got really good marks for history!

Sadly sleep learning has never been proved to work

Normal Sleep

There are three stages:

Rapid Eye Movement Sleep, usually called Dream Sleep, is when you do almost all what you think about as dreaming. But actually you can dream in any sleep state.

Light sleep, when you are easily disturbed and woken.

Deep Sleep, which is physically restorative. It is difficult to wake someone in this state; if you are woken that's when you feel groggy and it takes you a while to get going.

Transition from awake to light sleep to deep sleep at the beginning of the night, then to dream sleep and transition back to light sleep after we have been asleep for about an hour at the end of that time, constitutes one sleep cycle. Sleep cycles average out at about four to six per night with lots of natural variation in length between 70 minutes and 110 minutes with an average of about 90.

As you go through the night the proportion of sleep changes: you get most REM sleep at the beginning and most deep sleep at the end of the night. We all wake up briefly at the end of each sleep cycle; it's probably an evolutionary protection: we wake up just enough to make sure that we are still safe and secure, and if we are we go back to sleep and don't remember that we have been awake. We do that multiple times throughout the night.

From a paediatrician's perspective: most kids will have got most of their sleep out of the way by midnight so by the time you are going to bed they are more likely to be up and interruptive. So the problem for parents whose children wake up in the middle of the night is getting them settled down again to sleep.

This will give you some understanding of the normal but slightly weird things about sleep. Most people have the experience of waking at about five o'clock in the morning and feeling that they are awake and ready to go but the alarm is not due to go for another hour so I'm going back to bed, but when the alarm goes off at six you feel terrible because when you woke at five it was the end of a sleep cycle and but when the alarm goes off you are in a deeper phase. Even if you have had more sleep which is better for you, you feel worse.

Health Professionals and sleep

When I started to do this work it required a lot of pressure to be able to talk to people. I had to pester our medical director to let me have ten minutes out of their induction to talk to our junior doctors. (They have a whole half hour on hand washing and fire procedure!) The conversation over the last five years has got to the point where sleep deprivation has got on the front page of the BMJ, so we are getting there. I am willing to bet you will all be familiar with the feeling that you know that sleep is important and you have so many things that are affecting your sleep it makes you anxious – it is difficult living in the 21st century. This extract from a BMJ editorial is absolutely right:

The subject of sleeplessness is once more under public discussion. The hurry and excitement of modern life is held to be responsible for much of the insomnia of which we hear, and most of the articles and letters are

full of good advice to live more quietly and of platitudes concerning the harmfulness of rush and worry. The pity of it is that so many people are unable to follow this good advice and are obliged to live a life of high tension.

"Modern life" here refers to 1895! - the date of the editorial, and not much has changed.

So one of the challenges about this work is that none of it is new. This is all very basic stuff but trying to persuade people to think about it is difficult despite conclusive evidence that if you are fundamentally sleep deprived then your ability to cope with anything is impaired. That means that it will always contribute to peoples' vulnerability to burnout, but possibly more importantly than that, as daytime stresses and anxieties begin to pile up, as they begin to realise that they are at the point where they are not coping as they would wish, that absolutely affects their sleep. One of the biggest challenges in my clinic is that anxiety is nearly common as asthma in the paediatric population. We spend a lot of time teaching paediatricians to treat and manage asthma but very little on the management of anxiety. Anxiety impacts on sleep. The number of times children end up in my clinic, even young children, when the problem is that they are stressed or worried, is disturbing. I do see kids that are worried that Donald Trump is going to blow them all up, but actually it's usually things at school, for instance if they have fallen out with their friends; or if they are stressed because they think that Mum and Dad aren't getting on as well as they should but are too scared to tell anyone that because they think it will make it real.

So anxiety really affects sleep, and that is something we very much underplay in general terms. And the overlap with burnout becomes much more apparent.

Sleep deprived doctors

I started doing this work five years ago after hearing stories of junior doctors who had crashed getting home after a night shift. This could apply to any professional who works at night. I don't think it is completely avoidable, sadly, but it is certainly something we should be much more aware of and be much more proactive about trying to reduce the risk. In particular, when we ask people to work at night we make them exquisitely vulnerable. Most people working night shifts will have had the experience of driving home feeling unsafe, and about 50% of the people we asked admitted to having a near miss, waking up just as the car was drifting off the road. The danger is that you won't get home safely. Every time that happens you are potentially one of those that don't. That risk is real and prevalent at all levels of shift work, particularly in the NHS.

Data from *The national survey of the effects of fatigue on trainees in anaesthesia in the UK* <https://onlinelibrary.wiley.com/doi/full/10.1111/anae.13965>, looking at the impact of fatigue on anaesthetic registrars as a cohort give a very insightful look at the personal and professional consequences of fatigue and sleep deprivation at every level. This isn't new.

The RCP issued the guide *Working the night shift: preparation, survival and recovery* <https://www.researchgate.net/publication/7257474> *Working the night shift Preparation survival and recovery A guide for junior doctors*

about 12 years ago looking at this issue with great recommendations but these just vanished. The College of nursing did something similar. These are all high level efforts to do something about this problem but most of them vanish without trace because they don't translate into making differences on the ground.

So that is what I am trying to do: boil all this down to simple principles and start to think about practical things that will make a difference.

Hopefully you all got a good night's sleep last night. Could you do with an hour more? One of the challenges about this is that I'm usually pretty confident that regardless of the kind of audience I am talking to it includes people who are sleep deprived. We know that when we look at the data from adults in Western cultures in general, we see that most adults are probably missing about an hour of sleep per night. The amount of sleep you need is individual but the median is between seven and eight hours. You may think if you only have six to seven hours you will be fine - you'll just get more caffeine, you might be a bit grumpy but it's not a problem and you have more important things to worry about. But think about it: if you miss an hour's sleep every night you are missing the equivalent of an entire night's sleep every week. And I promise you that is going to have consequences. So my first challenge in trying to prove this is that I'm dealing with a population of people who are sleep deprived already, before I start thinking about them as health care practitioners working in a system that is going to make things worse. Shakespeare as ever has a nice way of saying it: if you are deprived of sleep you lack 'the season of all natures'.

Emil Kraepelin was one of the first psychiatrists to begin to think about the impact of sleep and fatigue and he gets it absolutely right: sleep is the most fundamental thing that underlies that. No matter who you are, if you don't get the right amount of sleep you are not going to function as well as you should.

What is more important than sleeping?

So why is this such a challenge? People will list such things more important than sleep as spending more time with their partner or family, work, watching TV and exercise, and there are studies showing how people in different countries rank the importance of these differently.

It is useful to examine why people prioritise things over sleep. In the context of burnout. After all, it does seem to make sense. If you are stressed at work you want to spend time with your family or partner. Work is often very strongly prioritised; people have a sense of guilt which compels them to keep going doing more and more when they should be sleeping.

Socialising with friends, doing exercise - these are all very positive things and very sensible reasons why we don't prioritise sleep. Watching TV is a problem; the CEO of a major TV company was interviewed last year and asked what his biggest competitor was and he said sleep! He sees it as something to prey on. His company makes money by persuading people to pay money to watch their programmes. They don't want people to sleep. He's now my number one enemy!

The role of light.

Light is what wires your brain; it keeps you awake in the daytime and sets your body clock and helps you to sleep at night. On a day like today, getting as much natural light as you can helps to keep your brain in training for good quality sleep. One of the most important things is getting exposure to good quality light in the daytime. When

we evolved, all we had was daylight and fire, so our body clocks evolved to be alert in the daytime and asleep in the night. We then got smart and invented electric light so we could have full light round the clock. The difficulty with that is that your brain doesn't understand that that night is not what it is meant to be. It thinks it is daylight and the body clock is confused. House officers are required to prescribe oxygen on the drug chart because oxygen, like a medicine, has side effects and we need to think about it and take responsibility for it. We should probably be thinking about light in the same way. Every time you are exposed to light at a time when the brain doesn't expect it to be it is the equivalent of giving your brain a drug which is telling it that it should be awake and alert.

As well as suppressing melatonin, disrupted sleep patterns also reset your body clock. It's the same when you go on holiday: you get over jetlag as your brain rewires, and if you are exposing yourself to bright light out of the normal time your brain expects it to, you rewire your body clock. If you work or study for till the small hours for two or three nights in a row and then decide you really must be sensible and go to bed at ten o'clock, your brain says 'it's 5 o'clock where I am' and you don't go to sleep at 5 o'clock, you can't get to sleep and it becomes a problem that feeds on itself.

This absolutely obliges us to be thinking about light sources round about us. Smart phones are only ten years old but now they are endemic everywhere. It's a normal experience to finish our day with one of these devices in close proximity. That does a number of things: it suppresses melatonin which is a natural hormone which helps us go to sleep. It re-wires your body clock, and no matter what you are doing or what device you are using it all seems to have the same effect. Blue light is the part of the spectrum we are most sensitive to which means the phone companies are being quite clever by using this. Intensity is more important than frequency so it's probably more OK to use them if you turn your brightness down.

These devices are designed, like Netflix, to prey on kids. Some with high functioning autism talk to us about a 'YouTube black hole': you start doing something at 10 o'clock and suddenly it's 3 o'clock and you have an in depth knowledge of the history of Launde Abbey but you haven't got to sleep.

If you look at the data - as a paediatrician most of what I have tend to be about children, but there is no reason to believe they don't apply to adults - just having a mobile in the bedroom reduces the chance that they will get the right amount of sleep by a significant amount. Of US teenagers who have a phone in their bedroom about 50% will re-interact with that device before morning, often without remembering, and that brief pulse of light affects their sleep quality.

Driving and sleep Deprivation

Most people are not drunk if they have consumed two glasses of wine. But the whole point about the drink driving legislation - most people observe this as they think they will be in trouble if they get caught - is that the evidence tells us that even a small amount of alcohol impairs you so that the risk of having an RTA rises significantly. When I grew up in the 70's it was believed that as long as you weren't paralytic you could drive, but we have shifted that so now it is simply: don't drink and drive. That is why we have changed the law. *But if you are functionally awake for between 16 and 18 hours your reaction time is impaired to the same degree as if you were at the legal drive limit for alcohol.* It varies from person to person but also from country to country, but the fundamental point is true. And that assumes that you have had the right amount of good quality sleep in the days and nights prior to that. If you are on morning four after three night shifts you haven't had nearly enough and that impact is exponential. But people don't hesitate to get behind the wheel when they are tired in the same way that they wouldn't after even a small amount of alcohol. Making the

point that driving tired is like driving drunk underlines the simple basic points that I am trying to get across

The BBC video Driving Tired (<https://tinyurl.com/DrivingTired>) about junior doctors driving home after a night shift vividly illustrates my thesis. It includes harrowing accounts of accidents, one fatal, and a sequence of a doctor in a driving simulator after an intensive care night shift; she gets home but has an increasing number of micro-sleeps including one of more than five seconds, and strays from her motorway lane many times. Every single micro-sleep you have on a motorway is a potential for death - it's terrifying but it's normal.

Have you been jet-lagged? It's unpleasant and most people with jet-lag feel out of synch. As well as feeling you should be asleep when you are awake and vice versa you feel slow and sluggish, you feel irritable, nauseous, achy. On average most people flying from Sidney will take four or five days to recover. It's very individual: some people don't suffer at all (there are physiological reasons for that) and some are still suffering after three weeks. You wouldn't get someone straight off the plane at Heath Row and expect them to work at their best in an ITU. But when we ask people to work at night we are asking exactly the same thing. At 3 a.m. every cell in your body is telling you that you should be asleep, but we in the NHS expect you to function to the same standard of care as at any other time. It just isn't physiologically possible. We should acknowledge that and the consequences to ourselves and our patients.

