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Contributors

Michael Bavidge, Retired lecturer in Philosophy, Newcastle-upon-Tyne

Diana Brighthouse, Retired Consultant in Pain Medicine, Southampton and Psychotherapist

Alastair Campbell, Professor of Medical Ethics, School of Medicine, National University of Singapore

Andy Graydon, Priest, Sheffield

Richard Huxtable, Senior Lecturer in Medical Ethics, Bristol

Kate Maguire, Social Anthropologist, Psychotherapist and Programme Leader at the Institute for Work Based Learning, Middlesex University

Willy Notcutt, Consultant in Anaesthesia and Pain Medicine, James Paget Hospital, Great Yarmouth.

Richard Raspa, Professor of English, College of Liberal Arts and Sciences and Adjunct Professor at the College of Medicine, Detroit.

Jeremy Swayne, GP, Priest and Homeopath, Yeovil

Ian Yellowlees, Consultant in Pain Medicine, The Borders

Robert Zalenski, Director, Palliative Medicine, Sinai Grace Hospital and Professor, Wayne State University, Detroit

Introduction

As this was the eleventh meeting of the Group, it was decided in some way to commemorate the ten (seven as a Special Interest Group) that have gone before it.

'Virtue Ethics' emphasises the role of character and virtue in moral philosophy over doing one's duty, or acting in order to bring about good consequences. Although we have never previously identified the topic in our discussions it became apparent that in many ways the ideas it embodies have underpinned much of our discourse over the years, and might even be said to be embodied in the ethos of the group. Indeed it might not be too much to hope that what we have learnt, or absorbed, from our speakers and each other has shaped what we *are* as human beings and as practitioners as much, if not more, than it has influenced what we *do* in our practice of pain medicine.

Although in the past we have been privileged to hear many distinguished invited speakers, we have been doubly fortunate in the quality of the contributions submitted by participants. The six people invited to speak at this commemorative meeting were chosen by vote as those whose previous contributions have stayed most in the memory. Although they all spoke on widely different subjects, it was remarkable to see how much their talks (and the subsequent discussions) tied up not only with each other but, very strongly, with Virtue Ethics.

The meeting was judged by many as the best ever, and it is to be hoped that readers will find much in these pages – and those of previous transcripts – to comfort (in the original sense) and inspire them in their day-to-day work with suffering people.

Peter Wemyss-Gorman
Philosophy and Ethics Specialist Interest Group

Virtue Ethics and the ethos of pain medicine: A dialogue*

Alastair Campbell (AC) and Richard Huxtable (RH)

“So the question for Virtue Ethics is what is the excellence of the human? What is the way in which we are genuinely human and fulfil our human nature or humanity?”

*This session started as a dialogue between the two speakers but soon developed into a dialogue between them and the audience. Contributions ‘from the floor’, as throughout this publication, are printed in italics.

Introduction

[AC] First of all, who are we and what different perspectives do we bring to bear on this subject? I am not the former press secretary to Tony Blair! After taking degrees in philosophy and in theology in Edinburgh, I did a postgraduate degree in the States in the relationships between religion and medicine. After a period in Edinburgh and New Zealand I finished up in Bristol in the Chair of Ethics in Medicine. I kept trying to retire but it didn't work out so now I bear the title ‘Chen Su Lan Centennial Professor of Medical Ethics and Director of the Centre for Biomedical Ethics’ in the Yong Loo Lin School of Medicine of the National University of Singapore. Today I am happy to talk about Virtue Ethics, partly because I come from a theological as well as a philosophical background, but also because my experience as a teacher in three different medical schools made me feel that the whole idea of character is fundamentally important in ethics. As you will hear later, we did some research in Bristol into the relationship between Virtue Ethics and being a patient, looking at virtuous patients instead of virtuous doctors.

[RH] I am here wearing four invisible hats. The first is my background in the law, a PhD in Medical Ethics which led me to Alastair's door, and my current position as a medical lawyer in a medical school. Those are three of the hats and I am senior lecturer and Deputy Director of the Centre for Ethics in Medicine in the University of Bristol. There is a fourth hat which I won't explicitly be wearing but I think implicitly and importantly, does have a bearing on most of what I will be saying and the case that I shall be referring to. I have a form of arthritis, so I come to this topic as an academic engaged with medical and law students as well as practising lawyers but always informed by the perspective of being a patient. So where I am coming from is a degree of devil's advocacy with which I shall try to unpick some of the propositions that Alastair is going to put forward.

[AC] We are going to begin with me risking boring some of you who are already familiar with Virtue Ethics theory but it seems to me that we should have the same starting point in the basics of what Virtue Ethics is, and how it differs from other ethical perspectives. This will be a fairly quick rush through a very complex topic. Then we will move on to a case study which we published in the *Cambridge Medical Ethics Workbook* and Richard will present this as a counter to some of the theory that I am putting forward, and pose some critical questions about the adequacy of Virtue Ethics raised by that case. We will then look in a little more depth at the kinds of criticism that might be made of Virtue Ethics theory, and how this might be answered by Virtue Ethics. The last part of the session will be reporting on the

European funded project we did in Bristol that looked at a whole set of patients with different chronic conditions from different countries to explore what we mean by virtuous patients.

Definitions of Virtue Ethics

The only piece of jargon I am going to use today is to make the distinction between *deontic* and *aretaic* theories. Deontic theories, which come from the Greek word *deon*, meaning it is a duty or it is required, are theories of obligation: 'what ought I to do?' Deontic theories take various forms like consequentialism and theories based on principles and rights. This is to be contrasted with aretaic theory, from the Greek *aretai*, meaning virtue, which doesn't ask the question: 'what should I do?' - but instead the question: 'what kind of life ought I to live?' – or 'what sort of a person should I be?' So where deontic theory focuses on actions or decisions, aretaic theory focuses on the character of the agent rather than the decisions or judgements they make. This is the fundamental difference between Virtue Ethics and other theories, and might be said to be both its weakness and its strength. The interesting thing is that in our day and age, Virtue Ethics has come back in and there are far more meetings and discussions about it compared with twenty years ago. It is a very ancient theory going back to Aristotle, coming through the medieval theologians and a Christianised version down to the present day. Of the many modern philosophers that have dealt with it, Alasdair MacIntyre is the best known.

What are the basics of the theory?

The first thing to say is that it attempts to deal with both emotion and reason. In that sense Virtue Ethics is not only interested in our rationalisations and decisions made at the conscious level but also in the way our emotions affect the way we relate to others and to our own lives. So it's an attempt to bring reason and emotion together in some kind of integrated account of what it is to live the moral life. That's one of the important features of Virtue Ethics because a lot of ethics in the West and in modern times has tended to be very rationalistic and seems to have rather assumed that the cleverest people are the most moral, which is evidently false: it doesn't follow that because you can think clearly you will be a good person. The other feature of this kind of theory is that it can't work without some kind of understanding of human nature and what humans essentially are. This gets me back to *aretai*. This is the Greek word for virtue but is used in a rather different way from the way it is understood in modern terms because of Christian influences and other things. *Aretai* simply means excellence. For example, it makes perfect sense in Greek to say that a knife has *aretai*. The excellence of a knife is that it cuts well; whether that knife is in the hands of a surgeon or an assassin doesn't affect the excellence of the knife which lies in its sharpness. So the question for Virtue Ethics is what is the excellence of the human? What is the way in which we are genuinely human and fulfil our human nature or humanity? Aristotle says first of all man is a rational animal; one of the things that distinguishes us from other animals is our rationality. But he did not understand rationality in the narrow sense in which it is often thought of today because he believed that there were different features of our rationality. Some of these are related to our capacity for practical wisdom.

Phronesis is good judgement: the way in which we can make good judgements in our lives and in our relationships to others. So while the other sides of reason are also important and have produced science and analytical philosophy, Aristotle believed that we truly fulfil our human nature not only by reasoning in that analytical fashion, but by actually using wisdom, reasoning in a wise way, to reach wise decisions. So

reasoning is both theoretical and practical and we get back to the relationship between reasoning and emotion.

Phronesis is not just an abstract thing; it has practical involvement. This ties in with the second paper this morning [see chapter The (cost) effectiveness of pain clinics: Who are we kidding? By Ian Yellowlees on page 57] and the area we discussed of personal involvement and the notion of empathy as part of what it requires, not merely the distancing and analytical. So that's already there in ancient Greek philosophy and Aristotle's understanding of human virtue.

There are a couple of other bits of Aristotle which are probably quite familiar to you: one is the so-called 'Golden Mean'. That is the idea that when we reason well in the practical sense we reach some sort of balance between extremes, so that we neither have an excess of deficit of any given quality. For example, courage is one of the virtues that Aristotle mentioned: obviously a deficit of courage is cowardice, but excess is rashness. So somewhere between cowardice and rashness is courage as a Virtue. (Notice again that these extremes are both rational and emotional – this is a way of channelling our emotions in an effective way). The whole idea of the Golden Mean is fairly central to Aristotelian ethics. One of the interesting questions is, is it useful? Does it help us in trying to understand what we mean when we say this person is virtuous? Is a balanced moderate person a virtuous person? Or is the virtuous person a bit extreme in some ways?

Christianity has had some effect here because in medieval theology the notion of the theological virtues was added to the three basic virtues that Aristotle suggested: courage, temperance and justice. The theologians added faith, hope and love. There were also seven deadly sins. It began to look as if Virtue Ethics was about being a special person, rather than something that was easily within the grasp of all of us. You have people that exhibit all these virtues – the saints if you like. (I say to my new classes in Singapore that it's a great privilege to be lecturing to a group of Mother Teresa's or Martin Luther King's, because in their interviews they have all been so perfect. They care about people and they're not in it for the money etc.!)

Virtue Ethics has tended to be dogged by this tendency to associate it with the very exceptional person, but in its origins it's not about that: it's about ordinary people acting according to their nature – the way they are capable of acting. This is where the word *eudaemonia* comes in; in its original meaning 'having a good demon'. (Socrates talks a lot about his daemon (or demon).) Its meaning is badly translated as saying it's about happiness; nowadays we prefer to say it's about fulfilment: a sense of fulfilment of your nature. You see how that ties together: we're not talking about saints; we're actually talking about people who are able to fulfil their own nature.

We'll leap through history now from the middle ages to the twentieth century. Alasdair MacIntyre's book *After Virtue* criticises the whole endeavour of the Enlightenment to say we can all get together fine as long as we are all rational and reasonable people, and we can work out a common morality rationally. *After Virtue* is saying that that project has failed. Instead, MacIntyre says we have to go back to the notion of what he calls *practices* which are doing things together that we feel have a worth in themselves. An example of a practice would be medicine: medicine is a common endeavour between practitioners among themselves and between practitioners and patients towards that which has value in itself and doesn't depend on an extrinsic value such as making lots of money. Education would be another example of a practice which our Governments don't understand anymore because they want outcomes all the time and forget that education in itself has value. MacIntyre is

saying let's get away from this grand endeavour of all agreeing to principles, but instead let's get back to communities working together on a quest for virtue in terms of practices. I think MacIntyre has rejuvenated the whole issue of Virtue Ethics.

Virtue Ethics and the patient

[RH] I am particularly struck by Alastair's assertion that Virtue Ethics are within the grasp of all of us. I am going to go into that by describing a real situation: this is based on an account by Ron Berghmans who is a Bioethicist based in the Netherlands. His story may sound familiar to you – at least it starts that way but quickly becomes something different. Some aspects of it are quite distressing. He offered this to us for the second edition of the *Cambridge Medical Ethics Workbook*. I'm going to read some of the opening extracts he gave us for that, and based on that raise some questions for our discussion later.

“My [Ron's] story started in 2003. At that time the chronic pain in my lower back was increasing and as this was different from normal I turned to my GP. She diagnosed this as non-specific and functional and prescribed pain-killers, and her advice was not to work too hard. The pain kept increasing, and after a few weeks I went back. She prescribed different painkillers which had little effect, as had the previous ones. I returned for a third consultation during which I expressed a wish to have X-rays of my back, which was granted only after a lot of pressure and persuasion. These showed no real anomalies although there was some minor pathology in the vertebrae, and the GP seemed to think this was causing the back pain. As there was no therapy the situation kept worsening. She then arranged for me to see a range of other health professionals and finally in July 2004 – about 18 months after the first consultation – a neurosurgeon decided to scan the whole of my back with MRI. On the basis of this scan it appeared that there was a process about half way down my spinal cord. A biopsy of this revealed malignant B-cell non-Hodgkin lymphoma, which was localised in the abdomen and the bone-marrow”.

As a result of this long delay in diagnosis and seeing a range of doctors it was not a shock – “I've got cancer”; the information had been dripping out and seeping into him and his family. He makes a quick aside that that gradual process must have some impact on our legal notions such as informed consent and advance directives. He refers to becoming more and more involved with the illness and the treatments.

“In my case, the experience of intense and enduring pain isolates the person from his surroundings. The physical environment has little or no meaning and personal contact becomes difficult, as the person is almost exclusively involved with and focused on the pain he experiences. This introversion increases the vulnerability of the patient who has difficulty in expressing his or her needs and wishes. This implies a need for carers to be sensitive to the unexpressed needs the patient may have. An illustration from my experience was the pressure sores on my back which had gone undetected for a while.”

So my opening gambit in this session is applying virtue theory not to the professionals to whom Ron has briefly made reference but to patients like Ron himself. The question would essentially be: is it appropriate to expect Ron to exhibit some sorts of virtues? What is the excellence you are seeking from someone like Ron if you maintain that Virtue Ethics is easily within the grasp of all of us?

[AC] That's a perfectly reasonable question. One of the things we were afraid of was that this sounded like talking about virtuous patients was putting another burden on people who are already struggling. But the other thing is that in the recent history of Virtue Ethics in medicine, virtuous patients have been seen as compliant, non-complaining, and cheerfully stoical and so on. So you have this noble history of doctors who are virtuous, and patients who have to be compliant, and there is some terrible inequality here. Is that the way to see the virtuous patient – as the convenient patient?

We need to ask the question: does it make any sense for us to talk about the patient who is easy for us, or a nice patient to deal with, but is in some sense virtuous? And that is the challenge that this case throws up at us and the theory that Richard is throwing at me quite appropriately. I want to suggest that you have to get back to the idea of excellence that is within everybody's grasp. It may be quite individualistic as well, in the sense that the way I would cope with Ron's case may be quite different from the way you would. This doesn't mean that I am right and you are wrong because what we are struggling for is something that brings some sort of fulfilment to me despite my struggles. It's a teasing sort of notion: you might say in a way it is challenging patients, but I think it's also – and this is me trying to defend the theory – if it is properly understood it is refusing to patronise patients; refusing to say this is the way you have to be because compliance is what we expect from you. Instead it is saying: in the circumstances that you find yourself, that you did not choose to be in, what can you be?

It seems to me that you are trying to suggest that the patient is a unit in isolation ... I am struggling with how you might apply the idea of virtuosity to the patient rather than to their interaction with the carer; surely the two are co-dependent.

Yes ... one of the other criticisms of Virtue Ethics is that it can be seen to be very individualistic and treats the person as if he were an isolated unit. Indeed that's what MacIntyre was trying to overcome when he said that we need to be in communities that share values and a common goal.

How does the term 'concordance' fit in with that? In the sense that the patient saw the GP and said 'my back pain is so severe that I feel that the point has come when I should have an X-ray'. The GP may feel that his task is to put up a bit of resistance because of the history or the findings or whatever. So there's this discussion taking place: we expect the patient to take up the role of challenging the GP but they have to come to an agreement. I believe we are all nowadays working towards concordance unlike the old days when the patient would not have dreamed of disputing the doctor's judgement.

So it's from compliance to concordance – a shift in the dynamic of the relationship...