The consequences of sleep deprivation

You are likely to come across the consequences of chronic sleep deprivation and health in your practice when patients who are shift workers have pain problems, and all those things are potentiated. Working at night increases mortality and morbidity. In the same way as these take years to come back to national average after stopping smoking, it takes time after you stop working nights. People who are working when fatigued take more risks. There is a simple experiment involving blowing up a balloon to just before it pops which shows that people take more risks at the end of a shift than the beginning. More importantly, although our judgement is impaired our sense of confidence doesn't change. If you ask someone at the end of a shift if they are safe to drive home they will say "of course I am." Almost every cognitive measure you can think of will be affected. It is said that empathy is affected when you are tired – that seems to be common sense.

It is fundamental to NHS practice that we should be promoting things that make us able to function well but we are putting people in situations where their sense of empathy is physiologically threatened. The GMC looked at this through the junior doctors survey, which also looks at the senior doctors who trained them. They told us that 20% of doctors feel fatigued in the daytime; not just when they are doing night shifts or when they are working around the clock. Every doctor in the service tells us that they are already feeling fatigued to the extent that they think it affects their practice regularly. This is endemic. This is sitting at the heart of the care that we deliver and is fundamentally linked to all these other things that are now going on.

Rest periods

We in the NHS have lost sight of the fact that the reasons why we do things are not always what we think they are. People think that having a break to have a cup of coffee for 10 minutes is a luxury and something that can be sacrificed if the workload is too big. What we have forgotten is that we haven't evolved to function in complex tasks for 12 hours at a time without stopping. We need to be able to rest to maintain

function. Rest and breaks are integral to providing safe, effective and efficient care, but we forget that as the workload gets heavier and heavier. And the bigger the workload the more we think it must take priority over sleep.

Other industries take a very different view. They shut the runway at Gatwick a while ago because there was only one air traffic controller on duty. Air traffic controllers are only allowed to work for two hours before they are required to stop and take a mandatory 30 minute break, because they are not considered capable of maintaining the standard of functioning to be safe for anything less than that. We do not have the luxury of shutting runways in the NHS. If it's not possible for an air traffic controller to function for more than two hours, how is it possible for a doctor in a busy GP surgery or an ITU to maintain function without mandatory rests? Airlines take this very seriously; they don't want crew falling asleep (though it has happened) and there are spaces in big airliners on long haul flights for the crew, and particularly the pilot, to take regular rests and sleep on 12 to 13 hour flights. The airlines aren't doing this to be nice to the crew, they are doing it to maintain safety standards. The US navy who keep crashing ships into one another have realised that the four hour watch system is not conducive to safety. The Highway Code tells you that you should stop and have a break every 50 minutes. Falling asleep while driving is no excuse in law. Gillian Pick, a nurse in the West of Scotland, was convicted of dangerous driving because after working overnight in a very busy respiratory ward, where it was more important to her to look after her patients than take any rest. On the way home she crashed her car. Nobody was hurt, but she ended up in court where the judge said he had nothing but respect for her and her dedication but in the eyes of the law he had no option but to convict her of dangerous driving.

It is quite wrong to suggest that problems arising from systemic issues can ever be the responsibility of individuals to deal with. There was a case of a long distance driver who drove his shift without taking any breaks and crashed and killed somebody. He was prosecuted, convicted of manslaughter, and went to gaol. But they also prosecuted the manager because he had the responsibility to make sure that the driver had had the proper breaks, and he also went to gaol for four years. That principle has never been tested in the NHS, and I keep waiting for that.

What can we do about it?

It's very difficult. My work is fairly non-acute these days and people tell me I don't understand what it's like in GP practices and emergency departments; 'we can't do this'. But actually the message needs to be the other way round. When the pressure is high the need to look after people under pressure is even greater. When colleagues burn out it becomes more difficult for those who remain.

In the children's hospital we have tried to do this by introducing teaching about sleep into induction. I give an hour's lecture which I hope will convince people that we need to turn this around. We focus on individual practice first: how can they get sleep when they have been on night shift when the sun is bright and the room is hot? So we advise them as to how they can optimise their environment to get better quality sleep, and talk about all the things they are doing which are probably bad for sleep. Most importantly, just as they wouldn't turn up to work having had a pint of beer, they need to realise that they have a responsibility not to come sleep deprived. That means not watching Netflix until midnight. We teach them tips and tricks to help get through a night shift. One is, if possible, to take a short power nap during a break which will offset the effects of fatigue. Regarding getting home safely, first of all don't drive. On a sunny day all that light is going to tell your brain: 'wake time!' – so something as simple as wearing sunglasses can help to improve your quality of sleep when you get home. We advise them on rebooting their sleep as quickly as

possible after a spell on night shift. We have done ST1 training in London for the last three years and foundation training for two, and have taught student nurses for two years, and anyone who will listen to me for I don't know how long. Just spending an hour with individual people at induction (which tends to be a box-ticking soul-less exercise) feels different: three quarters of them told us that it made a difference. They told us that they would make changes which they value as something which would help them to cope better. It's not difficult – there's no magic to it.



EDUCATION & PRACTICE

Fifteen-minute consultation on managing the effects of shift work on your health

Michael Farquhar

“You're not healthy unless your sleep is healthy”
Professor William Dement, Stanford University, one of the founders of modern sleep medicine

<https://tinyurl.com/ShiftworkTips>



The impact on burnout is very real. If you are already vulnerable in other ways; if you are chronically fatigued by working in a system under mounting pressure, your ability to cope with that becomes less. As you become stressed and approach burnout it will further affect your sleep which makes things even more difficult, so it becomes circular. In recent years there has been an over-emphasis on individual elements of responsibility. There undoubtedly are such elements but if we tell people that the responsibility is all theirs: be more resilient, cope better no matter how awful it is then we are sending the wrong message. I very much agree with Margaret McCartney when she says that if we don't care for NHS staff we are not caring for our patients. We have to think about systemic stuff at least as much as individual responsibility. Although there may be overemphasis on resilience, it doesn't mean that it is useless. Teaching about sleep and shift-work includes resilience teaching: how to cope better with a job that puts people at extremes of emotional experience. But it can't be the whole solution; it's only ever part. As you become affected by mental health issues or stress we see peoples' sleep becoming very disrupted and the vicious circle where everything goes wrong about sleep feeds in upon itself. Insomnia is a very positive feed-back process. It can be very difficult to address that; as you know cognitive behavioural therapists are very much into that, but equally it needs the person to be supported if they are living in an environment that is causing lots of difficulties. That very much ties in with initiatives such as the Practitioners' Health Programme which is there to support people when they feel they can't stick their hand up and say "I'm a doctor who feels depressed or stressed, and I'm turning to things I shouldn't to help me through this".

But the flip side of all this is that we have to make those systemic changes. That means changing the culture of the NHS. That is really difficult. The NHS is very resistant to change when it thinks it knows how to do things. We know that when we ask people to focus on the idea of power naps they tell me things like (in one

hospital) 'if I am caught sleeping my picture will be taken by a porter and sent to ...'

The culture in the NHS about sleep is completely wrong. We have done a lot of work in our hospital about power naps; I talk a lot to people at every level in many departments and have reached the dizzying heights of 48%, so I'm moving in the right direction. We presented this work to our College and suggested that this is something we should be doing in every paediatric department up and down the country. The Guy's and St Thomas's Trust regards itself as one of the best trusts in the country and we are very committed to trying to keep that position. I took this data to our trust management expecting a battle but actually one of the nice things about Guy's and St Thomas's is that they are often quite supportive of this sort of thing. We instituted a campaign for the whole hospital that emphasised the simple importance of taking a break, without which you are not providing good care. It hasn't transformed the hospital in this way but we have done a lot of work to improve attitudes.

Language really matters. Something as psychologically simple as taking a linen cupboard into the registrars' mess tells them that we expect them to get some sleep at night. Regardless of whether they get this regularly the fact that the Trust is enforcing that idea can be just as supportive in some ways as the reality.

The attitude that pilots should be superheroes was a massive problem in 50's 60's and 70's among the ones who graduated during the War; as long as nobody was dead and nothing was on fire it was a successful flight. It's only in the last 20 years that the airline industry has changed their attitude to health and safety. We spend a lot of time telling people in health care that they are superheroes and that they are amazing to work round the clock. The phrase "With great power comes great responsibility": was originally coined by Voltaire but has since been attributed to Spiderman; one of the things that moral comics emphasised in the 60's was that their heroes were human with human flaws and human problems, like Spiderman not coping with these but still having to be a superhero. It is important to think about pressure and how we manage it and we need to have that conversation with ourselves: *you are not superhuman*. Congratulating doctors and nurses on managing pressure without rest reinforces the message and holds people to an unattainable standard.

The new NHS contract has some provisions about this which helps to prevent it. The most important thing is that it links patient safety to working hours and rest, and recognizes that if junior doctors working this contract don't get breaks and rest they are not providing safe care. This should apply to everybody working at every level in the health service. The new contract is much more specific about the length and frequency of breaks. It puts a legal responsibility on trusts to do something about someone who says they are too tired to drive home after a shift. Trusts have a responsibility to every member of staff, not just junior doctors who are legally protected by the contract. There are mechanisms that allow us to raise these as points to get this across but getting junior doctors to engage with them is often challenging.

I do a lot of work with other organisations, including the anaesthetists (one of the doctors who died was an anaesthetist) They take this very much to heart and are doing a huge amount of work with fitting in resources around this, ranking departments around facilities and culture, and have very much taken on board the realisation that we have to change the culture. Other frontline specialities like emergency medicine have taken on the message that we must look after ourselves.

Conclusion

The loss of the US space shuttle Challenger which exploded in 1986 with the loss of the crew of seven was attributed to failure of O rings in a joint on one of the boosters possibly aggravated by the intense cold, but the enquiry revealed that there was a lot more going on. In the 80's NASA was staffed by believers: everybody believed in the mission, that they were doing the right thing for the right reasons, and that the mission was more important than them as individuals. It was also driven by targets: they had to beat the Russians; they had to be seen to be better. This meant that corners were cut and warning signs ignored, and critical decisions were taken by people who were fatigued. The decision to launch was taken by people who had been awake for well over 24 hours. They made the wrong decision and the shuttle was lost. Every single shuttle launch prior to Challenger carried the same risk. In the NHS we send shuttles up every day. The risk factors and warning signs are all there but we are in a culture driven by targets and staffed by people who believe that they are superhuman. We think we should be able to meet these challenges and that we are personally failing because we have been told that to admit that we cannot cope is a sign of weakness. That gets reinforced at every level, and the longer we believe it the worse is the problem going to get. Burnout is the symptom of years and years of a widening mismatch between resources and pressure as all of these cultural factors become manifest.

So what is my plan? It's very simple: to work with anyone who will listen to me, to encourage every department in every hospital and every healthcare setting to talk about this and think about rest and breaks, and to ask: "Are you in a culture where somebody says 'Do you know what, I know you are very busy, but no-one is going to die if I stop for a break and I will actually give better care to my patients if I do that'".

Postscript

Thinking about language, I was teaching sixth-formers at the weekend and trying to persuade them that the English language is as important for future doctors as chemistry. This poem is by Don Patterson ; one of his kids was born pretty sick and this is a beautiful description of what my job used to be like in this type of medicine.

Jamie made his landing in the world
 so hard he ploughed straight back into the earth.
 They caught him by the thread of his won breath
 and pulled him up. They don't know how it held.
 And so today I thank what higher will
 brought us here, to you and me and Russ,
 the great twin-engined swaying of us
 roaring down the back of Kirrie Hill

and your two-year-old lungs somehow out-revving
 every engine in the universe
All that trouble just to turn up dead
 was all I thought that long week. Now the thread
 is holding all of us: look at our tiny house,
 son, the white dot of your mother waving.

Discussion

Sleep is a big issue for junior doctors. I have heard from one that their hospital is withdrawing facilities for sleeping.

We should be providing facilities for power naps. At the children's hospital we have reclining chairs in the seminar room.

There are always answers: I hate getting messages asking what am I going to do to make things better for them so I say: *you* need to engage with this and work it out. These are clinical problems and you are clinical problem solvers. I can't tell you the solutions for your hospital but I promise you there is one and you have to find it. I can help you but I can't do it for you.

The two things that are missing from most modern hospitals are facilities for staff rests and breaks and things like doctors' messes, nurses areas and sleeping facilities, and the other huge loss is that of communal lecture theatres. We struggle to find a room to get the majority of the hospital staff into. Without that you lose a lot of the sense of community that I think drives good practice, and this is one of the multiple factors that drives burnout.

Top of the list of things we could do without is the executive suite. We have a fantastic boardroom – it's very quiet and would make an ideal place to sleep.

I was running a session on sleep in my programme and we were talking about the need to feel safe to allow you to sleep. One of the ladies participating came back and said that she had discovered a way to feel safe. She had been abused a lot but had resolved her sleeping problem by going back to her childhood. She had been brought up in India and always went to sleep to the sound of the air-conditioning. So she bought a unit and always had that on ...

There are two things about that. One applies to on-call physicians: even if you are at home and the phone doesn't go off at all and you don't get woken up, your sleep quality is always going to be less good and you are going to be more fatigued the next day because you have a sense of heightened anxiety. So being able to feel safe for sleep is really important. There was some interesting data produced at an international paediatric conference recently where they looked at teenagers who were in the looked-after care system. They asked them to draw images of their sleeping spaces and compared them with a control group who were in their natural families. Generally, the kids in the system, however well cared for and supported they were in the daytime, drew pictures of themselves in bed at night awake, or as very small, or used monochromatic colours; they just looked less safe, whereas the children in natural families where they felt safe and secure drew lovely multicoloured pictures ... it was really telling how obvious the difference was.

A problem for a lot of clinicians is that their working environment, its culture, doesn't feel safe ...

Kids waking up at night is often to do with that. Many children when they are younger fall asleep lying next to a parent or sucking a dummy, and that becomes part of their safe environment for sleep. That's great but if they wake up at three o'clock in the morning and Mummy and Daddy are no longer there and the dummy has fallen out

they lose all those cues that tell them they are safe and this triggers their brain to think it should be awake, and suddenly you have a fully awake child

I was struck by the shift working that we now put junior doctors through, compared with when I was a junior and the 'shift' started on Friday morning and finished on Monday evening. But I think theirs is harder because it's erratic. They have these ridiculous shifts, 12 hours from eight to eight, then they have to come on at six the following morning, and then one that finishes at 1 a.m. I think we managed to get some downtime for microsleeps, but they don't.

There is a lot of truth in that but I would challenge anyone who could claim that anybody could have worked the continuous shift pattern without showing impairment, and as you all know the intensity of the system has increased almost exponentially. If we were to try to go back to that system now everybody would break – it's just not possible. There are physiological considerations that should be taken into account.. Most peoples' body clocks move forwards and not backward which is why you get more jet lag travelling from West to East as you are going with your body clock one way and against it the other. There is no perfect rota design, but rotas should as far as possible be designed so you start with a day shift and roll onwards to an evening shift and to a night shift. One of the challenges is not just the length of time spent on nights but the number of changes. I was someone who could adjust their body clock so if I worked seven nights in a row I was better. If you can't do that seven nights in a row was hell, so we settled into a three/four night split which is the least worst option for the greatest number of people. But the trouble with it is that it automatically doubles the number of transitions between trying to be a day person and a night person. We are trying to help people to cope with this.

The other problem for junior doctors now is that they have much less support. We were in a team and now they are often strung out on their own.

It is multifactorial. Families have told me stories which are very powerful in getting a message across. I very deliberately steer away from cases of professionals who have committed suicide; there is a definite link between these and sleep problems but I deliberately don't make that connection with the work I do because I think it draws its focus the wrong way. But in the context of that wider question of the risk factors for burnout and why young doctors and nurses are killing themselves, this is definitely something that makes them more vulnerable. For an insecure teenager, your risk factor for suicide increases by 50% for every hour that you are sleep deprived.

They should be encouraged to talk about it more. [as a psychotherapist] I see a lot of doctors and they think that everyone else is coping. It needs to be shared.

One of the first steps in meeting that challenge is role modelling from a senior level. Juniors think that they can't take a break because the consultant never does; he tells them that they should take a break but he is role modelling the exact opposite.

We have had a lot of success with the implementation of Schwartz rounds. These can give that space where people can share experiences. The only problem with them that they may be a bit preaching to the converted: the people that attend them are the people already likely to be able to have those conversations. They have to be saying that this is something we should all be talking about.

That was an excellent lecture and I think it should be put on a DVD and sent out to every trust to use in the induction

I had an interesting head to head debate in the BMJ last year with an eminent professor of surgery in the American system. The Americans having experimented with regulating that their interns shouldn't work more than twenty-four hours at a stretch have decided that this caused more patient safety incidents because they are so bad at handover, so they have gone back to interns working 28 hours; they don't seem to realise that the handover is probably so bad because they are sleep deprived! The American system is just awful.

[partly inaudible] There is this competitive culture in the USA ... they are coming in earlier ... we have seen that in our own ... so big now people who are not fit to drive having an hour or two's drive home from a shift ... culture ...

It's about fundamentally changing that message to say sleep is not a luxury. This is the culture change we need at every level that sleep is essential

The ultimate difficulty is that we do not have enough doctors and nurses in the UK We need more staff to be able to do things safely. We don't have the power to be able to change that so we have to try to make improvements with what we have. There are meaningful interventions that can be made. The NHS published eight ways to improve things and one of them was to make water coolers available for members of staff so they can be rehydrated on duty. A perfectly sensible suggestion but cynics responded "so the solution to an understaffed NHS is a water cooler!"

I brought this subject up with the GMC last week and they made some comment about doctors having a moral and ethical duty to work, and I said you have a moral and ethical duty to protect doctors. But until we get doctors and nurses to stop being superheroes and to walk out and to say I can't cope the situation will be perpetuated as there is no other solution. What you are doing is fantastic but doctors have a moral and ethical duty to walk out and go to bed. I don't want to be operated on by a tired surgeon.

Another thing: most of the stuff that happens during the night doesn't actually have to happen at night in most specialties, most things, especially in general practice, can wait till the morning.

A lot of that will come from the other side. When we are doing work to try to improve patient sleep in hospitals one of the first principles is to minimize interruptions .

Until the law changes and says that no doctor should work more than X hours ...

This is why I really want somebody to be brave enough ... I have tried with the MPS and the MDU ... that case law is there. Managers of haulage companies have been prosecuted when their drivers have killed people because they haven't had a break, but we have never done it.

It's naïve to think that junior doctors will be putting in reports of such problems because they are worried about upsetting their careers

They have Stockholm syndrome. They are so brainwashed by the system to believe that this is normal they can't get their heads round the fact that they should be standing up and saying I have a duty not to do anything not to harm my patients and this is harming them. I have an obligation to look after myself to be able to look after my patients and that is recognised at a global level.

The trouble is too that in every kind of business this is happening.

Yes, but again in terms of trying to change the culture: in her book *The business of sleep* psychologist Vicki Culpin makes the point that a business makes more money if they get this right. Sleep deprivation costs us something like 2% of GDP a year. And companies like Google and Amazon are thinking about ways to make this better. And the evidence is that everything gets better. For us in healthcare, there is that financial bottom line that people need to hear, but fundamentally you don't want to be looked after in the small hours by someone who is fatigued and sleep deprived. We put up posters encouraging patients to complain if staff are seen failing to wash their hands, but we also need to be able to say "we appreciate that you have been waiting in A&E for four hours, but do you want the tired team to look after you or the team that have had a 20 minute break?"

My 80 year old father was admitted in the night (in Norway) with appendicitis and had to wait several hours for surgery. The surgeon came and told him he had just had a good break and a nice sleep so he would be in good shape to operate.

The system makes people feel that they are being forced into things; lots of people are being forced into non-training jobs to give flexibility. We have had four times as many paediatric trainees dropping out in London than ever before and it is all because they feel stressed and burnt out.

It's not so much the stress as the public's attitude towards them. Paediatrics is a dangerous profession to work in ...

... but from a practical point of view, if you've got a rota that is meant to have nine people on it and has seven they are more at risk of burnout because they are doing two extra doctors' work and if one more leaves ... it escalates and it's not going to get any easier until the magic money ...

... we don't value our time unless we are busy in it ...

It's not the problem for the doctors working six people instead of nine, it's not their issue, it's someone else's job to deal with that ...

People struggle with the 'exception reporting' idea which is meant to say that if you don't get the standards of your contract you fill in a report to say that that has happened, and there is a senior trust clinical management person whose job is to do something about it. If every single junior doctor in England filled in an exception report every single time that the contract tells them they should, the only possible conclusion would be that we are not staffed to provide care to the standard of that contract. But because they feel pressured they just don't. What then happens is that the senior clinicians say there isn't a problem. So using the legislation that we have is really important.

About these breaks when you are supposed to get a sleep: isn't it better to wake up after half an hour than an hour when you have gone into deep sleep?

15 to 20 minutes is recommended – you need some means of waking yourself up. Longer than that you do get into deep sleep. Some people say they can't do this quickly. What I advocate for those people is even if they are not going to sleep they should discipline themselves to go into a dark quiet room for 15 to 20 minutes and relax – if they can't go to sleep not to worry about it.

How many people can nap? – I've never been able to.

It is a learnable skill. I am also a person who can't nap on night shift but I was quite good at getting those moments of stillness. One thing I tell people is to take away the anxiety from it so if you say I can't nap I say that's fine, all you need is complete rest for 20 minutes. Some people find that if they do that they start actually falling asleep.

The art is not trying.

I sleep much better in England than I ever do at home in Australia ...

When I am working with people [with sleep problems} a lot of the time it's about identifying a whole lot of things that are contributing. In my clinic anxiety is often a hidden factor for kids

1 <https://onlinelibrary.wiley.com/doi/full/10.1111/anae.13965>

<https://www.aagbi.org/news/trainee-doctors-risking-lives-car-accidents-after-night-shifts-survey-reveals>

<https://shop.rcplondon.ac.uk/products/working-the-night-shift-preparation-survival-and-recovery?variant=6334287429>

Mindfulness for Burnout

Sangram Patil

Mindfulness is quite a fashion in pain medicine for helping people to deal with the sensation of pain, but we are talking about burnout today and I want to show how what has been described in ancient texts is one way of addressing this problem.

My talk is divided into three parts: first the basics of the technique as taught by the Buddha 2600 years ago. Then we shall have a 10 minute practice of Vipassana meditation, and third, the application of mindfulness to modern medical practice.