I'm thinking of Victor Frankl. The question for him was how could he survive the experience of the concentration camps? As Kate [Maguire] pointed out this morning, pain unmakes the body [See Chapter 'Being human in pain' on page 62] – I would not want to trade places with the patient – but looking at the issue of pain and virtue from Frankl's perspective, he survived the experience by looking for meaning in it and this became the basis for his therapeutic interventions. I'm thinking in particular of two people in the US who faced shattering experiences; one was Christopher Reeve (the actor who played Superman) who went through enormous difficulties until he discovered meaning for his life which he devoted to spinal injury research. That meaning-making was part of his virtue. The actor Michael J Fox (with

Parkinson's disease) says "I used to be a jerk before Parkinson's, so it's contributed to my life". This is almost unbelievable and contrary to common sense. These were people in the Aristotelian sense of character, courage and fortitude with the addition of meaning making.

(RH) I have two responses. The first would be although the establishment of the Reeve foundation clearly says something about the moral life, regarding your opening gambit about how do I make this meaningful for me ... I suppose I would ask why apply the word virtue to this at all? Can't we use other synonyms like coping strategies? The second would be on the lines of – and this would turn the reasoning on its head – if this is to be a moral theory, to make sense it also has to say something about immorality as well. So my concern becomes: are we going to say to every patient with Parkinson's or a recent diagnosis of cancer or whatever who doesn't exhibit the virtues that you are pointing to that they are immoral people? I wouldn't want to say that but I need to ask of the people who defend the theory: why can't we say that, and what do we do with that sort of repost.

Why is this ethics?

I don't quite understand why all this is being called ethics...

...You're not alone in that...

... We seem to be talking about characteristics of people which might be good ones but I'm not quite sure why this is called ethics. The deontic that I can understand is about actions etc. that they may make, but I think we are talking about character that people might have in the absence of doing anything at all – not interacting with anything or anybody...I just don't get it.

[Partly inaudible] I think the characteristics that person has leads to certain outcomes. (People like) Michael J Fox have characteristics that lead to actions like setting up charitable foundations, but just because people don't set up charitable foundations doesn't mean (they lack good characteristics). They may just be expressed in different ways – the way they interact with their children, anything – it's a different expression of those characteristics.

(RH) I suppose a lot would hinge on what particular virtues are that we think we identify and therefore what would be the excesses on either side.

(AC) Why is it ethics? It's all about...eventually...well, people can make all sorts of right decisions and never put a foot wrong, but actually we may not particularly want to emulate or admire them because of the sort of people they are. This bit of morality is, if you like, about role modelling and it seems to me extremely important in medicine because this is how our medical students actually learn. We tell them do this and don't do that and respect confidentiality and so on, but the way they actually learn is from their mentors – the clinicians that they work with, and some of these are role models that allow the student to learn how to be a practitioner in a way that is morally worthwhile. And that's not about specific actions; it's about attitudes to the patients and the job etc.

But it is still the actions of the mentors...?

In the *Diving Bell and the Butterfly*, this guy is in locked-in syndrome and can only blink one eye and writes this book about his experience. There is nothing he can do

except try to tell others about his experience in this appalling situation, and he is lucky that it has been spotted that he is not in a persistent vegetative state. I'm not saying that actions are irrelevant, but in Virtue Ethics it's the person from whom the reactions emerge that is perhaps eventually the important thing.

I don't mind if I can't persuade you; there's a long argument going on at the moment between these two camps.

Regarding character: I think all of us choose a stance in life – I see everything in life that everybody does as beneficial but sometimes only beneficial to a very few people... I think I should maximise the good to everyone around me which means I have to pretend I'm a higher being in my mind to see how God would act in this situation if there is a God. It doesn't matter what you call it; it's the intention and the action and the feedback you have within yourself to see if you can get better at it. I don't know if that has to do with virtue or not – I think we recognise a good human being when there is a tiny bit or a very big bit of worth. That's all I know: I watch people, what they say and do... a virtuous person maximises the good they can do in the world to the best of their understanding with feedback...

[AC] That's a very good working definition. I'm not saying we don't look at people's way of interacting... The moral life is about both how we view ourselves and our relationship with others. If we are just going to talk about some sort of self-perfection that doesn't relate to what good we can do in the world, in the state that we're in, it's not ethics. All that Virtue Ethics is saying is: doing the right thing is fine; we want people to do the right thing but there is more to the moral life than that. This gets very risky when we are talking about patients, because it is sounding judgemental and demanding. But if it's understood properly it is actually more respectful of patients than not treating them as people who can come to terms with the situation they are in and make something of it, however dreadful it is.

The origins of Virtue Ethics

[RH] My next line of attack would be to ask: where you derive this moral framework from? You have given us essentially two sources: Ancient Greece and Christianity. That immediately opens up the theory to attack insofar as first off, we won't necessarily espouse all the norms and values and ways of being that would be adopted and conducted in Ancient Greece – I'm not aware of surgeons nowadays praying and sacrificing to Apollo. Secondly in terms of an appeal to a Christian account of virtue: what about Atheists and those other faiths?

[AC] The reason I mentioned those sources is that they have been the most influential but it is Western culture as well. It's interesting though that in Asian culture there are quite a lot of similar ideas, particularly within the Confucian tradition. There is always going to be this fundamental question about is it the way people are or what they do or is it about both, and how do these relate. To some extent MacIntyre is very critical of the notion that we can get some sort of rational agreement across cultures and religions. I think he is right; there are very few things that we can do that way, but we can relate to each other in different ways and be aware of what we mean by human goodness. That's the argument about Virtue Ethics. So in a sense it is transcultural, even if it takes different forms in different cultures. Although I defend Virtue Ethics, I can very easily see its weaknesses as well – but it is the corrective for the notion that you can just reason your way to moral actions and that's all there is to it, which I believe is impoverished; and I think most cultures have noticed that.

I am still not quite getting it! We talk a lot about Virtue Ethics but I haven't really heard what it looks like and I wonder how that story of Ron continues and what happens with a virtuous patient?

That's coming in part two.

Judgementalism

I'm worried about the conversation so far because it seems to me very judgemental in tone. It seems to be saying that some people are good and some bad...

[AC] This is one of the huge dangers. When the Christians got hold of this they tended to make it sound as if this is all about exceptional people and if you're not good enough you're not among the saints. But actually the theory itself is not about *supererogation* (that is to say not about going beyond the norm) it's about seeking, beyond the circumstances you are in, fulfilment of your potential – and that's sometimes practically nothing – how in that circumstance can you still feel: I am a human, I have worth, there is some meaning in my life.

I'm getting more and more uneasy about this. There used to be a thing when I was a medical student which others of my generation will no doubt agree with that it was common for the registrar to say that someone was 'LMF' – lacking moral fibre; I kind of thought we had left that behind.

I think the patient is being virtuous in a sense because what he is doing is saying 'I've got this pain and the doctors don't believe me so I'm going to find out what it's all about and I'm going to fix it.' You could say that's being virtuous: he is being the good human being in going to sort himself out but he is not being virtuous in terms of being compliant with the doctor in the old-fashioned paternalistic sense of what a doctor is and does. Does that mean that the doctor is un-virtuous because she should have recognised her failings?

[AC] Yes. There are always two sides to these interactions and a power imbalance. The patient seeking medical advice is acting in a way to get through the situation; the doctor who fails to listen, doesn't pay attention and doesn't take what the patient is saying seriously, is failing...

[partly inaudible question]... isn't the doctor under obligation to treat him..?

Absolutely. But I haven't succeeded (in making myself clear) because everyone is still thinking that when I talk about a virtuous patient I'm talking about someone very exceptional and good ... I'm afraid I'm losing you. This is not about that, it's about making sense of your life and having a sense of fulfilment despite the circumstances that you are in. Some notion of courage and perseverance is one aspect. Of course the patient who whines and doesn't want to take care of herself still has to be cared for by the doctor. This is not about what is nice or nasty for doctors or what his obligations are: it's about understanding and seeking to help patients to be in the situation of patienthood.

Eudaemonia

It seems like life is a lot simpler than we are sometimes led to believe. I try to put myself in my highest level of functioning which is effective. For me, every situation has a set of good appropriate actions: things that make sense given the circumstances; given the doctor; given the personality of the patient; and with all

those sets there is at least one action which is the appropriate thing to do. People think the word appropriate has to do with rationality – no. Appropriate deals with everything about humanity: what does your heart tell you; what does your brain tell you; what would you say if you were the most evolved being in the world about how to behave; and it seems that the standard of behaviour is always to do the most appropriate thing that you can possibly do in the circumstances.

Psychological studies have clearly demonstrated that many mental activities are fully shared between all human regardless of cultural. This is the basis of Jung's concept of the 'transpersonal psyche', or 'evolutionary mind of mankind'. Subsequently, it seems that study of the transpersonal is a most auspicious place to initiate understanding of why our species persists in expressing certain behaviours and belief systems. To accomplish such, we begin looking at the psychological profiles and behaviours of the individuals comprising many cultural groups so to detect what neuropsychological components have been selected and have proven culturally successful. Once we have come to understand which neuropsychological components are functioning and influencing each individual within a culture, for example the cultural myth, medicine can do something to useful to reframe such myths and modernize them so to be more efficacious.

[AC] The Aristotelian view of that would be *eudaemonia* because what you have done is to manage to fulfil what's possible for you in the circumstances. Therefore, despite those being hellish if it's a very bad illness, there is something there that you have achieved, that you have fulfilled, instead of feeling totally abandoned, hopeless and not in relationship to others anymore which is what bad illness does to people. In a sense you have just summarised it in a slightly different way.

Is it the flip side of Christopher Reeve? We all agree that he was a virtuous person who found meaning for his life, but where do you place that young man recently who was also rendered tetraplegic who decided to go to Dignitas and end his life? Where does that fit in?

I find that a very difficult question because I feel that that's not the way to go personally. So I have to answer in terms of what was appropriate for him in his circumstances. I vividly recall a patient whom I was very involved in when I taught in New Zealand. She had become tetraplegic and told the whole medical class that all she wanted to do was die. We said you've got young children who are dependent on you and so on. She persevered – there was no Dignitas available to her – but when an infection came she refused all treatment and she died. I admired her hugely, and so did her children as we felt she was very courageous. The risk in the theory is that it seems to involve concepts like virtuous people and lacking moral fibre and so on, and asking, does she or does she not fit it? But the essence of the theory is not about that; it's about fulfilment of the self in a way that will make sense for you. It might not make sense for me so it's not judgemental.

So the virtues are subjective..?

Not entirely but I'm going to come back ...

Can I try this? I'm concerned about the judgemental thing – I don't think it's judgmental at all. This applies also to ordinary living. You made the point very elegantly when you said you are thrown into 'Heidegger-ism' – you are thrown into a set of circumstances, so how are you going to be. You have a lousy boss, a dead-end job, but you can still begin that kind of meaning-making. It's a continuum and it's when we get into the domain of illness that suddenly the model changes. I think in

ordinary life we face this all the time: how do we deal with circumstances we would not have chosen, and in this case it's an awful set of circumstances? So it isn't that you are a better human being if you are a paraplegic and you can make meaning out of it, or a bad human being if you can't or if you decide to terminate your life.

The sadness in terminating your life is that you have ended every other possibility, but I don't see this as a moral – as a judgemental issue: judgemental in the sense that you are bad for having done something. It's a thing we confront all the time, in the domain of relationship, the domain of work, and probably the most difficult, the domain of health. What happens when there is change in any of those three domains, and you are in a set of circumstances you would not have chosen? How do you stand with respect to that? How are you going to be? Before you get to do it you begin to deconstruct or to construct, however you want to represent that to yourself. That, I think, is a fundamental issue so virtue has to do with exactly what you said: the activation of potentiality: what am I doing here? I can't talk, I'm losing function – I can't see how I can continue to live, how I can continue to be in this relationship..?

Human nature

I'm not sure if I am missing the point. If people are fulfilling their nature, what if they don't have a good nature?

[AC] That is one of the issues raised by the person who asked if it was subjective. I said earlier on that Virtue Ethics does depend on some sort of theory of human nature. A theory of human nature implies that there is a way we can all be – a common thing, so it's not entirely subjective. If I were to say 'I find fulfilment in [inaudible]', there's something wrong with that. That would be the *reductio ad absurdum* of the argument. As long as it's right for you it's right. That can't be it so we are forced to begin to look at some common features of what we might call humanity as we would hope we can all instance. And so these people that cause us great distress; the extreme examples of people that cause harm to others are very hard to cope with. So you can't make it entirely subjective. And that's another of the challenges to us here because it has a tendency to begin to look as if it's each individual deciding what will fulfil them.

[RH] Isn't this a rather selective account of human nature, and to some extent doesn't it beg the question, in order to work out what we mean by morality we appeal to virtues which are themselves premised on a particular account of human nature which emphasises the good parts of human beings, and therefore we're in a bit of a vicious circle..?

[AC] Not really: it may be true but when we talk about people being inhumane a common thing we can say about people – we say this because there is something here that really is against the nature of humans and there is something that contradicts the very way humans should be.

It seems that the word resilience comes in here. Some people are very resilient and some just crumble (or lack moral fibre!). When I see people who have got depression because they have had a series of nasty events you can usually tell which are the ones that are going to bounce back eventually, but you also notice that there are some other people who have had serious early life adversity who never really completely recover. They have had adversity early and bad enough to destroy their humanity or their way of choosing or their way of being resilient and doing the right thing. It seems to some extent to do with earlier experience.

[AC] You've put your finger on one of the biggest weaknesses of the theory: the extent to which all sorts of things are created by nurture, or indeed nature and nurture together actually make it impossible for people to act in a way that might be most fulfilling for them. That whole question of the extent to which good character is just moral luck.

Surely we are making a judgement on this particular time in history whereas at other times in history things we would perhaps say are moral or immoral don't apply. Like a serial killer: if you're a Viking you could be deemed as a serial killer, but you were a hero, so we're actually making judgements very much at this one time period and not looking at the greater scheme of things.

[AC] That's a very fair criticism. The notion of what a good character is clearly historically and culturally relative in many respects. Aristotle was a great guy but ...

[RH]...he had some dodgy notions about women and children...

Another worry is that we seem to be talking as if these were fixed traits, so that people have them or don't have them. I don't think that's how life works. Life is a story, a narrative, a journey: we are changing all the time and as we have heard already each of our interactions with another person changes both people, so there is no fixed point here. To say these things exist – to say they are like a state, seems to be nonsense.

Virtue Ethics would agree with that. A lot of Virtue Ethics is about how we develop a good character. In a sense it is about community and the nature of community; a lot is about education. You're absolutely right. MacIntyre would say we are on a journey; we are going to change and we need help, and that's why we need small communities of shared endeavour in order to be able to make this journey in a way that will be most fulfilling for us and for others. It's definitely not fixed.

In relation to the suggestion that Virtue Ethics is an excessively judgmental and inflated idea: if somebody asks 'your friend Jim, what is he like as a person?' the answer is going to be in terms of virtues. We might not use that language but we're going to say he's reliable, he's kind, he's gentle, and these are all virtue words. We couldn't get by without thinking of each other as having dispositions. We are not just interested in a person who on occasion maximises happiness to the greatest number, we want to invite somebody round for dinner and be sure that they are fairly all right. We are interested in people's habits and virtue is a habit.

[AC] Speaking as a patient, there is no question that the character of the doctor matters and not just whether they act rightly (that's the trouble because some can seem like terribly nice people and are actually lousy practitioners). But for the patient this business about the character of the individual is part of what we are looking for and not just the right action.

Virtue Ethics, law and deontology

[RH] My opening gambit used a word that seems to scare most people: law. I'm struck by this assertion that in our interpersonal dealings we do use a virtue framework in some way. I did say at the outset that there was a considerable degree of devil's advocacy in where I'm coming from, but I do think there is a serious challenge that this is not going to be a sufficient approach to morality insofar as, and

this might be slightly optimistic, I think that you can use law as a social entity for governing, creating and representing morality. The judges claim that they don't do that. Famously ten or eleven years ago (at the outset of a ruling regarding separation of conjoined twins which involved the inevitable death of one of them) they said "This is a court of law and not of morals. Our task is to apply the law as it stands". They then spent about 120 pages talking about the sanctity of human life. I don't buy that and I don't think they seriously did, and there is going to be some moral bite to the law which is going to prohibit, govern etc. So in order to do that you have to play up the deontic side of things. I don't know how you are going to create the virtuous moral world unless you are going to have to talk about rules, duties, principles, false consequences and the like.