Ancient literature

Soon after the Buddha died 300 enlightened monks got together as a council to record the teachings of the Buddha during his 40 year lifespan, and this material was compiled into three big baskets of written material, called the Pitakas. There were five more councils called by different kings and religious bodies. The first in India, just before the birth of Christ, the second in Sri Lanka, around His time, and the fifth and sixth in Myanmar. Four thousand senior monks were invited from different countries to ensure that all the 500 versions of the Pitakas which were in use were exactly the same. So the literature is quite authentic and we can believe that the descriptions of the techniques and the discourses are as pure today as they were originally

The flow of life – the union of mental and material flow

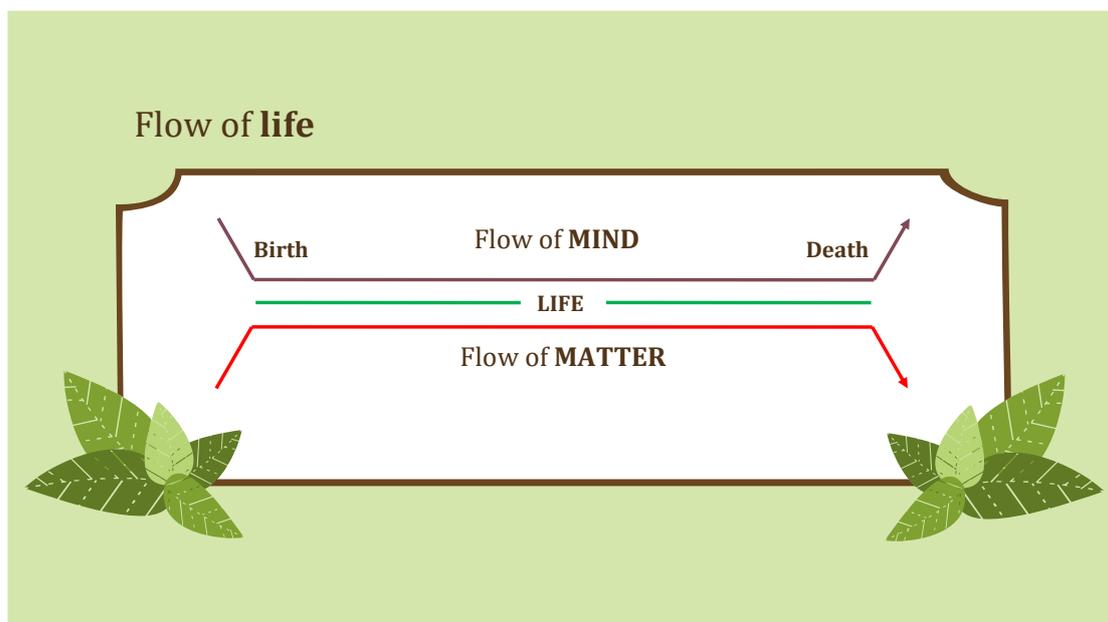


Fig 1

When a mother conceives the mental flow enters matter as life starts. They stay together and keep interacting throughout every moment of life. The interaction is very fast; Buddha described it as occurring a trillion times in the blink of an eye. When mental flow separates from matter life ends. The union of mind and matter used to be

called Yoga; nowadays we associate this with exercises but this is its original meaning.

We know that matter - the body – is composed of different things and we know almost everything about its constitution: its anatomy and histology down to the molecular and submolecular level. The mind is made of four parts called in Pali (the language of India in the time of Buddha) Vinyana, which translates as consciousness, Sanya or recognition, Vedana or sensations and Sankhara (in Sanskrit Karma) which means the reaction and motivation of the mind. These four parts play a role in every moment of every day. The human body, like any life form, interacts with both its external and internal environment through six sense doors:

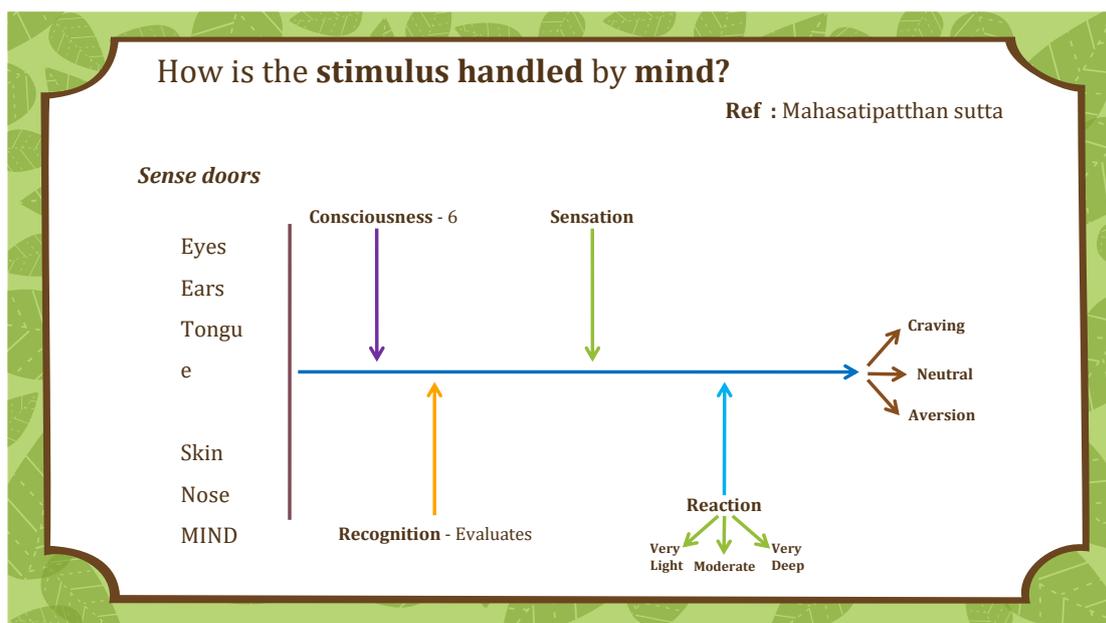


Fig 2

The five senses we know about but the sixth is mind itself which responds in the form of thoughts: the thought processes and its internal stimulus.

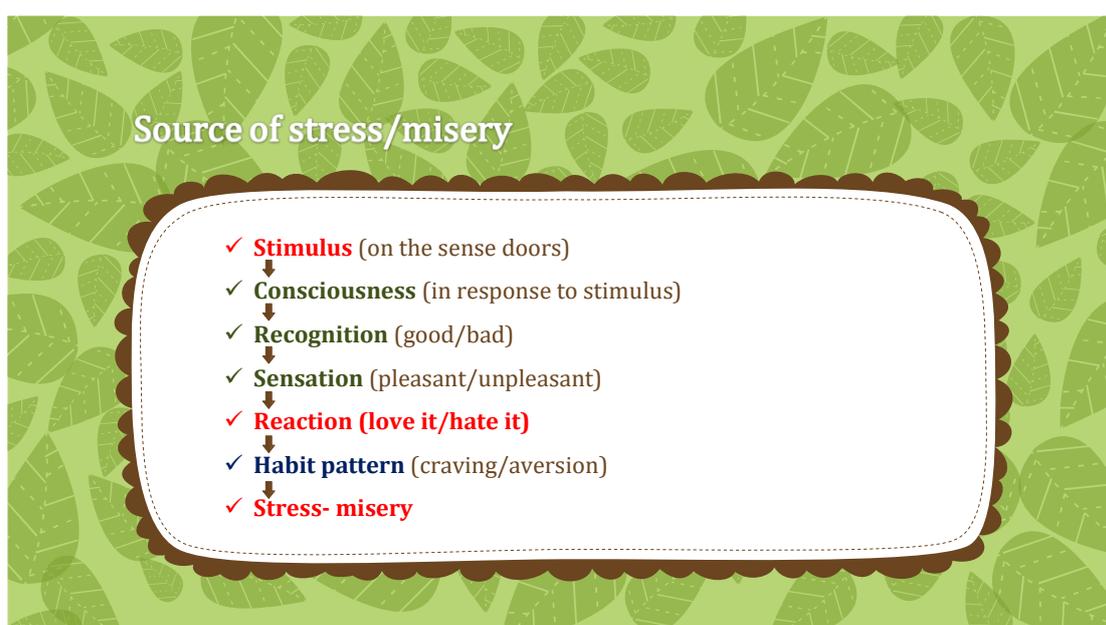


Fig 3

As soon as a stimulus arrives through any sense door, it is first perceived in consciousness: the mind knows something has arisen. Just as there are six doors, so there are six different parts of the mind or types of consciousness. So at the same time the second part of the mind starts to recognise the stimulus: so it's a sound? – OK, what kind of sound? – praise (good) or criticism (bad). The third part of the mind produces sensations all over the body corresponding to the judgement given by the second part; if someone says “Sangram, you're wonderful” these are very pleasant; if I am criticised they are hot, tingling and unpleasant. So the fourth part is my reaction: if the stimulus is pleasant I think ‘this is lovely - I want this sensation’. And that is the beginning of craving. If it is unpleasant it gives rise to aversion. Depending on the intensity of reaction this could be very mild: if someone enters the room quietly my mind won't bother with it and there will be no serial reaction. If someone slams the door and creates a disturbance there might be a moderate reaction. But if someone stops me talking I will be very annoyed and the reaction will go deep inside my mind.

Let's now see how these reactions affect the mind and create habit patterns. In the Buddha's discourses, of which the most important is considered to be the Mahasatipatthan Sutta, he said that these reactions are the cause of misery and suffering. Indeed he said the reactions: craving, aversion and hating, *are* the suffering.

Stress and defilement

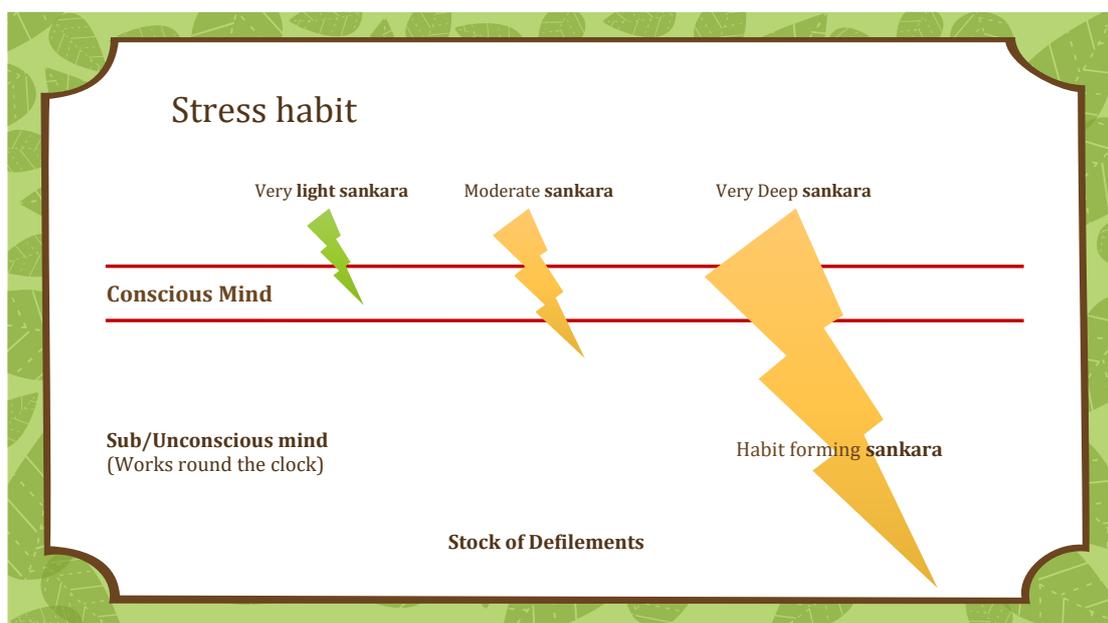


Fig 4

The habit of stress formation can also be called defilement. Believe me, we all of us have a massive stock of defilements inside our minds, which is why we react negatively by getting angry, frustrated, anxious or depressed.

The conscious mind is only active when we are awake. But the unconscious mind never sleeps. It enters the matter at the time of conception and leaves at the moment of death. It is even awake under deep anaesthesia. In yesterday's talk about sleep was described as an active process, and there is no doubt about this. The subconscious mind is still reacting to stimuli. If the room is cold we will pull over the blanket but we won't remember this in the morning. In India we will be slapping

mosquitoes in the night and find red spots in the morning but we don't remember the bites.

Very light reactions (Sankhara) don't have much affect, but if they happen again and again repeatedly they can give rise to defilements. Moderate Sankhara will penetrate to a certain level, but deep reactions have more serious and long lasting consequences. We ask our patients if they had any adverse childhood experiences or traumata which may have given rise to deep reactions as these can last for a long time. Nature doesn't behave in a compassionate way to a child who has been abused or lost his mum. If they have reacted deeply their habits are formed, and those will come up on the surface again and again in similar situations and keep harming them and produce similar reactions. That is how the stuff of defilements gets added to and added to at every moment even in sleep.

Dealing with mind

How do we deal with this habit-forming nature? The simplest is distraction: listening to or playing music, reading, walking, watching TV. This does help temporarily, but is obviously not helping to get rid of that habit-forming reaction; the subconscious mind is still working. Suppression: ignoring or trying to suppress emotions with smoking, alcohol or antidepressants can create psychological problems such as anxiety, psychosis and schizophrenia. As we have seen, reactions give rise to more and more deep habit patterns which surface in the future and give rise to more anger, anxiety and depression.

The best way of dealing with this is very simple: just face the truth but don't react. The ancient literature tells us that if something negative happens: anger, passion, anxiety, depression, or frustration, to accept that you are angry or frustrated and observe abstract emotion. This may be difficult. You know the story of the blind men who are asked to describe an elephant from what they feel: one says the leg is the trunk of a tree, another says the tail is a rope etc. Similarly when you are looking at abstract anger, the apparent truth is very different from actual, internal, reality. So the Buddha wants us to look at actual truth rather than abstract feeling. From Earth the moon looks very beautiful (the theme of many Bollywood songs) but we know that in reality it has a bleak landscape of mountains and craters.

A seminal Buddhist doctrine can be translated as:

Every mental phenomenon is always accompanied by corresponding sensations on the body, and change in the quality of the breath.
Observe the breath and body sensations 'as they are'.

These things happen with every mental process. Even memorizing a name ... if I just say my son's name in my mind, this comes with a sensation in my body, and affects the quality of my breath. Observing sensations as they are, not manipulated, is the best if not the only way to go to the roots of the interactions between mind and matter.

Changing the pattern

To return to the flow chart in Fig 3: if we want to stop these reactions the first possibility is to avoid getting exposed to stimuli. We feel refreshed after sleep because we have stopped external stimuli. But it's not possible to stop stimuli for ever; not even for monks who have to rely on the outside world for food and clothes. We can minimize stimuli, for instance by taking no notice of politics or avoiding

unpleasant situations, but that is not always possible, and we can't stop consciousness responding. We have no control over recognition or sensation. But we can control how we react, and this is where the role of mindfulness comes in.

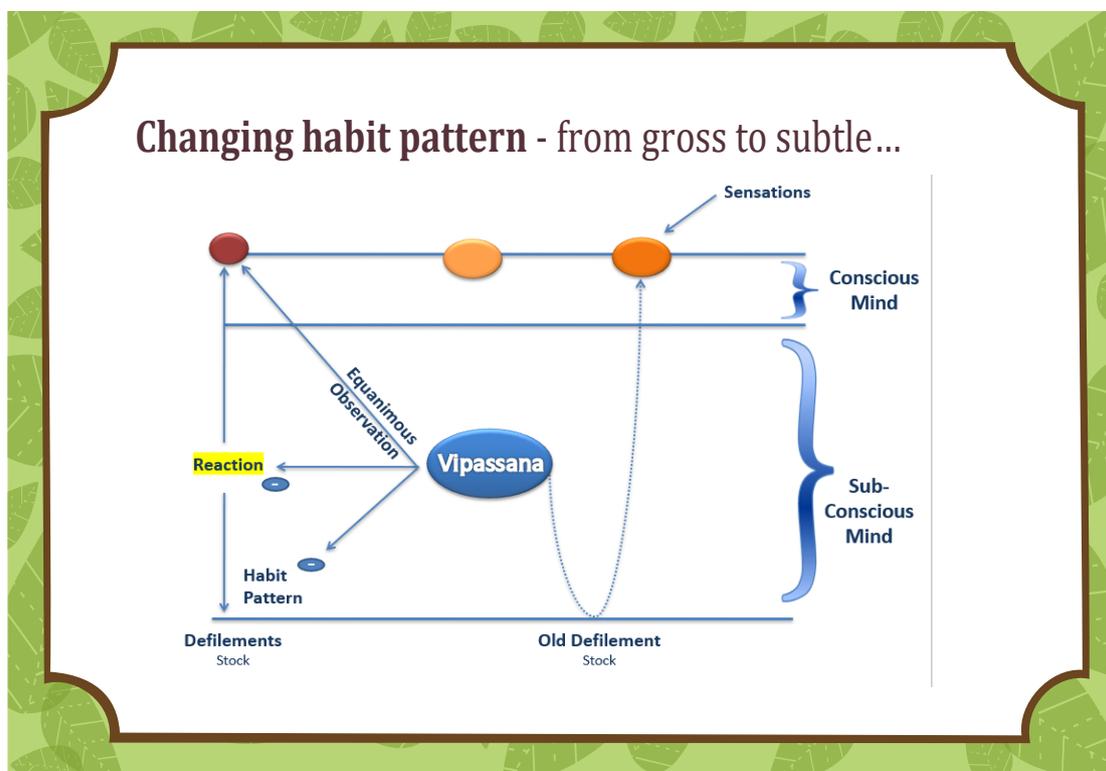


fig 5

The technique is called Vipassana in Pali which means looking at things as they are, and learning their true nature. Usually our conscious mind will react to every situation and produce defilements, as on the left side of the diagram. But if one starts observing sensations and stops the reaction, there will be no habit development, and no addition to defilements. That non-reactive state of mind brings peace, freedom from stress and happiness.

As one practices meditation and the mind becomes more and more balanced, old defilements, old habits, old Sankharas may come up to the surface of the mind and manifested in the body in the form of sensations. So while someone is meditating they will get more and more bodily sensations. We can observe this with a 'body scan' from head to toe and toe to head, and that helps to develop the habit of restoring the balance of the mind in any situation, and with any kind of sensation.

When an old defilement comes to the surface and is observed by the mind it gets eradicated; the mind feels light. As each pleasant sensation come you observe it and it goes away, and the mind becomes lighter and lighter until one day no new defilements are generated, and this is liberation and enlightenment; and one becomes Buddha.

You have been talking mainly about bad reactions but what about reacting to good stimuli – a beautiful day ...?

That's a very logical question. If something good happens you should enjoy it but be aware that it is not permanent. Don't get too excited as this creates cravings and when the good stimulus goes away you will feel unhappy.

It's similar to Christian meditation, as practiced by the monks in ancient monasteries. You push thoughts away using a sacred word to try to seek that complete silence.

Are we interested in pursuing this? – getting better in this life? Most of us aren't. We don't want to be Buddha. We want to live a normal life. But we want to find some freedom from stress and to help our patients manage their pain.

Vipassana proceeds in three steps. The first is to get this wandering mind under control. This is called Anapansati, a concept that existed even before Buddha. It entails *observing* the incoming and outgoing breath: the actual, natural breath, not the 'manipulated' breath, not faster, deeper or slower. The second step is Samadhi. Buddha said that every person who aspires to enlightenment has to pass through this stage of concentration of mind.

[The audience were then invited to participate in a ten-minute practice of Samadhi accompanied by a recording of the voice of a Buddhist teacher. This mainly featured repeated reminders to concentrate on the area at the entrance the nostrils

A few rules were suggested:

- Sit for the whole 10 minutes (challenge your mind!)
- Keep your eyes closed – you won't need glasses
- Stay still and stay relaxed
- Try to remain focussed as much as you can

After ten minutes ...]

I almost dozed off!

It's natural to fall asleep. It's wonderful for people who have sleeping problems.

It went very quickly

The act of focusing on the breath: it's difficult to observe it without changing it – and the internal dialogue provoked by having to think of left nostril and right nostril ... just a minute - which is which! ...

You're having a conversation with yourself which the instruction interrupts ...

Yes: the tendency now is to minimize instruction and leave you to do it on your own and to introspect

This ten minute practice is just the kindergarten. If you go on a 10 day course with this teacher he starts with an hour

There is a lot in common between this and other meditative traditions

Why the nostrils? Why not the eyes or mouth?

If you have any mental phenomena or disturbance of your mental flow it disturbs your physical flow as well in two ways: one is that you lose the naturality of your breath and the other is that you get vibrations all over your body. You can't go

directly to the vibrations; it's difficult to observe them with the wandering mind. For that you need Samadhi, the concentrated mind, aimed at single point, and this is the best natural way. There are other techniques, like in the morning we say *Om*; it's a wonderful word: it creates awareness of vibrations all over the body. So you don't have to address the wandering mind; you can look at the sensations you recognize. You can relax ... but this is creating a different sensation which we need to observe if we want to know the truth. So you can use whichever technique you find works for you.

I have heard an explanation of using the nose is that smells affect people ...

This sounds very logical, but when learning this technique on the first day you just observe where the breath is going through; the next day you observing how it feels, the third you observe sensations, and the fourth you learn to do a body scan.

Everything which arises in the mind has corresponding sensations in the body. As well as stress, addiction to a substance involves loving the sensations it produces or wanting to prevent the sensation of withdrawal. We say that someone is addicted to alcohol or a drug but the addiction is not to the substance but to the sensations it produces. Sensations are also involved in the effects of fear and anger, anxiety and depression, burnout, psychological and psychiatric illness, conditions labeled as 'psychosomatic' and of course pain. Pain is in itself a sensation and this is the best way of observing the pain, but observing abstract pain without any training in observing the mind is difficult: the patient says it is there today, it was there yesterday ... was there last year ... So it is better to approach this systematically and bring the mind under control, trying to be in a balanced state and then start looking at the sensations. Then if one learns to observe all the mental phenomena associated with chronic pain: anxiety, depression, fear avoidance, catastrophising etc. the mind is in a much better situation to deal with them with mindfulness.

Mindfulness and stress; mindfulness in practice

The Australian National Mental Health Survey of Doctors and Medical Students, October 2013, presented clear evidence that health professionals were more stressed than those of any other professions, with more suicidal tendencies and psychological problems, especially among females. The UK NHS survey in the BMJ, March 2016, of 600 professionals showed the same thing. Our survey of doctors in North Wales in 2017 came the same conclusion.

In the medical literature and practice, mindfulness has been shown to be useful in problems ranging from psoriasis to addiction, various mental illnesses and psychosomatic conditions. It is even offered by high street businesses along with massage and homeopathy.

So why be mindful? The 2010 worldwide study by Killingsworth & Gilbert of 5000 respondents in 83 countries showed that our minds wander 47% of the time, (I should have said from my own experience of trying to control my mind that this is more like 90%.) and this is associated with unhappiness. But mindfulness helps to bring happiness. Brown and Ryan (2003) showed that the capacity to be mindful provides enhanced wellbeing in daily life.

There is some evidence for the benefits of deliberate mind-wandering

There are different techniques which have been shown to be helpful; people should practice whatever benefits them.

They have been shown to increase grey matter by up to 15%

[partly inaudible] ... an interesting study by ? of mindfulness in psychiatric patients comparing two groups of therapists. In one they had been practicing mindfulness for a year before they started teaching it to the patients whereas in the other they just had a quick course ...

That has happened a lot in India; people without proper training starting teaching in their own way.