[AC] I want to respond to this as well as Ian's earlier question [about why Virtual Ethics is called ethics at all, as deontics obviously can be]. There are two ways in which the theoreticians approach this.

One is what is called the 'replacement theory', and the other is the 'complementarity approach'. The replacement camp says: all this stuff about deontology, principles and all that – that's making people into sort of legalists and it's not really about moral life; the whole thing should be about Virtue Ethics. I don't think that works. I am in the other camp. The complementarity theory says we actually need both. We need to talk about principles, about the boundaries that laws might create to enable us to live together, but they won't be enough unless we are also concerned about the development of character. And so the complementary theory tries to pull Virtue Ethics and some form of deontic ethics together in some sort of partnership. The implication of that is that we can't have a situation where the judge says 'this is the law in the country so here is how it is interpreted', because if that's so then the lawyers have no damn use for morality whatsoever. That's the law of Nazi Germany or Apartheid South Africa. So we need a law that is inspired by and imbued with some sense of morality (it is a struggle to find this particularly in international law), and to me there is a marriage between the notion of right and wrong moral duty and values that get you back to the notion of Virtue Ethics. So my response would be that I don't see that as a criticism, I see it as a help. I think we can be partners in this enterprise as long as the law is properly understood.

Research

I want to talk now about some research we did in Bristol. For this project we had researchers in the Netherlands, Italy and several different parts of the UK, with different groups of patients, some with arthritis, and some with endometriosis, chronic renal failure or depression. It was qualitative research. We were interested to see if people dealing with these chronic conditions felt if there were various ways in which they felt threatened; if they were able to be themselves or whether there were threats to maintaining their self-worth and finding meaning and purpose in their lives.

This diagram brings together things the patients themselves saw a 'virtuous patient' to mean: maintaining self-respect; maintaining realism about their disease and acceptance of it; having courage (this was very central) but also maintaining a sense of humour despite their situation. At the same time they felt the need to sustain themselves from threats from within and without. The internal threat was being pushed into self-centredness and the feeling of fragmentation – they didn't feel they had coherence any more. The threats from outside were expressed in terms of the exclusion; the isolation from others in social life; and being stigmatised. And then there were the straightforward threats to the body which seemed to be letting them

down, and fighting to deal with these. We saw this as a kind of dynamic relationship which involved both an external and an internal battle to keep some sense of the self. We believe this did actually fit quite well with what they felt themselves, and not to fit the stereotype of the patient who is always compliant and well behaved.

So that is one example of the application of Virtue Ethics theory to the notion of the virtuous patient. Although there are limitations I think it works a bit.

Criticisms and weaknesses

I want to spend a few minutes talking about criticisms and weaknesses of the theory, many of which have come out in our discussion already. One is that it can either be elitist or stigmatising. There is a risk, partly due to Christianisation, of creating saints and special people, and in saying these are these virtuous people, and these others lack moral fibre etc. That is the risk but I don't believe it is a correct understanding of the theory, because this is not about exceptional people; it is about the potential for any of us to realise that potential. There is also a risk that it is too subjective and too focussed on the individual. That is also a danger, but actually the quality of our communal life is very essential to this. This relates to the problem of isolation: if you have an illness that lasts too long and gets worse, you can get more and more cut off from communal life. So part of sustaining the person involves the quality of communal relationships.

The cultural aspect is clearly a difficult one. Suicide is an interesting example: some cultures have seen suicide as a noble act and others as entirely unacceptable. So is suicide entirely culture-relative? Another one is the 'Good Death'; what is it? That is *also hugely culture-relative. Attitudes vary from the young man who goes to Dignitas*, to the idea that you never tell someone they are dying, which is very strong in the culture I am working in now. I think one has to accept that this concept of the virtuous person is a slippery notion and hard to pin down. But I think it's worth the chase.

There is a very interesting philosopher called Martha Nussbaum. She is an Aristotelian, as are most people working in Virtue Ethics. She has talked about some basic human experiences that pull out the question of virtue as opposed to choice of action. One of these is that we know *we are creatures that are going to die*; that in itself makes certain demands on our character. Another is *generativity*: she says we all need to create something, to leave a legacy, whether it be children or books. The other is *vulnerability*: we are all subject to threats. Illness is an extreme example of this but it is the common human experience is that we are vulnerable. Nussbaum says these are a thin account of virtues and common across cultures; the thickening of them is culturally relative. Whatever culture you are in you are going to die, but the way a good death is understood is going to be culturally relative.

As a Psychiatrist, I do not think studying brain function using imaging technology is the gold-standard for studying human psychology. It seems helpful for establishing the importance of various brain areas in displaying psychological states and secondary behaviours but to insist that this is sufficient to understand why individuals and cultures seek meaning and value in life is bordering on secular religious fervour. To my understanding, the proper way to look at the cognitive-affective aspects of human functioning is to realize that we are dealing with psychoneural processes; the mind-brain is the unit and not just the brain. I think the Jung school has established this rather well.

It is clear that the mind is emergent to the brain and psychological function will not be displayed objectively without a proper instrument; but this does not support the concept that mind is only an epiphenomenon of the physical brain. In fact, the mind-brain problem is not solvable using this assumption. Something is missing, the question is what? Until we discover what this missing factor is, I would recommend that we don't throw out psychology and its introspective tools.

I have found that to study any system, one must use careful observation, looking for regularities and consistencies so to infer the set of operating rules and propose models to include our observations. This is the method of science. The deficiency of such a process is that it is linear and the presumptions underlying the model tend to bias our view. To prevent such biasing, it is equally important to learn how to properly observe the operation of all systems in general, and then, to guess or infer an operational rule which can be tested by observing the system under perturbation. The reason why a top-to-bottom approach is useful is that it is multidimensional, involving any number of mental associations for constructing a model. I have found that the greatest discoveries are made by 'guessing an answer' and then quickly testing it to see how it fits. One can make 99 wrong guesses and minimally test quickly, realizing that eventually one guess will be a good one and because it arises after the incorrect models will be richer in the end.

I think every scientist is better off being incorrect most of the time and correct now and again for it minimizes our vanity.

Basically what you are uncovering is this: discussion between people who have a scientific background who are used to bottom-up theory from data to hypothesisation and are only concerned with trying to get adequate descriptions of the way things are. And people like me who have always been taught the other thing which is trying to construct evaluative frameworks knowing that everybody will be wrong (just as theories are only temporary). So this is the basic conflict between the *descriptive* and the *evaluative* approaches. Ethics have got to touch reality. I'm a medical ethicist and I have got to know how to help patients and doctors and other health professionals. So Virtue Ethics does have to deal with questions like 'what about this person who is really rather nasty?', because it is an evaluative theory. It can't just say, 'well, the description says some people are like this and others like that because that's the way they are' – it tries to suggest evaluations or aspirations. So it's very tricky but I also think worthwhile.

Does Virtue Ethics 'work' in clinical practice?

You posed the question does this work and you lost me – work for what? Is it a description of the reality that you are after? Why are we discussing this? Is it going to help me to work with my clients? Does the concept of values come into this?

The answer to the second question is yes – both the values that your client holds and what you hold, and how they interact. The question 'does it work?' Doctors on the whole, and maybe other health professionals here, have been brought up on the principles of Beauchamp and Childress so you look at autonomy, beneficence, non-maleficence and justice. It's a formula, and you look and ask how do I decide what's best for me to do with my patients. While that has some strengths, it also has weaknesses. What I am asking is can this theory help you in your daily interaction with patients and clients? Or is it just theory and people like me playing with ideas? Is it useful with helping people in pain? I suppose what I have been trying to say is that perhaps it could be useful because it is looking at the character of people and

how we can help them develop those traits that will allow them to deal with the situation they are in. And also your character, and the nature of the way you relate to your clients – not just about whether what you do is right or wrong – but what kind of a clinician – what kind of person are you when you deal with your clients? I have tried to talk about patients today because I know others are going to talk about practitioners tomorrow. The patient bit is the harder and it can sound either impracticable or judgemental.

In my preamble to the programme I wrote from my very limited understanding of Virtue Ethics that it implied that people involved in pain medicine would have to be in it with heart and soul, but looking at it again after this morning I have been thinking maybe that sounds a bit pious ... but is it true?

Well, certainly heart. One of the popular accounts of what Virtue Ethics is about is that it is about 'habits of the heart' – in other words it is way you relate to yourself and others. 'Soul' will be open to the criticism that we are only talking about religious people here.

Aristotle believed in the soul...

[RH] I want to leave the last word to Ron Berghmans because I think it picks up on the last two points about this bridge between patient and professional around cancer. Talking about pain he makes reference to suffering which is going to be evaluated from two perspectives: the sufferer and the professional. He says:

“The most important aspect I learnt from my illness experience with a fatal medical condition is how crucial attentiveness and open and careful communication with the patient are. Being seen and heard and being recognised as an individual who is in serious need is far more important than being informed about statistics regarding prognosis and chances of survival. Authentic presence, and the expression of one’s own humanity, insecurity, doubt and fear by professional carers acknowledge at the same time that life is precarious and vulnerable, and that hope and fear go together hand in hand”.

Recommended further reading:

Ashcroft, Richard E., Campbell, Alastair V., Dieppe, Paul A., Swift, Teresa L., and Win Tad, (2002), 'Living Well Through Chronic Illness: The Relevance of Virtue Theory to Patients With Chronic Osteoarthritis', *Arthritis & Rheumatism (Arthritis Care & Research)* pp 474 – 478, Vol. 47, No. 5.

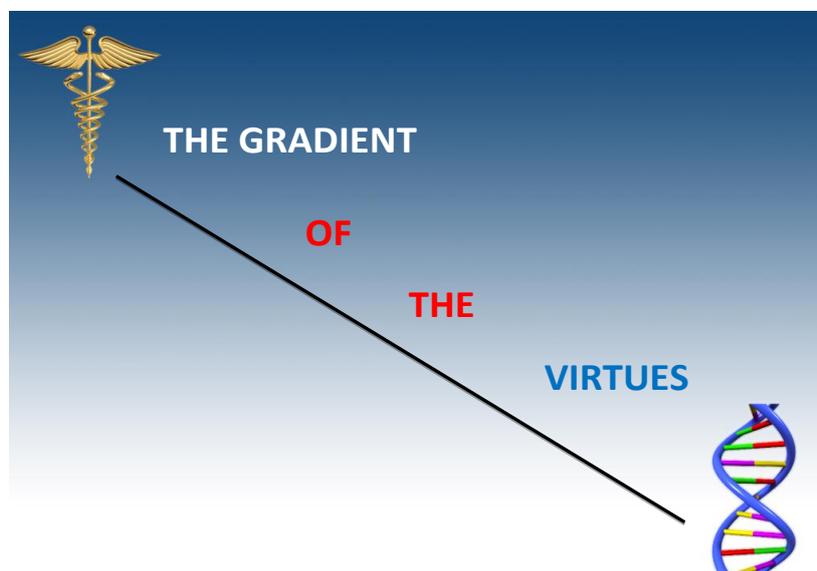
The gradient of the virtues

Jeremy Swayne

“...if medicine’s advocacy in pursuit of a remedy for social inequalities represents a high point on the gradient, then medicine’s complicity in torture represent its lowest.”

At the last two conferences you have generously allowed me to ride two hobby-horses. The first was the conviction that a proper understanding of human wholeness is essential to our understanding of medicine’s responsibility for healing; and essential in particular if medicine is to impart *meaning* to the experience of illness and suffering, without which true healing cannot proceed. And the second, that we cannot comprehend this wholeness unless it is understood to incorporate, and I mean literally embody, the soul; and that this requires a better understanding of the psychic dimension of life, and of the human psyche, which I suggested constitutes the matrix of the soul. For me, these two horses draw the chariot in which the healthcare professions must travel if they are fully to serve the goals of medicine and fulfil its healing vocation. I fear that Western medicine is precariously poised on a slippery slope that I have called ‘the gradient of the virtues’.

Yesterday’s speakers have all helped to lay a very helpful foundation to what I want to say. Ian [Yellowlees] really mapped much of the landscape, and it is possible that I may exacerbate some of the discomfort that he caused! Kate Maguire sketched out some of the dynamics of the problem, particularly with regard to what is going wrong with the health service, and she also mentioned something very important and has to do with this:



These two symbols which I use to represent the polarisation in medicine which I am interested in remedying, so to speak. The top one, the caduceus, originated as the symbol of the Egyptian god Thoth and progressed through the Greek adoption as Hermes, and subsequently as Mercury, and became the symbol of Aesculapius, whose daughters were Hygeia and Panacea. It gradually accumulated snakes as the years went by: it started as a staff which acquired one snake (the staff of Aesculapius is thought to be properly depicted as having one snake and no wings) and ended up

with two. The two snakes are commonly represented as knowledge and wisdom trying to intertwine and maybe compete or maybe relate to one another. To me that is a very important symbol of the problems we are wrestling within this group.

There are various people in various ways who claim that there is a crisis in medicine. This crisis has been identified by the newly launched College of Medicine (which is broadly representative of the great and the good in the mainstream healthcare professions, and of complementary medicine and patients) in their introductory policy document::

'Something has gone wrong with healthcare. Doctors tell us medicine is in crisis, while nurses say they are in despair. Despite the commitment of health professionals, the good intentions of politicians and administrators and unmistakable support of the public, we face a crisis of caring, a crisis of costs and crisis of commitment.'

October 2010. www.collegeofmedicine.org.uk

I want to suggest that in addition to this there is not only a crisis of morale, there is a crisis of morality. This theme emerged increasingly as I was working on my book *Remodelling Medicine* [2011, Saltire Books] which has to do with the conflict between medicine's responsibility for healing – its mystery, at one end, and the reductionist science of medicine which is so valuable and important to us at the other. One thread in the argument as it has developed is that the biomedical model has subverted medicine's essential vocation and goals – its healing vocation. Doctors have been consistently rated as the most highly esteemed of all professional classes and as such can I hope to be held to represent the whole healthcare profession. Our vocation and our role and our high esteem in society impose great moral responsibility. I am concerned that as a profession – not necessarily as individuals and least of all perhaps as members of this particular group – medicine is failing to fulfil that responsibility. This concern was greatly reinforced by reading the book *The Virtues in Medical Practice* by Edmund Pellegrino and David Thomasma (OUP, 1993).

Central to their case are the assertions that as professionals, we have great moral power, and that we should be a model and inspiration to others by upholding what is right and good in the context of the special human relationship we have with our patients; and that this requires above all, that we resist and refuse to do, anything which is not in a patient's best interests. We must not reshape our ethical codes to conform to the social or cultural trends of influences that may be demeaning to that special relationship. Being a healthcare professional imposes obligations that forbid us to become an entrepreneur, a businessman or an agent of social, fiscal or economic policy, or to adopt any role or attitude that is not completely faithful to our vocation.

The Virtues in Medical Practice is a chastening, but at the same time, inspiring book that all healthcare professionals, and certainly doctors, should read. It is chastening in that it sheds a harsh light on our lapses of moral responsibility, but inspiring in that it affirms the virtues that lie, or should lie at the heart of our vocation and our professional role. They get right to the heart of the matter when they highlight our responsibility to a person in need within that special and highly privileged relationship which is of course the restoration or improvement of health, but essentially to *heal*.

These virtues are hard to come by. And they are not the automatic fruits of a medical education, even though they are traits of character whose formation is every bit as important as the technical education that students certainly will receive, and that may have been part of their original motivation towards medicine. The responsibility to be

faithful to the individual patient is made an even harder task by a healthcare culture in which the relationship of trust has been in many instances undermined by a contractual relationship, by politically imposed targets and guidelines, by market forces or by an attitude in which the healthcare professional has become the technical servant of the patient's autonomy. Constraints such as these may seriously compromise our ability to discern what moral choice or course of action is really in the patient's best interests.