All the meditation techniques can be grouped under three categories: contemplation, absorption and insight. With contemplation the person recites inspiring passages from scripture: Bible, Quran, Hindu or Buddhist writings which help the conscious mind to find peace. Absorption meditation involves a object for concentration such as chanting or repeating a mantra; the conscious mind becomes absorbed in the object. Insight meditation - mindfulness based techniques - is based on the real life experiences of a human being. The best known of these, Mindfulness Based Stress Reduction (MBSR) which was introduced by Professor [Jon Kabat-Zinn](#), is widely practiced in the UK. Retreats, and internet and smart phone apps are available, and there are various other psychological interventions such as mindfulness based cognitive therapy (MBCT) using it to help acceptance and they all show very good results.

Vipassana is different from other techniques. It doesn't involve mindfulness of outside objects, abstract stimulations like sound, light, colour etc., created actions and sensations, apparent truth or body parts, external apparent stimuli, abstract thoughts, mindful relaxation of body parts, manipulated breaths, (as in pranayama and yoga), visualization, verbalization or chanting.

Buddha forbid his disciples to try to gain money from Vipassana. So if something is being sold it is not a pure form of Vipassana.



**Bhavatu sabba
mangalam!
MAY ALL BE
HAPPY!**

<https://www.dipa.dhamma.org/>

This is the centre in Hereford that runs courses in Vipassana meditation which range from ten to 60 days in length. They are all free, including food and lodging, and run on voluntary donations. There are several such centres elsewhere in the UK and more than 180 worldwide. They can be found at: www.dipa.dhamma.org

Discussion

I was interested in what you said about the union of mental flow with the flow of matter, which stops when you die. My feeling is that it can stop when people are chronically ill.

...Once mental flow leaves matter it enters another dimension - call it spirit or soul ...

That observation came from our study on knitting when we were observing that body movement combined with state of mind and became somehow unified. People with long-term illness or chronic pain had contracted in some way. When we are well we don't notice that mind and body moving together, but when we are unwell the two don't work together so well. Yoga and Tai Chi teachers endeavour to tap into that and bring bodily movement and mental state together.

Allied to that, when one is not aware, not equanimous, not balanced, then everything is a mess. We start making sense by bringing the mind back: when we start being alert, being aware, being calm, and become more in control; and then life - matter - and mind will flow together from beginning to end.

When is this moment of parting? ... when the heart stops or ...?

I wish I could come back after my death to tell you!

Nurses will tell you that when they lay out a body that they are aware of something still being in it. In the old days they used to open the window to let it out.

It seems terribly wrong not to wait after someone dies ... I feel ... I'm not a particularly spiritual person but I do stop people doing anything when the person has barely taken their last breath

That comes from ancient traditional ideas that although someone's heart and breathing has stopped they haven't left yet; mental flow is still there so wait...

We have a tradition that a body should be left in peace for two hours ...

Once when I was doing massage I went to see someone; I always used to start with my hands above the body and then move them down onto the body. I had a sensation which I can only describe as something 'going'. The person was alive and I said "there is something wrong... I can't do this; I think you need to call the doctor". What had actually happened was that she had had an ectopic pregnancy and lost the baby that evening. I have always wondered if this feeling I had of something like an energy leaving ... it struck me because it has never happened before or since, and what you are saying makes sense.

Healers who use their hands in this way say the transfer is a two way process

We are highly electric individuals. Every moment we generate power of 100 microvolts. There are ways of photographing the electrical aura around you

We are made up of all the vibrations: a continuous electrical phenomenon. One trillion vibrations in the blink of an eye. Buddha called it skalapa, which he described it as the smallest unit of matter, having has four primary characteristics and four secondary characteristics. Modern science doesn't recognise this – we know about electrons and protons and subatomic particles but we haven't reached the smallest possible elements.

Do you know where ballet dancers go to get better? Not orthopaedic clinics: they go to faith healers where they get hands on ...

I use Reiki as well ... it's very interesting what you feel when you work on the body. ..

... Reiki involves energies

Have you any experience of health professionals actually taking time out for Vipassana training?

I go every year for extended training; next year I am planning to do 20-day course. I don't know about others.

We have been looking in our anaesthetic department at getting mindfulness practice in during work time. We've got about 40 people and so far five or six are involved but it's a start. It's up to those of us with some experience of mindfulness to demonstrate some kind of positive benefits. It's part of a whole wellbeing strategy ... we are targeting people who feel they can't carry on under the pressure

We have a lunchtime mindful walking group. Some of those strategies work really well. It might be better if we had some space to go ...

... a hospital chapel is a very good place ...

There is a monk in New York who teaches Christian meditation to high-powered business students, and all their marks have shot up...

... That's not surprising. If students practice any form of meditation their concentration and ability to ignore distraction will improve ...

His name is Richard Rohr. He has written a whole series of books which I find fascinating. As well as Christian meditation he has researched Eastern and other traditions which is where I have found a commonality

[?] introduced it at a school in Kingston for children from 5 to 11. He had to call it relaxation rather than mindfulness as the other staff didn't like it. They got the best SAT's they ever had. If you are stressed the logical brain doesn't work; you are thinking of an emergency scenario, so to calm children down was they way to get them to ...

Kids are easier to teach that because they are close to it

A teacher friend of mine went to the Royal Opera House to learn how to get the children to put on an opera themselves. They had to write it and do everything themselves. After that all their work improved, they became better behaved.

Does the wandering mind improve?

After the 10 Day course it does improve at least for a few months – but nobody is perfect. The author of *Sapiens: A Brief History of Humankind*, Yuval Noah Harari, is an assistant teacher of Vipassana and he avers that it is a wonderful way to calm down and concentrate.

... when I can I sit and focus for ten minutes before a pain clinic, and when I do this I find the clinic runs differently and in some way it seems to work better for the patients.

The last part of this is called compassionate meditation. The pain population is the most distressed and unhappy. They bring so much negative vibration. Their every thought brings negativity in their body. So it is important for us to be equipped to deal with this. We need to be equanimous ourselves and send positive vibrations to them to help reduce their distress. I find this compassionate feeling very useful. I only started six months ago but I feel I am a better doctor ... I can cope with negativity ...

... it's kind of freeing ...

[Intermittently audible] ... shutting everything out and focussing ... mindful driving has been an eye-opener for me ... not mindfulness but if I'm caught in a traffic jam on the way to work I put radio 4 on because there is nothing I can do about being late, but I can choose what I want to do in my car ...

Mindful washing up ... I used to hate washing up but now I really enjoy it because I do it in a mindful way ...

How does finding your own way relate to the 300 people writing down all the Buddha's teaching ideas, which suggests that they should be practiced like a rigid doctrine, versus the freedom of following your own path?

Buddha has clearly said that you are the master of your own mind: don't believe anything because I am telling you to. You have to experience something first, and if you think it would be useful and helpful for both yourself and others, then accept it and carry on doing it. He says: "I am only telling you that this is the way I have achieved enlightenment.", and that you can only go to the roots of mind and matter and their interactions through experience and acceptance. So in that way he has given you freedom.

Are the circumstances in which you have to be careful with mindfulness? I have heard that it can be harmful for some people.

If mindfulness is used properly - if you keep your mind balanced – it can never be harmful. But if it is done in a wrong way: if instead of observing sensations with a balanced mind you start reacting to and focussing on painful sensations everywhere you start hating them and start craving for that pleasant flow ... then you are heading in the wrong direction and it can be harmful.

I was thinking about one lady in particular who had suffered abuse in childhood and had suppressed that but during a mindfulness session those thoughts surfaced and traumatised her again.

These Sankharas can come out; you need an expert teacher to deal with such problems , and a secure environment.

There are a lot of mindfulness courses and perhaps that kind of person can go on them thinking they will help.

Even on the thirty day courses experienced meditators find Sankharas come up which may disturb them. I knew a Spanish lad who had to come out of the course as the teacher said he wasn't prepared at that stage. He gave him some basic instructions and he sat the shorter course later.

Do you use mindfulness in the pain clinic?

No. I send people to a proper teacher. I have been trained to work with children; a simple technique to help them to calm down, but I cannot do Vipassana teaching. If I wanted, now I have done eight courses I could set myself up in business and become a Guru with my own sect. This has happened in India: Vipassana had been around for hundreds of years and then people mixed it with exercises and Reiki and everything and it disappeared. It then came back from Burma about 50 years ago. So if we don't keep it pure everyone will start their own sect. We have lots of Gurus in India now.

The compassion focussed therapy model can be helpful because it incorporates mindfulness; [?] uses it as a psychological technique for people with trauma; he's not using mindfulness but it is a component of the whole therapy.

They use the concept but they don't get deeper. If you try to go deeper in the clinic then it is impossible to control.

What about patients using APPs like Headspace?

They don't take people deep enough. It's superficial. If you want to go deeper ... a 10 day Vipassana retreat will take you to such a deep level ... every time I go I feel as if I am a new student ... I am intending to go for even longer courses in the future

Do you feel more at peace with yourself?

... peaceful, yes ... it's such a different feeling. By day 7 or 8 you start wishing you could stay longer ...

And does that feeling persist?

Yes - after the course you are supposed to continue with morning and evening practice, which I can't do. It improves your sleep, your time management and your ability to deal with distractions. Even if I'm not meditating I feel happy for about a month after the course and then I start reacting again.

In pain management we use a breathing technique. I was once asked to see a 19-year old boy with colitis on the ward who was screaming with pain. I just asked him if he could breathe with me and feel where his body was touching the bed and he went off to sleep.

This is very good for sleeping. My son is bad with sleeping but he usually sleeps after ten minutes of this. When I was at medical school I was an insomnia patient and taking diazepam (which is easy to obtain in India) but with this technique I overcame

the problem. Sleep is needed to rest your conscious mind. As long as we stop stimulating and reacting to stimuli that is nearly as good as sleep. Even if we don't sleep all night long, provided we keep awareness of sensations and the mind balanced that is enough – possibly even better than sleep. It is said the Yogi's never sleep, advanced meditators are awake all the time watching sensations.

How are the courses funded?

Donations which are entirely voluntary

Bad doctors and graphic medicine

Ian Williams

The character described on the back cover of my graphic novel *The Bad Doctor* as ‘cyclist, doctor, would-be lover, heavy metal fan and above all human being ... who doubts his abilities to make decisions about others when he may need more than a little himself ...’ is a thinly description of myself! I set the book in West Wales, rather than North Wales where I practiced, to throw my former patients off the scent!

When Maureen asked me to do this talk I replied that I couldn’t – I’m too busy, I’ve got a deadline coming up, I’ve got an 18 month old child and I’m not getting enough sleep, I’m feeling tired all the time ... and she said “perfect – it’s about burnout! Come along to this therapeutic environment - it will do you good.” And it has been marvellous.

I did a series of weekly strips for the Guardian for about 18 months called ‘Sick Notes’ . Each one was intended to reflect a news item, for instance one was about the Goth subculture and whether being a Goth made you more prone to depression or attracted depressives or actually find that being a Goth made you part of a therapeutic community.

I feel as if I have been burning out repeatedly throughout my career, with periods of quite disabling mental illness and intensive work. I gave up medicine completely for nearly two years but medicine - the medical matrix perhaps - is like the Mafia and hard to get out. People who do get out are viewed suspiciously. Graphic medicine is the interface between cartoons, graphic novels and healthcare and something I helped to set up - and something you should be reading.

The Bad Doctor

The Bad Doctor which was published in 2014 is based on my experiences in General Practice although the character is not me. In my early 20’s I had quite debilitating Obsessive Compulsive Disorder on a background of generalised anxiety and recurrent depression which has continued on and off. I went to medical school in a quite poor mental state and got worse with heavy drinking as well as hard work. I nearly got kicked out after my second year for poor attendance and failing exams. But I hid it and never told anyone. I still had it as a junior doctor; I thought it had burnt out in my late twenties. The Bad Doctor is a darkly humorous graphic novel about OCD, medicine, cycling and heavy metal. I wasn’t practicing medicine while I was writing this, but just before it came out I was applying for the job that I am still in as a part-time GP in Brighton. (I didn’t tell them in the interview that I was writing a book about a bad doctor!) The book is set in a fictional Welsh town

Iwan’s therapy is going cycling with his friend Arthur who is a GU medicine consultant from Cardiff. They put the world to rights while they are riding and it gives me a chance to draw the Welsh countryside. Iwan is obviously finding it difficult. He lives in beautiful countryside but he knows the people who live in the little cottages and their stories and feels their pain and distress. Clare (Gerada) was talking about the figure of the doctor who holds all the suffering and secrets of the community as a rural doctor. If you are at all empathic and the sort of person that relates to other people you can’t help taking on all the shit that people bring to you: tragic diseases,

This image of Iwan as a child was originally an experiment when I was trying to figure out how to represent OCD, with viral proliferating thoughts that are emanating from his head and forming a tree of life.

When I had OCD I didn't have any of the positive benefits like being tidy. Mine was more a descent into hellish pain and insanity and all to do with religion, luck, magic and those kind of things. I didn't know why religion came into it because I wasn't brought up in a religious household; we still had school assemblies and I went to Sunday School which was a traumatic experience – not in any way abusive but more to do with doctrine and the other kids rather than with anybody that ran it. I listened a lot to Heavy Metal and other Goth music which got into my brain.

I thought that OCD had burnt out in my late 20's, but looking back I think it just changed. It was nowhere near as disabling as it was and I don't think I would rate as having it now but I do still have a certain obsessionality, and my OCD morphed into something to do with work and relationships. In making the image what I was trying to do was to take something that had controlled me, but which I had never talked about, and change it into something beautiful.

I was a GP partner in North Wales for about twelve years and for six of those I wanted to leave. I feel that burnout is kind of a way of life for me. Whatever I do, whether it is enjoyable or not, after a while I get restless and bored and want to do something else. After I did my GP training I didn't want to go into practice straight away so I did anaesthetics for a bit. I didn't stay because I hated ICU, being up all night in an alien environment with very sick people. So I dodged and did different things and have had a rather strange career. After medical school I went back to art school and did a diploma in fine arts, and built up a parallel career as a painter and print-maker as well as working as a GP, and achieved some moderate success. But I felt split between art and medicine, and that the split was to do with language. I felt uncomfortable talking about my art; on the one hand I had medical language which was quite precise, pragmatic and technical and on the other the language of fine art which is mostly lyrical, non-specific and obscurantist - and often pretentious!

So I decided to try to bring those two things together and went to study medical humanities in which I did an MA. When I was looking for something for a dissertation I found the book *Mom's Cancer* by Brian Fies. I was already into graphic novels; in the last 25 years there has been a surge in autobiographic graphic novels, and a lot of those have been to do with health. So I thought I could present medical narratives in the form of graphic novels as my thesis. The more I looked the more I found; I made a huge pile of notes but rather than getting down to writing my dissertation straight away I put the reviews online and set up a website to do something with my thoughts about it (I did write my thesis and got a distinction for it) which I called 'Graphic Medicine'.

(I talk about comics here meaning the *medium* of comics. Comics in the plural mean both the floppy pamphlets and the medium with the practice that goes with it. A graphic novel has been described as a comic that needs a bookmark. Comic novels have given gravitas to the medium; over the last ten or twenty years they have been respected enough to be reviewed in broadsheets)

Setting up this website changed my life. People started contacting me from all over the world. People like Professor Michael Green who was using comics to teach medical students and MK Czerwiec, who was an HIV hospice nurse who used comics to talk about her experiences as an HIV hospice nurse in Chicago. She produced a book called *Taking Turns* which is like an oral history of her hospice.

We drew up the Graphic Medicine Manifesto which was published in 2105. In the manifesto I define graphic medicine as *the interface between the medium of comics and the discourse of healthcare*. It has become an amazing non-hierarchical community. It is both a movement for change and an area of academic interest. We

have held eight international conferences: our first in London in 2010. We rapidly sold out all our 75 spaces, and people came from all over the world. Everybody was so excited and we knew this was something we had to keep up. A year later we had a conference in Chicago, then Toronto, Brighton, Baltimore, Riverside California, Dundee and Seattle.

Ellen Forney has written a brilliant book, *Marbles* about Bipolar Disorder.

Why are comics important?

(I'm talking about 'art' and autobiographical comics here: comics drawn by one person about their individual experience and vision; not about the superhero comics that grew out of the underground culture of the 60's and 70's) Compared with TV and film there is relatively little editorial input in comics, so what results is relatively raw. Reading a comic is like a short cut - a window into the mind of the creator; it has been said that it provides an empathic bond between reader and creator. One message we in Graphic Medicine have tried to promote is that the people in the best position to represent illness and care are those living with it rather than the 'expert' health professionals. I am aware that as doctors we are very good at taking other people's stories and presenting them for our own self-promotion and make us look good. I have been very careful not to do this in the *Bad Doctor*. The stories are focussed on the doctor's perception of what is going on and what would have happened, loosely based on real events, and they are mostly constructed to make the story more interesting, and their effect on the doctor.

The book by MK Czerwiec about being a nurse in an HIV hospice in the 90's when people were dying of the disease contains stories about what it was like to work there; about the staff and how they coped with it. She got their permission to include real patients but it is mainly about the healthcare professionals.

Another good thing about comics is that sometimes the condition of the artist comes through in the line of the drawing. Paula Night who has fibromyalgia and chronic fatigue, draws with her left hand because her right hand and arm are too painful. She did a very interesting work called *The facts of life*; she has been progressively more disabled by her pain but most of the book is about recurrent miscarriage and childlessness. Some of it is very critical of the medical establishment in the way she has been treated and the failures of communication. She expresses her pain using visual metaphors such as being trodden on by an elephant and crawling up a hill dragging a weight.

Pain is really strange by Steve Haies, with art by Sophie Standing is a really good book. I don't generally recommend comics to patients as I'm not sure which ones will be helpful but I think this will be. The author is an osteopath but seems to have some interesting ideas that are based on neurophysiology.

Patient education comics are very hard to do well. They have been used since the 70's by public health and there are some hilarious examples. They are problematic and rarely have any impact. And comics are supposed to be playful.

I have taught medical students and doctors to make comics about their own experiences and they have come out with some amazing things. Anyone can do them - you can use stick men so you don't have to be able to draw. It can be a therapeutic activity. Drawing forces us for a while to switch off the verbal bit of our brain. It is so labour-intensive and takes so long that you have to condense your

thoughts into relatively small packets, and it's a good way of working out what you really think about something. And it's fun! Doctors tend to worry about taking part in activities they think they may not be very good at, because they are competitive, but we have had some really successful workshops. It's an opportunity for play and in our professional lives such opportunities have always been a bit limited and recent structural changes have limited them even further as our lives become more and more work-oriented.

Comic artists play with the medium and the medium plays with our perceptions, creating a fluid and enchanting experience. It speaks to us all as a playful species and allows us to absorb complex prepositions while experiencing enjoyment, whatever the subject matter.

From the Graphic Medicine Manifesto.

If you never read another graphic novel I recommend *Maus* by [Art Spiegelman](#), a Pulitzer prize winning account of his father's experience in surviving Auschwitz, and his relationship with his father, published in 1986. The Jews are portrayed as mice, the Nazis as cats and the Americans as dogs. It is phenomenally powerful; it was criticised as people thought it was trivialising the holocaust but it's not; it was done for a reason.

When MK Czerwiec is teaching doctors and nurses she makes them use crayons because this is less threatening. In Vermont people are getting war veterans to make comics reprocessing their experiences to make a cohesive narrative out of the chaos. The director James Stone describes comics as a therapeutic blowtorch, and so far we have only lit a few cigarettes with them.

I set off making comics about my own experiences of my time as a junior doctor in North Wales. I was twenty-three and telling people they were gong to die. I have been present at the turning points of many lives. As a gynae SHO I was told to get a blood sample from an aborted 22 week foetus by sticking a needle directly into its heart. I still had OCD at the time and it sort of triggered it. Maybe these repeated small traumas build up and led to burnout. I published a cartoon 'I am a shit doctor' which other doctors responded to and non-doctors seemed to be reassured by, knowing that doctors had self-doubts and sometimes felt like shit. But a friend of mine who was a very successful GP didn't get it at all. He said: "Is this you? - you're not a shit doctor –you're a good doctor, so why have you drawn yourself like that?" I asked him: "don't you ever feel like that?" He paused - and replied: "no, never – what the hell is wrong with you?"

I have a new book coming out at the end of the year called '*The Lady Doctor*' which includes the theme of empathy. It is debatable whether empathy is either achievable or useful – or even just misplaced sentimentality. In one exchange the doctor character wonders if although she listens to patients she doesn't *feel* anything much means that medicine has screwed down her emotional response valves.

Discussion

How long did it take you to do the Guardian cartoons?

About six hours each week; it was really stressful as I would have about 48 hours to do it because I would have to agree a subject with the editor and some weeks it was really fallow. Jeremy Hunt was in the news every week and I didn't want to do him all

the time. The difficult part was coming up with something vaguely funny – especially when the news was about something like meningitis. And this wasn't my forte, but having done one strip I was asked to do it for a month, and then another month ... and so it ran for 18 months. It was getting difficult to say anything new, and I started to ask myself if making fun of the NHS and saying how crap it is was contributing to its demise?

You said something to me about the readers filling in the gaps between the pictures ...

People who study comics, their history and their cultural significance from a semiotic or structural point of view ask if they constitute a language in themselves. Most people think they are a hybrid medium of text and image that combine to form a whole that is more than the sum of its parts. It is said that the magic of comics occurs in the 'gutter'; the white bit between panels which is where your mind creates the narrative.

You could draw a parallel with the transitional space in a consultation between doctor and patient which is where the healing takes place ...

... the space between notes in music ...

Artists, certainly comic artists, and musicians work like this ... they take an idea or a tune or a phrase and experiment and play around with it ... known as 'generate and test'. In the generation phase you are risking failing or making a fool of yourself which is something we can't do in health care.

I went to a conference recently about pain and belief and one of the neuroscientists talked about the importance of play because it improves your creative thinking and ability, and that widens your experience base so when your brain is making decisions it has more information to draw on. So rather than being narrowly focussed on problems you can explore different things ...

It has struck me in this discussion ... about the pause in the gutter ...that's when it happens. These pauses ... spaces ... if you are having a conversation with someone and there are no pauses it's usually just two people talking at each other. This meeting is different from any other meeting because there are almost deliberate pauses and spaces.

It's like the artist handing over control to the reader in that space; he knows the story and constructs it as they see fit, but it is a collaborative reading process. There are subtle differences that will happen in dreaming the story to life. Scott McCloud has written popular books in comic form about making and reading comics which are very clever. He talks a lot about the magic in the gutter [the space between the inner edges of adjacent pages]; he says as a comic writer you can control the timeline and pacing of the comic but the reader has ultimate control because unlike a film you can read it any way you want; you can start in the middle and read backwards and control the pace of your reading – I guess you can do that with novels to some extent but this is less didactic ...

It leaves more to the imagination ...

I know I'm a bit evangelical about this and I'm not saying that comics are better than novels or film, but they can be an equally sophisticated art form; in the UK they

have got more 'respectable' recently but in Belgium, France and Italy they are regarded as a more profound and important medium.

I find an association between Adam Kay who wrote a best-selling book about his experiences as a junior doctor, which is a tragi-comedy, and your book which has such poignant drawings although a comic is a humorous organ. Does the humour help you with your work? Can humour be a defence against distressing experiences like sticking a needle into a dead baby ...?