The eight virtues

Pellegrino and Thomasma describe eight cardinal virtues, which I have paraphrased slightly here:

Phronesis: The link between the intellectual virtues - those that dispose to truth (as represented by art, science, intuitive and theoretical wisdom), and those that dispose to good character (e.g. courage, generosity). A sort of blend of practical intelligence and wisdom.

Prudence: Recognising what is right and being disposed to do it.

Trust

Justice: The strict habit of rendering to others what is due to them. This is not always compatible with autonomy.

Fortitude: The tenacity to obtain the required treatment for a patient; resisting any pressure or temptation to do otherwise

Temperance: Self-control, discretion; the responsible use of power on behalf of patients.

Compassion: The ability to feel something of the unique predicament of the patient.

Integrity: A close correspondence between the integrity of the practitioner and the integrity that we are seeking to restore in our patient; between the person of integrity and the integrity of the person. The completeness, wholeness and unity we seek to restore in our patient must be reflected in ourselves and in the integrity of our values.

Medicine and society

Pellegrino and Thomasma highlight the influence of technology, and the changing roles of the medical profession in response to public and private expectations. Policy makers want us to be gatekeepers of society's resources and instruments of the bureaucratic 'apparatus'; while 'patients want absolute autonomy and see health professionals increasingly as instruments of their wishes.' These issues undermine medicine's moral obligation to place the best interests of the individual patient at the heart of the healthcare process. Some other instances that compromise our virtues in this regard are: decisions based on fear of litigation; submitting to policies contrary to clinical judgement; colluding in medical entrepreneurship; colluding in the use of treatments or tests of dubious necessity or validity; tolerating iatrogenesis; and failure to take risks on behalf of the patient – all of which involve an understandable but inexcusable falling back on legitimate self-interest.

But is this criticism fair? Surely medicine has shown great moral leadership in promoting many changes of benefit to society? Certainly it has. Medicine's longstanding condemnation of health inequalities is one still topical example of medicine providing powerful advocacy on behalf of the sick, and fulfilling its moral responsibility towards the society in which it is embedded.

This represents a high point on a not altogether admirable gradient in the moral relationship between medicine and society; the gradient of the virtues that I am

describing. The nature of this gradient can be starkly illustrated like this: if medicine's advocacy in pursuit of a remedy for social inequalities that are at the root of much sickness and suffering represents a high point on the gradient, then medicine's complicity in torture and the medical atrocities of the Nazi regime represent its lowest.

It may be something of a shock to you, as it was to me when I first read *The Virtues*, to be asked to think of medicine like this. But its harsh analysis of the potential moral failings in medicine does put many issues central to the remodelling of contemporary medicine in an uncomfortably clear perspective. Because if medicine is to look different in the future, the implications of its social and cultural responsibilities have to be addressed.

Key 'bands' in the spectrum of relationship between medicine and society, in addition to advocacy, include people's respect for medicine, its role in ethical controversies, its influence on life styles, its role in shaping and implementing public health policy, its role in setting occupational health and health and safety regulation, its role in shaping and responding to expectations of healthcare, and its role in shaping attitudes to life and death. This is a very broad spectrum. It reflects both the high degree of medicine's responsibility towards society, and its vulnerability to social and cultural trends and influences that may not be consistent with its virtues, vocation and goals. The way it copes with these determines its place on the 'gradient of the virtues' in any particular instance.

Issues raised by this entanglement of medicine with society are sometimes straightforward, sometimes impossibly difficult, and sometimes very subtle. Where there is an obvious social ill to be challenged and a common will to do so the responsibility is clear. For example in the UK there is a reasonably broad consensus about the scandal of health inequality. In America, where the debate about healthcare reforms has been fierce, the situation is more difficult because of the lack of consensus. In the UK the medical profession is at a high point on the gradient of virtues in this regard. But in America its position is much more ambivalent because of the degree of medicine's collusion with the status quo that deprives millions of healthcare.

Abortion is one of the impossibly difficult issues. Abortion is a legal procedure in the UK, but the legislation is controversial, and the range of ethical opinions extreme, depending on different understandings of the value of the life of the embryo, the stage at which it becomes a person, the 'right to life', and the freedom of the mother. Some doctors and nurses will have nothing to do with abortion because it conflicts with their belief in these matters. Some see participation in abortion as wholly consistent with the goals of medicine and high on the gradient of the virtues; others quite the contrary. This is just one area where clinical, ethical, social and political factors interact in very complex ways, and there are no right answers. But there is no escaping medicine's role in all this.

Acquiescence or resistance

A difficult issue of quite a different kind arises when local or national management or policy decisions direct or constrain the actions or decisions of clinicians in everyday practice. Very often this has to do with the cost of a particular drug, service or procedure; perhaps in relation to the number of people who will benefit from it, or the evidence for its efficacy. Inevitably this often limits the freedom of the patient to receive the treatment of their choice, as well as the freedom of the clinician to do what he or she believes is best for the patient. Recent examples range from the

provision of certain expensive drugs for 'minority' diseases, through the closure of some small hospital units, to the availability of homeopathy on the NHS.

Many consequences of the frequent 're-organisation' of the health service have also made it difficult for doctors to exercise clinical freedom and for patients to feel valued. To be treated like an item on a conveyor belt in order to comply with a bureaucratically acceptable outcome may provide *efficient* care but it does not provide *humane* care. Another consequence has been the emergence of new risks such as susceptibility to hospital acquired infection due to rapid turnover in bed occupancy, inadequate out-of-hours cover in primary care and poor clinical outcomes in NHS treatment centres.

Tolerance of organisational problems like this might be variously attributed to collusion, acquiescence, inertia or a feeling of impotence on the part of health professionals. Whenever they result in a diminished quality of care they constitute, to some degree, the 'moral malaise'; they allow medicine to slip down the gradient of virtues. This is a harsh thing to say, but whenever a practitioner follows the path of least resistance when facing a decision on behalf of a patient when another course of action would be better, he or she is moving down the gradient.

The respect in which the healthcare professions are generally held by the public in the UK would seem to reflect their high position on the gradient of the virtues. The great majority of people are immensely grateful for the skill and the care they receive, and are likely to blame errors and failings on the system rather than on the individuals who work in it. But this respect imposes great responsibility. Health professionals seem to have become pawns on an organisational chess board. They have also become trapped within a biomedical framework that has narrowed the focus of patient care, greatly to its detriment. This is not the way it should be, and medicine's acquiescence in this reflects a failure in its moral responsibility.

Pellegrino and Thomasma state the problem unequivocally:

'The physician – and the nurse and other health professionals as well – are at the moral centre of healthcare. They are society's delegated advocates for the sick. Ultimately they are the instruments through which health policies are implemented. They are the final common pathway through which all that happens to patients must go. They have enormous moral power if they choose to exercise it. No one can make health professionals do what is thought to be harmful to patients. As long as the reasons for resistance encompass the good of the sick, doctors can prevail against unethical practices and policies, and win public support for their resistance. Unfortunately, their collective professional societies are often so patently self-serving that they lose all moral credibility.'

Medicine aspires to bring relief from suffering and better quality of life where there is illness, disease or disability; or where there is an imminent threat of these. Its first responsibility is towards the person affected or threatened in this way. Its second is for advocacy on their behalf. That advocacy may concern those involved in the personal life of the patient, and perhaps their family – and, indeed, towards managers and policymakers - to represent and inform, and sometimes to resist. In both cases there may be a duty to resist the expectations and demands of others that are demeaning to patient care. Clinicians seem not to be so good at the advocacy that resists unenlightened care. In fact, they are often acquiescent in healthcare policy of that kind, even while lamenting it. Why is this?

Recently I was part of a small group of university contemporaries meeting informally to reflect on life at retirement. They all had considerable responsibility and influence in their various roles and occupations, and all identified areas in their respective fields of experience where creative change was badly needed, but where inertia and resistance to change prevailed. The reasons they gave were primarily bureaucracy and fear; fear, of rocking the boat, of loss of job security, of litigation perhaps. A third constraint in some instances was ideology, or the impasse created by competing ideologies.

Medicine's acquiescence in policy and practice that it distrusts or deprecates probably has similar causes, and is an instance of the institutional inertia and resistance to innovation that is evident throughout the history of scientific medicine.

There are subtle but profoundly important ways in which medicine has the opportunity to influence social and cultural values and attitudes for better or for worse. Foremost of these is the way that medicine conveys a mechanistic biomedical message or a humanistic person-centred message in conversation with patients; and the way that it achieves or fails to achieve a healthy, whole-making balance between the two. When the *person* ceases to be the focus of care, medicine has failed.

Core principles

There are ten core principles of the therapeutic process that are necessary to preserve this right balance:-

1. Presence (*being* there for the patient)
2. Attentiveness
(observing, listening, hearing; giving our *whole* attention; an aspect of 'presence')
3. Compassion (humaneness, empathy)
4. Time
5. Knowledge
6. Competence
7. Trust
8. Integrity
(honesty, humility, maturity, self-knowledge, integratedness; essential to trust)
9. Discernment (insight, awareness, imagination)
10. Inter-professional awareness
(knowledge of and respect for other expertise that may benefit our patient)

Together these represent the essential ingredients of the relationship that as patients we may seek and as practitioners we should offer in any healthcare encounter and that will ensure that the relationship is wholly virtuous.

In the introduction to a book by James le Fanu called *The Rise and Fall of Modern Medicine* (1999) he states a paradox that lies at the heart of the dis-ease that affects many healthcare professionals. In summary, he says, what needs to be explained is why the spectacular success of modern medicine over the past fifty years has had such apparently perverse consequences, leaving doctors less professionally fulfilled, the public more concerned about its health, alternative medicine in the ascendancy, and an unaccounted for explosion in health service costs. Understanding the cause

of so many doctors' discontent (the proportion expressing 'regrets' about their choice of career quadrupled in 20 years) is important, because 'those unhappy with their trade may lack the passion necessary to practise it well'. When morale is so low, the moral effort required for virtuous practice will also be depleted.

In a Personal View in the British Medical Journal (BMJ), Accident and Emergency (A&E) Consultant Nigel Rawlinson bemoans the harm done by targets, specifically the requirement to discharge patients, or transfer them to other wards or units, within four hours. The department engaged with the policy philosophically and conscientiously. Indeed, there was little choice:

'We had to engage with the targets that had been set, and use them to attract the resources we needed to treat patients faster'. The pressure to move patients on within the deadline is reflected in the fact that most leave the department within the last 20 minutes of the four hour target period. He identifies several sorts of harm resulting. First, the direct clinical risk that serious conditions that might have been better stabilised if the patient had stayed longer in the department will, for example, require more intensive care subsequently than would otherwise be the case. The task of taking a patient's history has changed from one that seeks to be holistic to one that is problem solving; the ability to listen is undermined; open questions designed to help patients tell their story are replaced by closed questions that categorise them into a convenient group; the opportunity for more subtle assessment of "the story behind the story", and to involve social and community services in solving the problem underlying the clinical presentation, is lost; vulnerable, frightened inarticulate patients become objects of annoyance rather than subjects of care, and astute diagnosis of more subtle clinical conditions is compromised. Targets, 'while achieving a great deal in terms of resource and timeliness, have done this at the expense of holistic patient care - - (and) detract from the pursuit of clinical excellence.' (Rawlinson N. 'Harms of target drive care – a personal view', *BMJ* 2008; 337:237)

The claim that those gains have improved patient care for the majority is a totalitarian argument that compromises the doctor's ability to be the advocate of the individual patient. To sacrifice this personal commitment for the sake of the majority, Rawlinson argues, is poor patient care. And in this he echoes another quotation from Edmund Pellegrino which concludes:

'The commitment of the physician is not just primarily to the patient, it is fully patient-centred. Considering the common good is not an add-on; it is morally wrong.' (Pellegrino, 1993, *ibid*)

Perhaps the most shaming example, because it is so simple, comes in another BMJ Personal View: *Could kindness heal the NHS?* by GP Dr Angela Jones. She reminds us in a catalogue of examples that apparent unkindness is too frequent an experience in the NHS. She contrasts the experiences related in anecdotes and official reports of poor treatment with the commitment in the 2009 NHS Constitution:

"to respond with humanity and kindness to each person's pain, distress, anxiety or need. (To) search for the things we can do, however small, to give comfort and relieve suffering. (To) find time for those we serve and work alongside. We do not wait to be asked, because we care." (Jones, A. 'Could kindness heal the NHS?' *BMJ* 2010; 340:c3166)

And she suggests that:

'What might seem to be a ridiculously touchy-feely notion becomes, on reflection, anything but. If we abolished unkind acts, trays of untouched food would no longer be taken away from debilitated patients on wards. Cries for help unheard and buzzers unheeded would become things of the past. Administrative delays leaving patients waiting for weeks or months in pain or fearing undiagnosed cancer would not occur. Concerned patients and relatives would no longer be brushed aside, ignored, or patronised. Furthermore, the universal application of kindness would mean that the needs of staff, in terms of training, support, and workload, would be acknowledged and met. This in turn would enable us to avoid the desensitisation that occurs when there are simply too many demands on our time and we feel forced to block out our patients' needs so as to function and survive.'

The meaning of life

And finally, medicine's big question: the meaning of life. Medicine is inescapably bound up with the human condition. Medicine meets with birth and death on a daily basis. Pain, disability and suffering, doubt and fear, hope and courage, anguish and joy, fecklessness and nobility, are its common currency. Even the petty bodily and emotional inconveniences that people take to doctors are episodes in the story of that person's life. Even these say something about the meaning of that life. Every medical encounter is an encounter with meaning. Everyone engaged in any activity that contributes to medical endeavour is implicated in formulating and expressing the statement that medicine makes about the meaning of life. The researcher, the pharmaceutical industry, the technician, the administrator and the politician, just as much as the practitioner, engage in day to day encounters with patients. By virtue of our role in the lives of men, women and children, and of the intimate and personal nature of that role, we are constantly helping to define, for better or for worse, what it means to be human. That is a fact of life that medicine may ignore but it cannot escape.

This is the nub of the healthcare dilemma: to reconcile medicine's struggle with the precariousness of existence with the affirmation of meaning in life that transcends the precariousness and the pain; to manage the biological precariousness without diminishing the biographical significance of life. Openness and truthfulness will make it at least less difficult, if never easy, to resolve these tensions within that special individual patient-practitioner relationship where ultimately they have to be resolved. The quality of that relationship will be critical, and critical to informing and facilitating the wider discourse within medicine, which discourse, in turn, will play a part in the still wider discourse within society about its values and priorities. It is an enormous responsibility that we have, and must keep us struggling upwards on the gradient of the virtues against the prevailing wind of the cultural trends and forces that presently seem to be shaping our society.

Discussion

Although I was agreeing with most of what you said, one thing that has been worrying me throughout all of these discussion is that if we take this approach and say we should be striving to do the very best we can for the patient and resist all temptations to do otherwise, that is fine and very virtuous, and great for that patient. But what I think we miss sometimes is that if we do that, what we are likely to be doing is compromising the care of the next patient.

So are you going to compromise the care of the first patient because you don't want to compromise the second..?

The General Medical Council (GMC) would have us accept that our only responsibility is to the patient in front of us .It has it in its code of practice. And the patients we haven't yet seen are not our responsibility at all. That is tricky because if we commit all of our time to the patient in front of us we will compromise what we can do for the next and I think that's a difficult balance...I think it's fundamental...

It is fundamental and it's a really tricky compromise that in daily practice we do have to make. The solution to that problem goes much deeper. It has to do with some of the things I touched upon to do with the meaning of life and our responsibility for how we shape and respond to expectations within the relationship with the patient. You may know one of my favourite quotations which comes from a story by Kafka: "to write a prescription is easy, but to come to an understanding with the patient is hard". What is harder still is to help the patient come to an understanding of themselves, and the understanding that we have to reach with patients is to do with the compromise which is having to be made. That is an almost impossible task in the prevailing healthcare culture: to achieve that level of understanding with patients whose expectations we have helped to shape into something that is quite unreasonable and unmanageable, and unaffordable. But if things are going to change we have got to start doing it. That is why I used the words 'openness' and 'truthfulness'; we have to have the courage to develop a new relationship with patients.

I forgot to mention, when I was thanking yesterday's speakers with helping me today, that having wrestled throughout the evening session with the idea of the virtuous patient I eventually came to an understanding that I found really helpful in thinking through this difficult balance between the virtuous practitioner and the virtuous patient: that it is a *symbiotic* relationship. It is a huge challenge and actually requires each one of us to have the courage to behave differently and converse differently with patients. There is no easy way out. We have to do something about that compromise so that people understand that what happens to them is going to affect somebody else. This has also to do with the concept of healing as something that relates not just to the individual, but also to the community, and healing within an individual has to do with that person's responsibility to the community and their greater capacity to contribute to that in the future.

I don't disagree, but I think there were two glaring omissions from your talk. One you did touch on but then skated over was the assumption that all medics might share the same ideology whereas I see it as entirely possible. Indeed I encounter it daily with my husband as we come from diametrically opposing social and political ideologies and yet I would hope that we both have great integrity as medical practitioners. But we would have completely different solutions to the current position in the NHS.

Secondly what we didn't mention was money. If we had lots and lots of time and resources to devote to our patients then we might be able to practice the most virtuous medicine but the country might be in the same position as Greece or worse...

Virtue Ethics and end-of-life care

Richard Raspa and Robert Zalenski

“We are going to go from the premise not that death is an arbitrary endpoint in this unremitting journey through the years...but rather that there are stages in a life cycle.”

[RZ] In the USA we have this two stage curriculum where you get a college degree, and then go to medical school for four more years. The pre-med curriculum is focused on the sciences so they make sure that you understand what an atom is, before you understand what a biochemical molecule is, before you understand what an organelle is etc. They carefully layer it over four years so then you can jump into medical school. But there is no organised planned layering of what is a relationship, what is healing, what is listening; what are the virtues needed to practice medicine, such as confidentiality, respect and kindness. So Dick and I are endeavouring in our university, where there are hundreds of brilliant, hungry pre-meds, to have this curriculum in premedical humanities.

Our goals today are to talk about four different things. One is the current biomedical model of living versus a Life Cycle model, and then to talk specifically about the Final Stage of Life, based on Erik Erikson's concepts; to discuss a little bit about the goals of the last period of life, and from there, springboard to Virtue Ethics and to a critical case, that of King Lear.

The current biomedical model

Did anyone read an article in the BMJ in the Nineties which included an off-hand remark that anyone reading it would undoubtedly be dead in one hundred years, which provoked numerous letters to the editor saying that is prejudicial, false, pessimistic etc.? I have just been reading the wonderful book about cancer, *The Emperor of All Maladies* by Siddhartha Mukherjee. The author mentions that between 1950 and 1960, a thousand new medications were introduced to doctors and in that period, if a patient came in with a disease you couldn't do something about, the question was did you really know your stuff, because it seemed that there was a potential cure for everything? I think somehow this got launched into our culture and consciousness so the way we think now – the public particularly, but even physicians - is that every disease is at least potentially, if not actually, curable. I've had patients say to me “I want you to resuscitate me completely, even if it just means I have a heartbeat” and if I ask them why they say “well you never know if a cure for my condition will come up and if I still have a heartbeat I still have a chance.”

So if every disease is potentially curable there is no cap on human life span. Any limit would be artificial – say one hundred or one hundred and ten years. Most people acknowledge that death will win in the end, (if I ask audiences: “are you mortal?” everyone who has been paying attention raises his hand!), but the timing is optional, and it's really up to the family and the individual. Should we stop fighting and die now or go on for a few more months? In the US we have Long Term Acute Care units (LTAC's) which are where you go when you finish with your ten, twenty, thirty or forty days in an Intensive Care Unit (ICU) on a ventilator with drips and every kind of antibiotic, for another 25 days. They remind those of us in palliative care of torture chambers but when people have completed the circle: Emergency Room (ER), ICU

and LTAC, and finish up in a hospice, the ones from an LTAC are the most tenacious – “I’m in the hospice to get stronger till I get a cure, right?”

So this dominant biomedical view of the end of life involves an implicit view of the body as a broken machine, and the period from terminal diagnosis to death is a wasteland. It is a heartbreak time, especially if they come to the ER for their headache or hip pain and are found to have metastatic disease. This is a very common scenario in the US, especially in inner city medicine, for the initial diagnosis to be metastatic cancer. You hope to get through or out of this wasteland with some dignity and without terrible suffering. Cicely Saunders talked about doctors abandoning dying patients and tried to correct it on a worldwide basis, in which she was very successful and we don’t do nearly as much.

The Life Cycle Model and the Final Stage

This is the alternative; it’s not an original idea, I’m sure Cicely Saunders talked about it and it also comes out of the work of Erikson. We are going to go from the premise not that death is an arbitrary endpoint in this unremitting journey through the years (and a lot of my patients say their goal is to live to at least one hundred) but rather that there are stages in a life cycle. When you suggest that there are stages of the life cycle: birth, childhood, adolescence, adulthood and senescence, most people will readily agree that there are these stages, and that it makes sense that they are at once physiological, sociological, psychological and spiritual. But then you say: “and how about the final stage of life: is there such a thing?” I spoke to an audience of thirty family practitioners and residents only a couple of weeks ago or so and only four said they believed in it, and when I asked a believer he said something nonsensical. It’s clearly not a well understood or well accepted concept.

So what is it? If you believe in these other stages in life, what about a final one which is physiological and anatomical, meaning it’s not just a psychological state, not just something we’re making up – not just something to get you off the conveyor belt? I truly think it provides a framework of language and understanding that we can use with patients. It can occur at any age. My daughter was born in the final stage of life: she had a *truncus arteriosus* (no separate pulmonary artery and aorta) which was not fixable. We were told to take her home to die, and when she didn’t die there was the suggestion that she could be fixed by an operation. But neither was true: she cycled between doing well and suffering terribly and finally died at ten months.

If you say to someone you’re going to die right away – you’re wrong. If you say you’re going to have children – wrong again. You are setting all the wrong expectations. If we had been told: ‘I’m sorry, your baby is in the final stage of life’, that would have been an explanation that would have helped us, not to say she would die tomorrow. So it can be at any age (usually elderly of course) that a person has a disease that cannot be cured, that is progressive and fatal. We recognise that all these things are true, and it’s both an ontological state (do you actually have a fatal disease?) and an epistemological state (do you know this? Has the doctor confirmed it?) and there are ontological or epistemological stages. You may say: “this pain that’s bothering me may be metastatic pancreatic cancer. I certainly don’t know if it’s true or it’s not true”. And in the same way, in the epistemological phase (I know it and the doctors know it) – you can still debate whether it’s true: “you say it’s my final run...no it’s not; I’m going to seek these various cures and in a little while we’re going to find out if I’m right or not or you’re right.” We like to frame this as trials of therapy: we’re going to trial this as maybe you’re not in the final stage; maybe there is still a chance for us to extend your life meaningfully by years or decades.

In the US; we frequently see people arrive in the ER who are completely demented; virtually mute; they don't know who they are or where they are, or can't express it. And because they are by now septic, they get antibiotics and a PEG because they can't feed and they get tracheid and put on a ventilator. This is routine. (I discovered recently that the hospital gets 14 times the payment for the basic diagnostic category, e.g. heart failure, if you have a tracheotomy).

Metastatic renal cancer, advanced lung cancer and ventilator dependent respiratory failure are other examples. I had a patient recently with metastatic prostate cancer who came to the ER with delirium, shortness of breath and pain, and had been that way for a couple of days. He had received every conceivable kind of chemotherapy and other adjuncts and was transferred (by an enlightened ER doctor) to our inpatient hospice unit. I asked his wife where he was in his illness and she talked about further treatment to make him stronger but hadn't been told he was dying. His Oncologist confirmed that there was no more useful treatment but *that he had never said he was dying*. When I explained to his wife that he was in the final stage of life and was getting the best treatment in the hospice she took that quite well, as people often do, as you can argue about it, but not with it, and it seems to have a weightiness and a frame to it that is difficult to resist either intellectually or emotionally.

The background to this is Erikson's model of the eight stages of life from birth to death. Each stage involves crises with which you can cope in an adaptive or maladaptive way and each crisis may precipitate an opposite response. He called Stage Seven 'the crisis of meaning': when you get to the stage when your kids are born and you are trying to figure out what's next. He said the positive virtue in this phase is that you can develop *generativity*: caring about the next generation, coming up with tools that are going to help – perhaps creating a foundation like Bill Gates – whatever is your way of showing caring for the world you are leaving behind you. The alternative is stagnation: "I can't do anything more. I've had my shot, I've had my kids and now I'm just bored" The virtue is caring.

What we want to say, and I think Cicely Saunders would say, is that in this final stage – Erikson's Stage Eight - is not just: 'you're dead, have a good one, we'll see you', but 'you've entered this last stage of life and it has its own virtues, rewards and possibilities. You can go from thinking: if I have cancer I want to get all the therapies that will keep me alive longer, to saying to my doctor: dammit, the mandate I am putting on you is to let me know when I have six good months left, because I want to use those six months to do those things in the final stage of life for me. You're robbing me of life if you use up all my time left with these treatments that aren't going to cure me anyway'.

What is universal about the final stage (and Dick will talk about this in the context of King Lear) is that it is time for a life review. Have I lived a good life? Have I helped people? Have I stood for what I have always believed in and why I became a doctor? The alternative can be despair. I work part of my time in the Veteran's Administration hospital (VA) where we see so many people who were drafted to Vietnam in the 1960's whose lives had become utter wrecks – who have experienced a kind of torture with PTSD and all those things; estranged from their families; afraid to die; knowing they have done horrible things; maybe killed the enemy's children, and come back on drugs and abandoned their own children or destroyed what families they had. Such people can easily fall into despair in that final stage. Erikson talks about *potency*: if you can navigate these shoals of despair you will become wise.

Wisdom is a virtue because we are none of us perfect and life can only be understood backward but has to be lived forward, as Kierkegaard said.

It's a very important stage so you help patients through memory reviews, you can make CD's and so on. Harvey Chochinov is a Psychiatrist working in palliative care in Manitoba who has advocated what he calls 'Dignity Intervention': someone asks you questions like when did you feel most alive, what are your wishes for your children, what wisdom would you pass on to them and so on and assembles all this into a document. You get to edit this or approve it, and hand it on to people you love or care about. It is a formalised way of integrating the segments of your life, what's present or what is missing, letting go of regrets, fear and anger; and you develop the positive result, wisdom, rather than despair.

So your goals in the Final Stage of Life might include strengthening connections, discovering meaning, fulfilling ambitions and dreams (like a patient of ours who wanted to return to Florida where he had spent his formative years and met his wife, and rediscover all the things he had accomplished there: when we had drained his ascites he was able to make two trips there – a wonderful pilgrimage). You can do what Ira Bycock called 'The Four Things that Matter Most', expressing appreciation, gratitude, saying 'I'm sorry', 'please forgive me' or 'I forgive you', saying 'I love you', and finally saying 'goodbye'. (I think it's somewhere in *Tristram Shandy* – "all our goodbyes are really practises for the final goodbye")

We have hypothesised that there are three components in this final stage. The first is 'the Turn'. When people have run from a terrible diagnosis: when they have been diagnosed with metastatic cancer there is so much to absorb, so much fear – this is normal and expected, and you have to give people time to assimilate it. 'The Turn' happens when they are ready to face that they are mortal. We all of us believe that we are living in a temporarily immortal life phase and none of us think much about death, but once you have flipped over into the phase of daily awareness that you are going to die, you have achieved a psychological turn. The next is the 'Transformation', which is a favourite topic of plays and movies but does happen in real life, when you shed the false values of the ego: you realise that you can't take the Mercedes with you. And you recognise the things and properties that have become incidental to what might be most important, such as a love that transcends or goes beyond death, or connecting with those you love or a higher power. Hospice care gives a framework and support and opportunity to accomplish these goals; otherwise if no-one explains this to you it's only going to happen by chance. The last phase is 'Flourishing' (or *eudaemonia*) where there is something really vibrant, and people can share moments of love, joy and peace with those closest to them, which can be treasured for years after.

[I have copied the paragraph below from Rob's abstract. He did not include it in his talk but it struck me as particularly apposite – Ed.]

'The utilitarian approach may satisfy the best use of scarce resources, but in so doing, may augment the suffering caused by loss of life. A loved one's life appears beyond measure in the last days before death. Virtue Ethics, especially, fosters empathic action and communication Virtue ethics promotes in doctors a quality of caring for the patient without relinquishing analytic reasoning and disciplinary practice, a quality that can, ultimately, animate healing in the dying person and network of family and friends.'

Virtue Ethics and King Lear

[RR] Virtue Ethics is something we are trying to incorporate more and more into our teaching. We are taking an overall Aristotelian approach and like Aristotle, use the words virtues and potencies when we talk about facing crisis. We are dealing with med students in that stage of life when someone is just initiating their career, be it law school or med school or maybe a relationship, when there is a crisis of commitment. And when you tell that to med students it is an extraordinary opening for them. The question opens itself in two domains: 'do I want to be in a career that demands so much from me?' 'I don't have a life; I'm studying all the time: I'm connected to everybody through my iPhone; do I want to do this for the next 30 years?' And the same question is reflected in their relationship: 'do I want to be with this person – do I want to commit myself?' Erikson is absolutely brilliant when he talks about the double 'yes' that goes in a powerful commitment. He argues that you must move through that phase and in order to have a powerful career or a powerful relationship you will have to face that crisis. ('YES - I *really* want to practice medicine') but you don't really make the commitment until you encounter that in its everyday manifestation; people are going to come and they are going to complain to you every day – but that's still the job you want. It's the same issue in dealing with a relationship: if you want a powerful relationship it's a double yes: 'I want you, you're the love of my life. But then I notice that you use dental floss...you're not as perfect as I thought and your feet are large...' But it's that second 'yes' – 'I want you'. Powerful stuff for someone who is 25 years old and about to move into a residency and is wondering: 'do I really want this ...?' But you need to understand that everybody goes through this and if you don't face it, it follows you till the next phase in life, so that at 45 you're still debating: 'do I want this job for life or do I still want to be in this relationship?' And can you imagine the alternative, stagnation? – do you want to *tolerate* your work or this person? 'Do I want to live this way?' - A life of quiet desperation: 'I've lost my passion, I've lost my juice'.

So Virtue Ethics focuses on the question of being: 'how do I want to be, how do I want to *be* a physician, how do I want to *be* connected to this person?' And there is the teleological question of ultimate purpose: 'how can I achieve eudaemonia?' I think King Lear is a wonderful example of this, and raises these questions in the context of facing death, as well as the epistemic question: 'how do I know it? As a practice, how do I become the person I know I ought to be and want to be?' In yesterday's debate, imbedded in what people were saying were these other ethical systems. Certainly Kant was in the room yesterday: rule, duty, obligation, law, utilitarianism and consequentialism; these are all examples of systems competing with Virtue Ethics and Aristotle, but the fundamental difference is this idea of being instead of doing.

Art, literature and metaphor

So we think that we can understand Virtue Ethics and end of life care from Shakespeare. I am really privileged to do this work with Rob in the medical school looking at the intersection between medicine and the humanities – looking at art as well as literature, because we think that these imaginative moulds can illuminate the practice of medicine, and provide a richer understanding of sickness, death and dying, though metaphor, narrative evocation and meaning.