Yes, it is a therapeutic experience. There were things I never told anybody ... I found my voice through comics and they have allowed me to talk about things like mental illness that I had previously found shameful. The Bad Doctor was marketed as a fictional story and right up to the publication date I wasn't sure if I was going to admit that it was at least loosely autobiographical, because I was worried about the response of my colleagues and my family; I had told my partner about my OCD but I had never talked to my parents about it. In medicine it was like ... "carry on as if everything is fine, don't show vulnerability ..." But reading other comic works I realised that the authors were making themselves vulnerable. There is a tradition in comics of 'bare it all'. Failure and vulnerability is common currency in this type of comic. So if you have something to say about mental health or terrible mistakes in your past or been a horrible person that is actually good material for comics, especially if you can make it self-mocking and funny and there is a big audience for it.

When the book was published the publisher sent it to the broadsheets and I got a request from the Independent to write an article about being a doctor with OCD, which I did, and it blew it right open! The response has generally been extremely positive.

Lots of doctors have OCD. It can be protective if it leads you to attend to detail etc. But it's funny that they don't want to talk about it as part of the problem is that you think you're the only one, but only eating disorders are more common.

Perhaps people who don't like it [doctors who acknowledge their own problems] are betraying their own vulnerabilities. It takes a lot of strength to admit to these.

It's actually giving back to the medical matrix

There is a GP trainee in London called Kate who has been diagnosed with borderline personality disorder and she started making comics about this. When I met her she told me that she had been open about her disorder but not about being a doctor (which seems the wrong way round) but when she got a positive response to her comics she revealed her profession and everybody said how brave she was!

A doctor killed herself having written a blog about her experience of bipolar disorder: she was referred to the GMC ... and eventually she killed herself. The coroner said that the whole system is lopsided ...

[only partly audible] The images drawn by the patient with fibromyalgia suggest... catastrophising ... could it drawing it be harmful? ... reprogramming into the ... reinforcing ... a downward spiral?

I don't know. Some comics are very depressing. If you tell people you are into graphic medicine they will often say they bought a very funny comic for a friend who was diagnosed with something. This could be a mistake: the worse example of this concerns a brilliant comic novel called *epileptic* about the artist's brother who had

epilepsy since childhood as well as neurodevelopmental problems; he has had a horrendous life and is going downhill and now institutionalised. It is about growing up with his brother and the effect his illness had on family life. It is a work of genius but really depressing; there is no happy ending and things only get worse. A friend of mine saw it and gave it to a couple with a two-year old who has started getting fits without reading it ...

Another very good picture book is 'To Quiet the Mind' by Matthew Johnson (who also wrote Black Dog) about meditation.

The field is getting bigger and bigger. When I first started I tried to read everything that could be relevant but this has become impossible, there is so much stuff being printed or provided online.

One way I have benefitted from being involved with this movement is that it has made me much more careful in the way that I speak about illness and disability. When I started Medical Humanities I didn't know what I didn't know. I had been processed into a 'medical' way of thinking, using medical terminology and I simply didn't know that there were other ways of looking at the world. We did modules on literature, philosophy, social science and disability theory. The last was the most inspiring, in particular the social (as distinct from medical) model of disability. I'd never been told at medical school that the problem was not impairment of the individual as the way the psyche is set up. Because I am a privileged white, male heterosexual etc., I still blunder when I am talking about illness, health and disability but I have become much more aware of the pitfalls. I hope that has made me a better doctor.

Comics can get away with things that other media can't, partly because it is regarded as a fairly 'throw-away' medium; they can get in 'under the radar' unlike writing for a newspaper (I have a friend who writes comic 'essays' viciously ripping apart things like chiropractic without fear of recrimination or litigation)

The GMC don't read this stuff. But does the GMC have to come back to within the medical matrix?

The GMC is another story. The GMC is the Black Dog that is haunting everybody; but there are far worse regulators including the Dental Council, the Health Professional Council, the Nursing Council and the NFC.

We now have a yearly appraisal, but that is not the place to dump your pain. The guy that did my appraisal last November is OK but he is quite high up in the medical system in Brighton. I had never met him and he Googled me before my appraisal and saw that I did comics for the Guardian that were quite political. When I turned up he was slightly on edge. Before the appraisal started he questioned me about my political views and what I thought about contractors in the NHS. The appraisal went OK but at the end he said: "I warn you, Ian, people like you who have unusual careers ring alarm bells in the corridors of power. Decision-makers don't like people like you."

Creative writing

Sara Booth

There are lots of ways to be creative and it is clear that being creative is not a sort of hobby extra, but an intrinsic part of who we are. But it often gets squeezed out. I am going to talk about creative writing not only because it is something I enjoy doing, but also because in many ways it can serve a very useful purpose.

A lot of the writing I do is 'professional': writing: papers and factual things. When you are working in a hospital you have to be very careful about what you say: you have to measure it and restrain yourself, and think of the possible impact. As we have been saying, not thinking about this in our emails carries a potential big fallout. The thing about creative writing is that it allows us freedom to reframe difficult situations in a new way. But there are difficulties for us both in freeing ourselves in this way and in developing a habit of writing. So we are going to do some writing today.

Among the things that came up this morning were meaning and purpose, and I would like to add hope. A lot of our everyday clinical encounters are difficult: they touch on something in us and perhaps feed into the negative narrative that we have about ourselves or our work, and which is particularly there when we are feeling under pressure. One thing I have found about writing, even factual writing about breathlessness, is that it helps you to understand and gain insight into the things you are doing every day but don't really understand until you write it down, and have to put it into words. That may help us with what we think of as our factual self narrative.

The writing exercises

[Readers are encouraged to try these for themselves at home]

One of the ground rules for this exercise is that any writing you do is just for you, as it important that it should be disinhibited. We must beware perfectionism; we may want to write and start writing but think it's not good enough ... not proper sentences ... I didn't mean to say it like that ... and the whole thing unravels. So I want you to spend ten minutes writing about a recent encounter: it could be about a patient with a lot of problems, or just about someone you met in the car park or something that happened in the supermarket, but it has to be something that that disturbed or perturbed you and involved another person. Use as much colourful phraseology as you like - you don't have to be restrained. Try to use your five senses: what you saw, what you heard, what you were wearing, what you smelt, to build up a vivid picture. This should be a real event, not something out of your imagination

.....
How did that feel?

I had kind of put it out of my mind but when I was writing it I found myself coming right back into the scene - the sounds and smells and what I was feeling.

I am so used to writing patient notes every day ... I had to turn it around ...

When I started writing about the scene I realised that what I had thought disturbing about it was actually something else that happened afterwards

We are discouraged from being creative when writing about patients but when you look at notes from 50 or 60 years ago you see that people wrote very offensively

If you look at notes from 100 years ago they are often in very 'literary' and expressive language!

You can see that you may have done something of value even if you haven't sat down at your desk – you've just taken what you had and done something with it.

There are various courses out there in using writing as a form of healing - as a way of reforming our narrative about ourselves or reframing difficult or painful events and bring back purpose and hope. One of the things we do with difficult situations is a distancing exercise like projecting it onto a screen or dissociating ourselves in some way; writing may be a way of doing that. To give a more formal suggestion, one idea is that you spend fifteen minutes a night for four nights writing about something that has upset you or is worrying you; you don't go on for hours until you have resolved the issue, but at the end of that time you reconsider.

The next exercise is intended to encourage a bit of creativity. I want you to write about what happened from the other person's point of view, or what might have happened to them in the run-up to the event. Don't worry about perfect sentences, punctuation etc.

.....
Any feedback?

-Writing from the other person's point of view gave me a completely different view of myself...

...less judgmental?

Yes

I became more judgmental seeing my self from the other person's view

I was worried that I was sitting the other side of the table – interpreting them - because I know that their style is quite different from the way they are thinking.

There are some people we can't get into ... we just can't understand what is making people behave as they do. But maybe trying to imagine what they are thinking helps us to get a bit closer

Actually I realised that the other people quite enjoyed rescuing me whereas I had focussed on my own embarrassment

It actually gave me greater distance ... you read into it that it was a personal experience but it wasn't at all ... it was random , anyone else could have driven by ...

So now write it in the third person - an observer
.....

So how did that feel - more distanced?

The language was different ... it was less colourful

“Fatima was suffering severe pain in the legs. Only 21 years old she had suffered a catastrophic stroke affecting her spine. She could not move her legs. She could move her arms, her face and head. She was very pretty. Her friends and sisters tried desperately to help her and she was aware of her sadness for her.”

You can still get the emotion in even though you are looking at it from the outside.

Sometimes it can give you more of a picture of what you are seeing every day but don't realise what you are seeing. I saw an interesting study where a nursing sister took pictures of elderly people on the ward - their pressure sores even – and showed them to the nurses every day in a teaching session and some of them were totally shocked as although they had been nursing these people they somehow hadn't seen them

When I work with sexually abused people I get them to take away all ideas of grammar and just write 'I feel ...', go into their childhood and write from a child's perspective, and put it away for several days. Then when they are back in their adult role I get them to read it as if somebody else has written it – some child they know – and report back, and try to get a communication going between those two different personas. I have found that that is the most healing thing that I can do with those people.

Do they forgive themselves?

Yes. It is phenomenally powerful.

One of the most difficult things with writing is starting. One recommended way of starting writing – or any other creative activity - is to make yourself a rule, e.g. that you are going to do it at six o'clock in the evening, or before you get out of bed in the morning, even if no more than five minutes. If you want to produce something more polished it's useful to regard the first 800 words or so to be like turning on a tap that hasn't been used for a while; you get some rusty water coming out at first. So you don't judge yourself and feel you should stop because that is just the beginning.

Do you make a distinction between hand writing and writing on a screen?

Some people do say you get more spontaneity out of handwriting because we are so used to all this spellchecking and going back immediately to make corrections. Editing is probably better after you have written a fair amount. But we are thinking at the moment of writing as a therapeutic activity rather than worrying about structure and plotline etc. If you are using it with patients or people with severe problems it is a matter of letting them to be able to be free to write about what is happening. Some people think that in being asked to write they are being demeaned if they can't read or write very well so getting them to use just words instead of sentences is important to counter that.

They can intersperse words with drawing or even scribbling if they feel like it, no-one is going to see it.

Yes, but they can share it if they want to share something in a way they couldn't otherwise.

The other thing in the wellbeing literature is the suggestion that you should always be writing about the things you are grateful for. But sometimes it's not possible to feel grateful, or you may feel that you are only writing some things down because someone has told you that they are good things to write about. Sometimes you feel that you shouldn't be asking them to write things they're thankful for because they have so much hurt ... they're just not in that place at that moment.

One thing that is said to be helpful is instead of trying to write positive things all the time is asking : what would be the best version of yourself in terms of how you want to live and the values you want to live by? – and perhaps writing down some of the steps you might need to get there.

So please spend the next seven or eight minutes writing about the best version of yourself and how you could get there.

.....

It is our automatic pilot to be critical and perhaps that is something that is worth looking at. Having critical managers and people who don't support you can be very disabling. If we are not supporting ourselves, this sort of behaviour is going to feed into that. If the management behaves in the same way as you are talking to yourself we are getting to the burnout stage. If we can't rely on external forces always to be helpful and supportive we have to rely on ourselves to do that and maybe look at how we can build that positivity in, and writing is one way of doing that.

Clare [Gerada] talked about when we reflect on our own ... health professionals can be very self critical and generate negative rumination ...

... which predisposes to depression ...

and it's hard to renourish ourselves and nurture ourselves ...

Writing is a good way of getting out of rumination, particularly when you distance yourself by writing from the third person point of view, because it gives you that perspective instead of, as in the first person, it's all about how we have failed or didn't act in a way that was helpful.