Metaphor is a way of understanding something in terms of something else (as Robert Burns *My Love is like a Red, Red Rose*: the rose is sweet and beautiful but has thorns, so when you fall in love there will be pain.) Narrative is our way of making

sense of life; Jamieson speaks of it as the central expression of the way the human mind operates: putting things in terms of stories. We could even see diagnosis and prognosis as a story; a narrative that the patient begins and the doctor becomes a collaborator in completing. Prognosis is clearly a narrative and involves subjunctivising: 'what if – what if?' The subjunctive talks about an option: 'if I were to see you tomorrow', and is the mode of possibilities. Narrative gives us the opportunity to pursue 'what if' questions. Evocation is different: in both ordinary and medical discourse you attempt to widen the net of associations and so the language is highly charged and when we look at something evocatively the idea is to bring forth some of the texture and the feel of the experience so in the presence of a great work of art or literature that can touch you so deeply because it has the feel of lived experience. It's all about meaning-making and ways of endowing something with significance.

King Lear

King Lear is perhaps the greatest work of literature dealing with end of life and dying, and may be the greatest play in the Western canon that dramatises Virtue Ethics. The central ethical question it raises is: 'what kind of person should I be?'

At the beginning of the play, Lear is in the phase of the shattering decision that he made to abdicate and to divide up his kingdom. His question is what kind of king should he be? The issue in Lear is death, the fear of dying, and the fear of losing all the things that he has come to love: loss of power, loss of vigour in old age, loss of life through death. He asks: "how can I be with this – how can I open myself to it?" There are two families involved, Lear and his three daughters Goneril, Regan and Cordelia, and Gloucester and his two sons. Lear's daughters and Gloucester's sons also have to face the question: what sort of children should they be?

So Lear announces his intention to abdicate:

*"Know that we have divided
In three our kingdom: and 'tis our fast intent
To shake all cares and business from our age;
Conferring them on younger strengths, while we
Unburthen'd crawl toward death....
Tell me, my daughters,--
Since now we will divest us both of rule,
Interest of territory, cares of state,--
Which of you shall we say doth love us most
That we our largest bounty may extend?"
(Act 1.1)*

If you read this text it sounds like he has nothing much to worry about; he's retiring, and this is a logical thing to do, to give them their legacy now. He seems to say: 'I'm aware I am reaching the final stage of life, and I don't want to bother with bureaucratic stuff and make decisions – I don't want to deal with this anymore.' But then he inflects that slightly by putting it in a game structure: we're going to have an auction and put love on the commodities market. So Lear is saying: 'I am old – I am going to die'. But why then does he do this? Why does he want to hear from his daughters that he is the most important thing in their lives? Why does he need to hear that?

So the daughters wonder how to play this game and connive. How are they going to get what they want? They know what Lear wants to hear and Goneril says:

*“Sir, I love you more than words can wield the matter;
Dearer than eye-sight, space, and liberty;
Beyond what can be valued, rich or rare;
No less than life, with grace, health, beauty, honour.”*

And Regan:

*“In my true heart
I find she names my very deed of love;
Only she comes too short: that I profess
Myself an enemy to all other joys,
Which the most precious square of sense possesses;
And find I am alone felicitate
In your dear highness' love.”*

So why does Lear need to believe all this unbelievable hyperbole? I think the issue is one of contingency versus necessity. It is very clear that his body is growing old, and will die someday, and it is very scary. He is going to lose everything: beauty, wealth, power, authority - and eventually life itself. So perhaps if he is surrounded by people that tell him he is necessary – more important than anything – maybe he can soften or suppress the fear of loss.

Cordelia's response involves the categorical imperative: duty. She refuses to play the game, and this is her ethical struggle: how to be a person who loves and honours her father, and at the same time somehow signal or suggest that he is being foolish? Lear demands:

*LEAR: What can you say to draw
A third more opulent than your sisters? Speak.*

CORDELIA: Nothing, my lord.

LEAR: Nothing!

CORDELIA: Nothing.

LEAR: Nothing will come of nothing: speak again.

CORDELIA: Unhappy that I am, I cannot heave my heart into my mouth: I love your majesty according to my bond; nor more nor less.

This is a strategy: in order to wake Lear up she is doing her duty. Instead of her sisters' hyperbole she is going to tell him that there are boundaries in life. She goes on:

*“Good my lord,
You have begot me, bred me, loved me: I
Return those duties back as are right fit,
Obey you, love you, and most honour you.
Why have my sisters husbands, if they say
They love you all? Haply, when I shall wed,
That lord whose hand must take my plight shall carry*

*Half my love with him, half my care and duty:
Sure, I shall never marry like my sisters,
To love my father all.*

Angry – impatient – aggressive – shocking. She is facing the ontological question: how to be? – the question in Virtue Ethics – how to be with Lear in his foolishness? And the first expression of that is that it does not work. Lear is furious and banishes, cuts off and disowns her.

As we see, as the play continues, Lear's behaviour springs from this motivation to somehow deny death, and in the process he loses everything: home, family, friends, power and mind and finally body itself. He leaves his castle and is excluded from one daughter's home and then the other, and finally when he is shut out of Gloucester's small mansion he finds that the one place of shelter from the storm on the heath is a hut. He leaves the storm in a kind of psychosis: he has lost his mind. He finds a doctor who treats him and then he is sent to prison. So we see his progression from castle to mansion to hut to tent to prison – all homes, and that declension reflects and monitors the transformation that occurs in his own consciousness. And this raises the deep question of what it means to be at home in this world in which people experience inconsolable suffering. The Fool, who symbolizes the inverted world, not only in Shakespeare but in all cultures, and turns the social system on its head and has the licence to laugh at authority and rationality and all the systems that humans construct to solve the problems of daily living, is faced with the question: how can I be with Lear in his foolishness.

FOOL: Dost thou know the difference, my boy, between a bitter fool and a sweet fool?

LEAR No, lad; teach me.

*FOOL: That lord that counsell'd thee to give away thy land,
come place him here by me, do thou for him stand,
the sweet and bitter fool will presently appear,
the one in motley here,
the other found out there.*

Again this is an attempt to waken Lear to the harm he has done, and the Fool is struggling to find what he can do. How he can be around this man to help him through all his foolish ways, his arrogance and his narcissism when he exiles people like Kent, his most favoured confidant. And the Fool is still with him when he enters this madness, when Shakespeare is suggesting that what Lear is facing is so profound, so terrifying, that he does not have the mental categories to deal with it and his system for organising life has been fractured; he has been looking for accommodation and has not found it. And for the next three acts he is looking for home. We find him on the heath with the Fool and Kent and Gloucester's son Edgar (in disguise as mad Tom) and he is so upset with his two other daughters who have rejected him that he hallucinates that they are there and puts them on trial. So there is this deeply existential search for accommodation, home and hospitality – somewhere he can be safe from harm, and psychological harm: to be himself. He couldn't find this in society so he looks for it in nature, but can't find it there. In the height of the storm which is raging in Act Three, he yells at the sky:

*"Rumble thy bellyful! Spit, fire! spout, rain!
Nor rain, wind, thunder, fire, are my daughters:
I tax not you, you elements, with unkindness;*

*I never gave you kingdom, call'd you children,
 You owe me no subscription: then let fall
 your horrible pleasure: here I stand, your slave,
 A poor, infirm, weak, and despised old man:
 But yet I call you servile ministers,
 That have with two pernicious daughters join'd
 Your high engender'd battles 'gainst a head
 So old and white as this. O! O! 'tis foul!"*

But then he begins his transformation and his first shift towards virtue, as he addresses the Fool:

*"Prithee, go in thyself: seek thine own ease:
 This tempest will not give me leave to ponder
 On things would hurt me more. But I'll go in
 In, boy; go first. You houseless poverty,
 Nay, get thee in. I'll pray, and then I'll sleep*

*Poor naked wretches, whereso'er you are,
 That bide the pelting of this pitiless storm,
 How shall your houseless heads and unfed sides,
 Your loop'd and window'd raggedness, defend you
 From seasons such as these? O, I have ta'en
 Too little care of this! Take physic, pomp;
 Expose thyself to feel what wretches feel,
 That thou mayst shake the superflux to them,
 And show the heavens more just."*

...and he takes another turn toward virtue as he looks at the naked Tom and says:

*"Why, thou wert better in thy grave than to answer
 with thy uncovered body this extremity of the skies.
 Is man no more than this? Consider him well.
 Thou owest the worm no silk, the beast no hide, the sheep
 no wool, the cat no perfume.
 Ha! here's three on's are sophisticated! Thou art the thing itself:
 unaccommodated man is no more but such a poor bare, forked
 animal as thou art.
 Off, off, you lendings! come unbutton here!"*

(Tearing off his own clothes)

And so, as later with Gloucester, blinded by his own child, we see him with his heart breaking in compassion – he is *being*, not doing anything. We see his final transformative move to Virtue Ethics in Act Five when having lost the battle with Regan and Goneril, he has been reunited with Cordelia and is led away to prison:

*"No, no, no, no! Come, let's away to prison:
 We two alone will sing like birds i' the cage:
 When thou dost ask me blessing, I'll kneel down,
 And ask of thee forgiveness: so we'll live,
 And pray, and sing, and tell old tales, and laugh
 At gilded butterflies, and hear poor rogues
 Talk of court news; and we'll talk with them too,
 Who loses and who wins; who's in, who's out;
 And take upon's the mystery of things,*

*As if we were God's spies: and we'll wear out,
In a wall'd prison, packs and sects of great ones,
That ebb and flow by the moon."*

This is eudaemonia: in this moment with his daughter, Lear *flourishes*.

Virtue Ethics: Further discussion

Alastair Campbell

“There is a risk that Virtue Ethics can be socially quite conservative ...so we never question the thing that is wrong.”

Clarifications

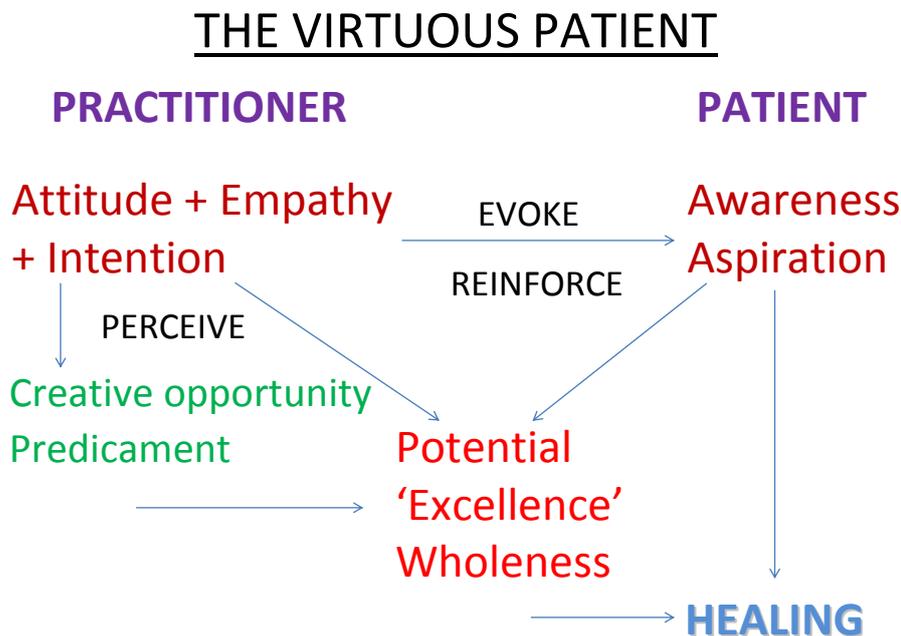
I have just three things requiring clarification that have arisen in discussion and informal conversation. The first, and perhaps the most important point is that the language itself is a problem. The way we use virtue, and even more so vice, immediately seems to deny us escape from being judgemental or over-demanding. Equally the term excellence which Aristotle uses can be misleading. It may be that we are in danger of losing the strength of the theory because all the associations of these words are wrong. Maybe the notions of process, of realising potential, of fulfilment, which are also in the theory, are better ways of thinking what Virtue Ethics is all about. So a vice is failing to realise a potential, whether by your own fault or being prevented your circumstances, and virtue relates to development and the possibility of eudaemonia: the prospect of some completion or wholeness that we can attain whatever the circumstances.

Secondly the connection between action and being: this is clearly a strong theme we have to keep thinking about. Another term used in Virtue Ethics which might be helpful is *habituation*. This is the way in which we almost don't have to think about how we act and the attitudes we adopt. Virtue Ethics then is about developing character in such a way that we do something because we have learned and habituated to that way of doing it. A lot of good medical practice is like that. Again, when you are helping patients through these crises of end of life, chronic illness or pain, in a sense you are trying to habituate them to other ways of feeling about it, and responding and acting. This might help you to think of Virtue Ethics as more practical and applicable. Virtue Ethics is not episodic: (i.e.) what the patient will decide at this moment; but more a way of 'being with' that may result in action.

The third clarification – and this may be the trickiest area, and something that came out very strongly in Jeremy's talk this morning – is the relationship between the personal and the social in Virtue Ethics; the extent to which Virtue Ethics is an indulgence for the individual, as opposed to its having a place in the formation and transformation of societies. There is a risk that Virtue Ethics can be socially quite conservative in the sense that this is the way we think we ought to be, so we never question the thing that is wrong. You may think of Frankl in the concentration camp, finding meaning there, but also ask why is there such a thing as a concentration camp – why do we tolerate such a thing.

Virtue Ethics has not been as strong in social critique, for instance, of NHS management as it has been in guidance of the individual. But the potential is strong. To go back to MacIntyre and the ideas of transforming community and shared commitment, which can bring change to society, you can see yourself as that community: bringing change when you go back to the real world and your practice. So social transformation is a possibility in Virtue Ethics, and we need to work on this lest we become too personal, too objective.

I want now to ask Jeremy [Swayne] to present his diagram illustrating these relationships.



[JS] I struggled as many of us did with the session yesterday afternoon, and resolved the problem by asking the question: how does this concept help me in my vocation of healing? It seemed to me that the essence of the virtues that Alastair was describing is this: that every human being possesses some potential for excellence – a potential for a way of being that is unique and special to them. This is something I would term wholeness. An individual patient may have some, or a great, degree of awareness of these attributes in themselves, and a degree of aspiration to fulfil those potentials in themselves. The practitioner has, we hope, those necessary virtues which include their attitude, their capacity for empathy and their intention to promote healing in their patient; and those have to be brought to bear to reinforce their patient's awareness and aspirations. This is the symbiotic relationship between the two within the healing process. That requires that the practitioner perceives both the creative opportunity that exists in the predicament of the patient and this unique potential within the individual person. When that all works, then you get healing.

I would just like to offer an illustration of Virtue Ethics that came to my mind: I was thinking of the Biblical description of the salt of the earth and light of the world: that might encapsulate it in some way – and I would hope that we all go back to our communities saltier and shining more brightly! And then a quote from an American philosopher Ralph Emerson “I cannot hear what you say but who you are is shouting loud in my ears.”

Insufficiency of time

[Addressed to Jeremy Swayne] I wonder if you would frame this in the context of insufficiency of time, about which there has been a lot of discussion. If we look at this philosophically in terms of Virtue Ethics and you begin with the premise that there is not enough time, then what you do will come out of that presupposition. In the clinic it means that when I am with the patient I am doing things out of that belief, because I have to get to the next patient (and I won't have enough time for them or the next one after and so on). So my whole practice can evolve out of a basic epistemological

belief in the insufficiency of time. If I shift from 'I don't have enough time' (not to 'I have all the time in the world', because that would be obviously false), but to 'I have sufficient time', then my practice changes. Because as you have pointed out it doesn't take a lot of time to be with someone for one minute; in that minute the world goes away and all that exists is that patient in front of me. (A researcher looking at experience of the perspective of time found that when surgeons who had been on their feet for six or eight hours doing a complex procedures were asked how long they had taken they estimated forty or fifty minutes, explained as a shift in consciousness.) So if you can say: 'in this moment this is all there is', the practice shifts dramatically - there is sufficient time – and I'm with this person. Virtue Ethics can show up an understanding of time that is sufficient: our first reaction might be 'in the real world what with all this bureaucracy etc. I don't have time, but if I can reconfigure time then maybe this can happen – I don't need an hour...'

In my pain clinic, my colleagues and I have worked out that if we have half an hour for new patients and quarter of an hour for follow ups ...what I find is that some patients will take five minutes, especially follow-ups, and new patients take on average 20 minutes to tell their story – rarely much longer. Sometimes you have a patient that needs a very long and involved discussion which may take an hour but it averages out and I still finish the clinic on time. So I think each patient in my clinic gets the time they need.

To go back to this concept of time... time is limited and for that reason we have to use it well. We're talking in terms of consultation periods of twenty minutes instead of half an hour but if we take a longer view time spent now may save us a lot of time later. It's not just our time but also our clients' time that we are saving and also unnecessary suffering [for] somebody who could have been helped much earlier ...

May I recommend the book 'The Fifteen Minute Hour' by two American GP's, Stuart and Lieberman, which deals very well with things like quality time, and describes lots of little strategies you can use to focus the patient, and go for the most troubling thing, and empathy...

I buy into all that has been said but I think we're not comparing like with like. I'm not suggesting that your average general surgeon seeing a patient needing their gall bladder out needs more than five or ten minutes, But within twenty miles we have two large pain clinics, one of which is highly interventional and sees no complex patients whatsoever and the other which does no interventions and sees only complex patients. And I maintain that you cannot properly establish a trusting relationship with a patient like that in twenty minutes, particularly if you are also being pressurised into limiting your follow-ups to two or three. So it's both optimising the time we have with a patient and maintaining a long-term relationship.

So you don't want to give an ounce to the bureaucrats by saying if we use quality time then we don't need any more resource. This is the same thing – between the quality of the relationship but also the environment in which we are required to work and which we must always question if we believe that the answer is not just the intensity of the encounter but also that the conditions are quite wrong. Your [Robert Zalenski] perverse example of getting fourteen times the payment if you do a tracheotomy – that is a classic example of how a system can determine the failure of quality care.

Can I ask Dick [Raspa] about Virtue Ethics and Lear? It struck me about the stages he goes through: do they mirror the five stages of dying described by Kubler Ross?

[interference on recording]...it has a much broader application than the final stage of life...her topic was grief but we are really looking at human development and those negative emotions that inhibit development...

...but he did come to accept...

...and that is important and the road to acceptance can take the rest of your life and you may not make it...you could read it that way...there is a shock and then denial... and then you have the bargaining. From the daughters' perspective he abdicates – he says I don't want to be king any longer but I want to be treated like a king – I'm going to be staying with each of you for a month and bring one hundred men with me...and the daughters can see these eating and drinking, gambling and womanising in my house... Do there is this bargaining ...

The virtuous (or un-virtuous) practitioner

I am intrigued – in the case you presented yesterday – by the GP (see pg 7, Virtue Ethics and the ethos of pain medicine: A dialogue). Was she not virtuous?

This actually relates to the discussion we have just been having. It would appear from this account by the patient (and of course we don't have her account) that she was looking for a way of getting him out of her surgery – perhaps due to pressure of time – and it took ages for her to investigate him properly. Why should that be? We don't really know. She certainly wasn't vicious – really being hard ...but it was a failure in what she could have achieved ...

You explained the word vice as not using your virtues to the maximum ...

....not using your potential – I'm trying to get rid of the word virtue because it then comes back to this idea of excellence. We are looking for 'good enough', not for perfection. As soon as we start to have theories about perfection and never making a mistake we are lost and it will never be any use as a theory. Basically we are looking at good enough, and aspiration to be better. And we want to create situations where that is possible for many people and not just a few.

There has been an element of conflict of interest between the patient and the GP in that scenario, which may be non-judgemental, because the GP is following the guidelines which are not necessarily driven by management but by good medical practice. The radiology department may have told them you have to get the numbers of back X-rays down because they don't often explain back pain. We don't know about the interaction between the patient and the doctor: there may have been a misunderstanding. If you see a patient frequently you may get into the position where you can't see the progress in the disease as you might if there were a big gap in between consultations. They might see a different colleague who might say: Oh my God - what's going on here ... because they think of the time in a different way from the one who has seen the patient fifteen times in a row.

...We have to think of the prevalence of a disease and oftentimes it is relatively rare. We can't rule by exceptions but by probabilities. I sometimes think physicians get less than their due if they were right probabilistically but not about the exception...

One thing I was struggling with yesterday is that to discuss this you have to idealise the characters. I found a shortcoming of the example is that it's not an ideal one because there were too many variables. One other variable that is important for us is

that the patient may not know themselves, or be unable to express correctly at the time, what their concerns are or to find the right words. So they may not have been able to say then what they tell you later is their memory of the GP consultation; this may actually have been very different.

I agree that that case had too many variables and actually we didn't want to focus on that opening thing because the case was more about this man's journey, not about the initial consultation.

Good enough ethics'?

You made a comment a few moments ago about things being good enough, and I just wondered if it would help if we re-christened the session 'Good Enough Ethics', because that's what we're talking about: the complexities in the real world. We are encouraged to do a lot of facet joint injections despite fairly good evidence that they don't really do a lot of good, but they bring a lot of money into our unit – money we can use to pay psychologists to address the important issues ... I don't feel very 'virtuous' doing this but it's 'good enough' in the circumstances: to bring money in by doing procedures to patients who are very grateful!

That's a great point. That scenario fits consequentialism very well: you get maximum benefit out of a situation without causing too much harm and indeed the patients feel they have been helped so the overall outcome is of greater benefit.

Ethics is aspirational. Maybe we need to make a distinction between aspirational and idealistic: idealism suggesting that things can all be so perfect when clearly they cannot. Aspiration is saying: maybe we can do better than we have been, but we'll never do it perfectly. 'Good enough ethics' would have been a super title!

Intention, being and doing

This issue of doing or being: somebody told you in the pub last night that doctors are doers, and there is truth in that. So how can we have this set-up about being? The other concept I wanted to bring up is that of intention: you and Jeremy and others have emphasised the importance of this and I strongly believe that intention is critical. But also as I can't let go of my positivist side I believe that the communication of intention must be through our doing something – be it only subtle facial or body language. But actually we are doing things to transmit the intention.

I have tried to suggest that we have to get away from this rather simplistic distinction between being and doing. Creating habituation – 'habits of the heart' - these result in actions of a different quality, so there is a relationship between being and doing; it's not as if they were separate things.

Regarding intention: it's all very well saying 'I intended to do this' if your actions never reflect your intentions. Take the doctrine of double affect where you say: 'I didn't intend to kill the patient but just to deal with her pain'. That has to be measured by actions so if you suddenly escalate the dose to a massive level that's obviously not the case. The intention is measured by the nature of the action so if the pain relief is proportionate to need to control it, it is very different. We can't separate actions and intentions, but the reason why intention is important is that this externalisation of ethics as just a measurement of behaviour and the outcomes of behaviour, is so utterly impoverished it's not ethics.

Medical education

Regarding medical education – and I couldn't agree more with what was said earlier about this – we need to be constantly asking what we are doing and what kind of medical practitioners we are producing. The trouble is that it's then what happens when we get out there. We may create false expectations about what it's going to be like to be a practitioner. We have been hearing about medical humanities in pre-med school in the USA and I worry about some medical school courses in the UK, that they are simply reinforcing the biomedical model – and things to *do*, that's all there is and it doesn't matter what we are.

Certainly to separate what's going on inside and what shows on the surface is a false dichotomy. Maybe ... in place of attitudes and empathy I would substitute the word attention. I have just started to read the book 'The Master and his Emissary' by Ian McGilchrist (in which he identifies the Master as the right hemisphere and the Emissary the left). He makes the point regarding attention that there are lots of different ways in which we pay attention to another person in different contexts, and the way we pay attention conveys a very clear message in each. There is a very definite quality of attention we can give within each practitioner/patient context which brings about this process.

You mentioned habituation: McGilchrist is writing about the relation between the left and right brains and describes an interesting phenomenon that by behaving in a certain way and adopting a certain attitude and behaviour, you develop the habituation in the balance between right and left brain activity. He is very anxious that in our recent history within our culture and our science, we are promoting a left brain dominated process of habituation, and really have to stop doing this.

I've been wondering about how to become a virtuous person and I suspect it's a bit like humility – if you think you've achieved it you've almost certainly lost it! But is there some positive feedback between doing virtuous acts and becoming a more virtuous person?

I don't know how to answer that question. Given that we're not talking about saints but rather the good enough realisation of our potential ... that's when it's not really subjective, not individual or personal but more a group thing. In other words we get feedback from people we trust and that will change us as we hear things from them ... it's a social process. Aristotle as much as everyone else thinks that it all starts from childhood anyway, and this habituation is partly related to upbringing, education and schooling. One has to believe that however bad that is there is a way out for those who have had a bad start. But there is feedback within the milieu of those who will respond and be honest to you. But I don't think we are very good at judging it for ourselves. "O wad some Pow'r the giftie gie us To see oursels as others see us!" (Robert Burns)

Some people suspect that Virtue Ethics is inherently conservative: there has been a fear that it is a short step from Virtue Ethics to Communitarianism, to the Tea Party and Sarah Palin! That may be a danger but we need not fall into it. A central point of Virtue Ethics is that it is opposed to the idea that we can just generate morality out of our own individual resources. For example, it rejects the Kantian theory that morality springs from individual autonomy and the Nietzschean idea that each of us can invent a whole value system by sheer force of will. In contrast Aristotle, who is the key figure in Virtue Ethics, thought that morality is primarily concerned with becoming a good sort of person, developing the virtues that make for a good member of society. The initial emphasis is on the moral tradition and upbringing, but it is not

irredeemably conservative: morality starts at home; it is where you've got to start, but you don't have to end up there. Morality involves being firmly rooted in social life but it also involves creativity, imagination and aspiration.

The Tao of Pain

Willy Notcutt

“Thinking about pain has come a long way in the last thirty or forty years but the old Cartesian approach is still pretty prevalent in much Western medicine.”

The character for Tao consists of two elements: ‘go forward’ and ‘head’. Taoism has been described (by me!) as half philosophy, half psychology and half religion. The main work about it is the *Tao Te Ching* by Lao Tzu, and I’m going to dip into it as we go along.

I happened this morning to read a little bit of *Ecclesiastes*, and realised it is very similar to the *Tao Te Ching*. Tao is described as ‘the Way’ but it is more a way of life. I had already looked at the Tao about twenty years ago but it was in about 1980 I got into the book *The Tao of Physics, An exploration of the parallels between modern physics and Eastern Mysticism* by Fritjof Capra, a seminal work that comes out of California. It might have previously been thought that these were two ends of an infinitely long line, but they were shown to be, so to speak, two ends of a circle, which is always the same place. The third edition had two extra chapters added by Capra, in one of which he identified six paradigms of scientific thinking that covered all of science. I reflected that if that is so we should be able to apply it to pain. There was for me another seminal moment at a meeting in Brussels called ‘Europain’, where in a session where someone was talking about doing unspeakable things to rats it occurred to me to try to bring these things together.

Tao and pain

So I took this description of Tao:

*Tao is a thing that is both invisible and intangible.
Intangible and invisible, yet there are forms in it;
Invisible and intangible, yet there is substance in it;
Subtle and obscure, there is essence in it;*

Tao Te Ching, chapter 21 (1)

and put it together with the IASP definition of pain we are all so familiar with:

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

and came up with this:

Pain is felt by all but it cannot be touched. It cannot be seen or directly measured, but its patterns can be recognised. Elusive and ill-defined yet it has substance and specific characteristics.

In about 1995 I did a paper on it for Pain Reviews.* I came back to it after digging into the later work of Patrick Wall and Ronald Melzack, which got into journals but didn’t come much into the public domain, on the Neuromatrix:

The Neuromatrix theory of pain proposes that pain is a multidimensional experience produced by characteristic neurosignature patterns generated by the body-self neuromatrix in the brain.

These patterns may be dependent on sensory inputs or may be generated independently of them. In particular, most chronic pain syndromes defy explanation in terms of peripheral sensory change and present a challenge to current theories of pain.

This was very complex stuff but did lead us into some broader thinking about pain.

Thinking about pain has come a long way in the last thirty or forty years but the old Cartesian approach is still pretty prevalent in much Western medicine. Pain is still a target which we locate with the radar of our scanners, then bomb it with chemicals and stab it with steel and cauterise it with fire and ice. Even if you look at some psychological approaches you do wonder if they are possibly damaging patients as they explore things that were covered up.

Capra's paradigms

My presentation has some different perspectives on pain. This is not a definitive study. If you look at Capra's work you find that there is no such thing! But what I want to do is to look at Capra's six paradigms of scientific thought and see how the Tao of pain evolved.

To start with Capra's first paradigm:

Knowledge of the structure does not predict function.

Which derives from:

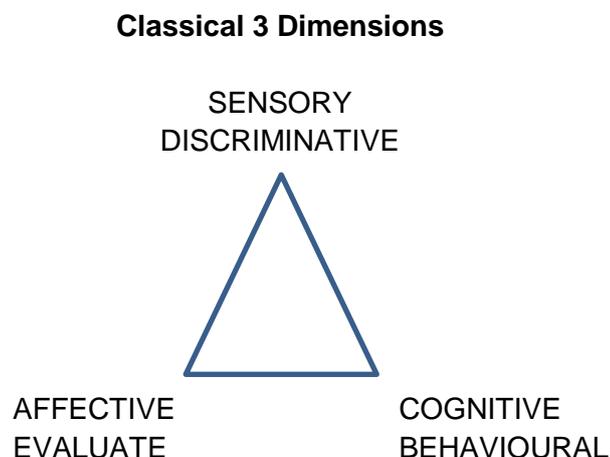
*When you organise, you must of necessity use names and order.
But given that, you must also know where to leave off naming and structuring.*

Tao Te Ching, Chapter 32 (2)

Capra says that in the past we have thought that if break things down to the fundamental bits of what we are looking at we will find out how it all works and be able to put it together and understand it. But unless you know the dynamics of the whole you won't. But we still need to look at the properties of the parts. What are they?

Dimensions

In recent times we have used a sort of three dimensional model:



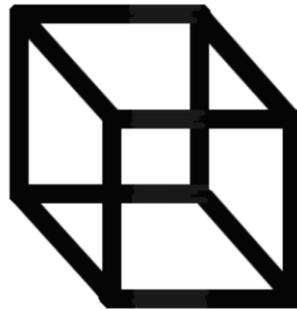
It looks nice and we can fit most things into this, and put pain into one or more of these categories in our therapy. But I have always thought that was too constricting and didn't tell all the story, because there are a lot more dimensions to pain.

When we consider the *neural* dimension we think of the classic Descartes picture of the boy and the fire and illustrations of complex neural networks from modern textbooks, and of the billions of neurons each with thousands of connections, and the much quoted estimate that the number of permutations and combinations is greater than the number of particles in the universe. One way I often think of a neural network in pain is as a spider's web which if you tweak it at any one point every other element in it, length, angle, position and tension, changes. Patrick Wall didn't like the original *Gate Theory* diagram at all, although he put his name to it, because he knew that what would happen to it was that it would become the wiring diagram to explain all of pain and people wouldn't think any further than that.

The second dimension is the *chemical* dimension. There are at least 250 molecules which have been described as associated with the process of pain, and probably since this figure was published, many more. [Referring to a hugely multifactorial diagram 'explaining' noxious sensory input via the dorsal horn to the brain] The caption describes this as *simplistic!!* We go and dump a single chemical into the nervous system, and sometimes it *works!* We often ask why something always work doesn't but the amazing thing is that it ever works!

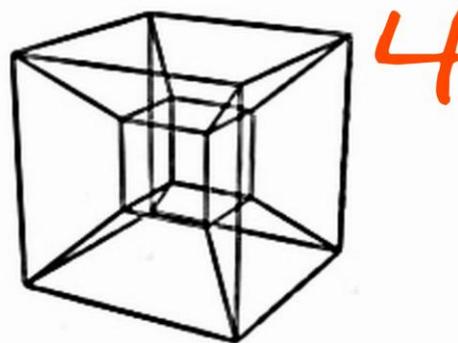
Thirdly, the *psychological/psychiatric* dimension. We all recognise the patient who has not coped with life since he was born, the patient who is desperate for something to be done, the patient with the severe drug dependency problem and the chronically depressed patient, in all of whom psychological problems are having a massive impact on their pain problem and are hugely important.

This is a physical representation of a three-dimensional cube and we are going to look at this again from a slightly different perspective.



Dimension four involves *social and cultural factors* including environment, family, work and past experiences which have a profound effect on pain and are hugely important. We all recognise the situation where someone's pain seems to have got inexplicably worse and then we discover that there has been a family tragedy of some sort: divorce, bereavement, job loss. Cultural factors may influence reaction to pain; for instance the Masai youth who is expected to have his foreskin removed or the woman to have a baby without any expression of pain, otherwise you bring shame on your family. So your culture is part of your pain.

So now we have a four dimensional cube:



– Actually a two dimensional representation of a three dimensional drawing of a hypercube. Getting a bit more complicated?

My fifth dimension is *time* (actually the fourth dimension in physics). I like this quote:

The events of the first 3 minutes [after the Big Bang] generated responses across orders of magnitude of space and time and determined the evolution of the Universe.

An individual's pain experience in the hours or days following an acute injury may determine his or her response for months or years to come.

Sun-Ok Song and Daniel Carr
(Pain Clinical Updates, IASP, Spring 1999)

Pictures we have seen of an expanding supernova provide a nice metaphor for the way spreads outwards.

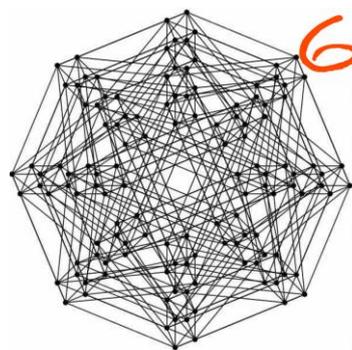
Many believe that if we don't treat acute pain well in the early days we are setting people up for major developments in the future. We can expect this from our knowledge of neuronal plasticity: changes in receptor sensitivity and receptive fields, new synapses, changes in gene expression – these sorts of changes go on and on over time, some more quickly than others.

So this is a hyper-hypercube which is getting more and more complicated:



My sixth dimension is the *genetic* one. This is a topic which is coming more into recognition. Melzack identified the neuromatrix as having a structure and function that is genetically determined, as is our response to drugs. There is also the XY chromosome issue: how gender affects our response to pain.

So now we have a hyper- hyper-hypercube:



The seventh dimension is *unpleasantness*. This is sometimes included in the affective dimension but I think this is quite different. Donald Price has identified primary and secondary unpleasantness. Post-herpetic neuralgia, for example, is not only painful but has excruciatingly unpleasant feelings associated with it. If I ask any patient what their pain is like and they say it's horrible, that usually speaks of unpleasantness. So as well as the primary, the neural element, there is a secondary element. If you are an arachnophobe and I blindfold you, and tickle your arm with a piece of cotton and tell you it's a spider, it's extremely unpleasant. So there is a sort

of top down experience of unpleasantness, which may be unrelated to the intensity of the pain, and can work both ways: this came to me while having massage: although it was quite painful I kept falling asleep. Pain can be like any other sensation like touch, neither pleasant nor unpleasant. And there are those who find pain is actually a pleasurable experience, I'll leave that one for another day!

The eighth dimension involves the *immune* system, and the response to stress. I won't go into the complexities of this today but we mustn't forget its importance with regard to pain.

My ninth and tenth dimensions – and you may think there are others - are the *metaphysical*: the impact of pain on our spiritual lives, and the *system* and its defects including waiting times, lack of education, referral patterns leading to seeing the wrong doctor, inappropriate and ineffective treatment.

I wonder if any of you read the New Scientist last week. It contained an article entitled '*Top Down Pain Relief: the orgasm is a strong analgesic*', which included an MRI of the investigator having an orgasm. "Orgasm is a special case of consciousness if we look at different ways of inducing orgasm we may better understand how we can use top-down processing to control what we actually feel. People who suffer chronic pain conditions can be coached to relieve some of their symptoms through such top-down techniques." Something new for our pain clinics?

Capra's second paradigm states that:

Process is primary and determines structure.

Which derives from:

*Clay is moulded into a pot
But it is the emptiness inside that makes it useful...
...Therefore, existence is what we have
But non-existence is what we use*

Tao Te Ching, Chapter 11 (2)

If you haven't got the emptiness inside the pot it doesn't work. We have the classic example of evolution. There is no such *physical* thing as evolution; it is a *concept*, yes, but it is a process that has gone on determining our gradual change. So with neuroplasticity, pain is changing the structure of the nervous system as it goes along, and gets out of control, as with conditions such as Reflex Sympathetic Dystrophy (RSD).

The third paradigm states that:

The observer is part of the whole system

From:

What we must do is see the whole world as our "self".

Tao Te Ching, Chapter 13 (2)

(Which goes along with Heisenberg's principle that you can't separate the observed from the observer in quantum physics). We are archetypal observers of our patients (and their relatives) and they observe us. The good observer produces beneficial effects but patients may not always perceive doctors (and surgeons) as beneficial! There are two observers: my observing the patient may induce changes in him, and the patient is also observing me observing him, which may change me as well. Therefore all our relationships with patients are dynamic, two-way, complementary, on-going, for better or for worse but never static.

In his fourth paradigm Capra asserts that:

There are no fundamental equations

Trying to explain it will only exhaust you.

It is better to hold onto a paradox.

Tao Te Ching, Chapter 5 (2)

Our colleagues in Intensive Care deal with pumps and number-crunching when they are treating patients, but even there the equations don't tell you the whole story. And pain is unlike most other physiological systems in being a subjective experience. It has no exact definitions, and there are no hard measurements you can use to construct basic equations. There are no tidy theories we can use to plan pain therapy and predict the response to it. Visual Analogue Score (VAS) and Numerical Rating Scale (NRS) are used as measurement tools but in reality they are merely scores for an individual to rate his own personal pain experience. (A blood sugar level of 5 has some concrete meaning across a population but what does an NRS of 5 mean?)

We have seen in the past (although much less frequently than we used to, still too often) how doctors and nurses predict pain levels and use rigid prescribing criteria (this type of operation = that type and severity of pain) – and describe people who don't fit these and ask for more analgesia as 'over-reactors'. We've got round that a lot now with Patient Controlled Analgesia (PCA), but there are still problems.

The fifth paradigm:

All descriptions are approximations.

He who pretends to know but doesn't is ill.

Tao Te Ching, Chapter 71 (2)

We know that the old Cartesian paradigms were based on belief in the certainty of scientific knowledge. But science can never give a completely definitive understanding as it always deals with limited and approximate descriptions of reality, whether we are talking about quantum physics or medicine and biology. Back pain is a classic example; we may look at the scans and surgeons may operate because they tell them that this disc is protruded or that vertebra slipped on the next – but is that necessarily the reason they have back pain? It may have been part of it but trying to work out the contribution of any particular lesion is always an approximation. Sometimes with our approximations we do even worse than that and patients get

pictures of discs popping in and out and their spine crumbling like a packet of digestive biscuits. And there is the 'failed back', widely used as a diagnosis by failing surgeons.

Paradigm six:

Cooperation, not dominance

Heaven's way is to nourish not harm

Tao Te Ching, Chapter 81 (2)

Capra admitted that this one was different, moving as it does from an observation of nature towards a position of advocacy: he proposes a shift from an attitude of domination and control of nature to one of co-operation and non-violence, caring for the world, the environment and the person. We know this from our own experience: if we don't take care with treatments involving immunosuppression such as giving steroids for rheumatoid arthritis, we are going to cause damage. We know from the example of leprosy the damage that loss of pain sensation can risk, and the possible dangers of pain therapy pushed too far.

We still use a lot of violent, military language: we talk about 'pain killers', 'nerve blocking' – destroying nerves and tissues. We have our armed camps: the 'needle jockeys' and the 'tea and sympathy brigade' (and 'brigade is a military term!). Doctors say things to patients like 'you'll be in a wheelchair in five years' time', "you have the spine of an 80 year old"; and the Australian Orthopod who looked at his patient's X-ray and opined 'sorry mate – your back's f*cked'!

And we mustn't forget that a lot of our therapies may be harmful. We know the dangers of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs); recent work from Canada has demonstrated an increased mortality from opioid therapy. But doing nothing may also lead to the patient despairing and committing suicide.

The essence of Tao, described by Wu Wei as 'Action through inaction' doesn't mean do 'nothing and wait for everything to get better' but rather practice of the minimum necessary action to enable things to get better, to which we might add *primum non nocere*. Pain isn't a simple wiring diagram through which an alarm signal is transmitted. How we look at pain is going to depend on whether we see it as a sensation, a symptom, an experience, a disease, or a combination of all four in ten dimensions. It is complex but never simple.

Discussion

Thank you for a brilliant exposition of the complexity of pain. One of the things I find fascinating about pain is that it explores the complexity of our own [identity?] A colleague of mine who researches anaesthesia says we still don't know what it does to the Central Nervous System (CNS) and pain is like this.

Willy's article in Pain Reviews was one of the main influences which gave rise to the

idea of the first meeting of this group, and he gave this talk at the beginning of that very first meeting. I think you can see how it was, and has remained, seminal to so much of our thinking and discussion over the last 11 years.

The more we discover about pain in molecular terms the further we seem to be from solving its problems: we are just more aware of its complexity.

Everything in the universe is complex and that includes the wiring of the brain but pain is a simple thing – either you have it or you don't have it. If we think things are complex the patient is in an even worse position than we are because complexity means you don't have an idea what to do for sure. Sometimes I think we should be more simplistic and think how we are going to deal with the problem – not in a way that's going to make it worse.

I suppose as Alex Cahana might say the phenomenological response to that might be that as you have your patient in front of you, you become aware of what their issues are, and you relate to that patient as much as their own understanding enables you; you don't necessarily emphasise the complexity but try and answer their issues, and give them an explanation that they can understand...

Which is why I never like to think of the 'crumbling spine'; I saw a patient once who had been told that his discs were crumbling and was sitting tensely and when I told him they were perhaps a little softer but certainly not crumbling he said "does that mean I can move about?!" – "YES!!" It is for us to realise that we don't have all the answers and it is hugely complex and if we are only going to understand a little bit we have to take that on board rather than apply the simplistic solutions like 'here we are, we just fix this or put a screw in that'. Some years ago I visited a clinic in New York where I met people who had had nine or ten back operations. I thought – haven't you got the message yet – this doesn't work!

Don't you think it's about the [perceived] power of explanation though – I can spend a long time with a patient explaining what we know about pain, and then they go and see an orthopaedic surgeon and come back gleefully saying "I've got a failed back!" I sometimes feel I'm just going to wave a white flag...As a nurse I have to realise that once the surgeon has spoken I lack the power – I'm just on a hiding to nothing if I'm trying to persuade them that they can move and so on ...

The advantage of seeing the complexity is for us to know that there are many doors and portholes to influencing pain: culture, emotional sub-frame - and receptors. You probably need all of them at one time and some of them all of the time. You need just to be aware that there are many ways to enter and use your imagination and draw up from the patient. This is invaluable because there is no one, two or three way approach which is going to work.

I found the imagery really suggestive, particularly the empty pot. This is part of the spiritual practice, so what you are suggesting is that the conventional separation of science and the art of medicine need to be integrated. I like the idea of using the word practice not as a verb but as a noun so you have a practice – something done

consciously every day, so there is a kind of philosophical practice that frames the analytical practice which you need to involve the scientific knowledge that involves all these levels of relationship...

...as Capra uses the Tao to bring together the philosophical and the scientific ...

The idea of emptiness is very powerful. From a biomedical point of view... one of the basic premises is I already know ... this sense of mastery means I have mastered this phenomenon so I am expected to perform as a professional in this context; and then step back and say – no – your premise has to be you don't know and open to a different kind of observation and a different kind of intervention. So it's very helpful to see those images from the Tao.

I really enjoyed your talk but it makes me feel profoundly depressed! One of my mentors when I was a young doctor used to say that if a doctor could do more good than harm 50per cent of the time, he or she was a remarkably good doctor. When he taught me that I thought he was a silly old fart. Now I think he was absolutely right, because most of us make pain worse most of the time. You used lots of examples in your talk. We are probably quite an enlightened group, and a bit better at not doing harm than most, but we still do harm.

Regarding what you said at the end about Capra's last paradigm: could you expand on what you think about when looking after people in pain, doing nothing is an appropriate approach.

*Inaction isn't totally doing nothing. It's bringing it down to a minimalist, if you like; not prescribing a whole list of drugs but trying to ... We are great *doers* – we like to write the prescription or put the needle in; even psychologists like to be doing things with patients. Sometimes it may be that just that stepping back and maybe letting patients do it themselves – you are taking a stand of relative inaction rather than 'up-and-at'm'*

Isn't it also passing the responsibility back to the patient? ...

...and also the choice

... But it's enabling the patient to understand a little of the complexity of what's wrong with them. And allowing them to tell their story, and that's therapeutic in itself.

We are dealing with a very small corner of the pain world, and the surgeons do a fantastic job as for instance orthopaedic surgeons do for many patients with joint disease; we have palliative care, morphine, amitriptyline - brilliant, carbamazepine for trigeminal neuralgia –fantastic drug. It's a complex corner and that's why we are here and what we are interested in. We're dealing with a distillate of all these problems.

Don't get me wrong: I work with spinal surgeons and have no problems with them at all – we sometimes have to say this guy really does need an operation, and it could be said that the best spinal surgeon is a reluctant one! And in palliative care we do

know what to do, how much morphine to use and so on. That is doing things, but the emphasis is on doing no harm.

As a Psychiatrist, sometimes I find modern medicine is focussed so much on 'machinery' - even talking about the unconscious we want to know how it 'works', and look to an MRI for this. We see pain patients' problems as a long chain of linear cause and effect but we know the brain doesn't work that way. People have been induced into a state of hopelessness and loss of control. I sometimes find it helpful to ask a patient to tell me something good that has come out of their condition. They have been forced to think one way, it has been so restrictive and they never get out of it unless you open up the story, and when they can think of it differently and understand that their lives don't have to be so constricted and so on the pain may still be there but it's different.

I'm interested in the imagery of the crumbling biscuit etc. These are hypnotic suggestions and you can flip them over. People who are made aware that that kind of imagery can be very damaging can use other imagery: we can say "your back is so strong and you've got lots of muscles there which you can use" and you can use metaphors like your spine is this fantastic strut that lets you walk around. Instead of simply saying that's not true we can put in other images.

I just wanted to emphasise the point that words are more powerful than Selective Serotonin Reuptake Inhibitors (SSRI's)... and we don't recognise this as doctors. The first thing we should do to medical students is to slap each one in the face and say 'watch what comes out of your mouth!' I've had patients come to me and say "my bones are riddled with cancer" – these images are completely destructive. Our words need to be so carefully chosen not to falsify the picture but ... If someone tells me my spine is like a 70-year old I'm like 'well screw you, buddy!' Words tick off our neurotransmitters in so many ways; we have to be much, much more careful. I haven't heard anyone campaign about this ...

You hear this sort of things on ward rounds. We shouldn't even use these words to one another or they tend to spill out to the patient.

I was talking recently to an artist friend who works in medical humanities and she was saying that doctors always work to a deficit model – looking for what's missing and how to fix it, which is very helpful for some things, but artists were trained to look for what's good, what's positive, that every person has a value, and that's sometimes a useful contrast to the deficit model.

I was fascinated see the slide of the orgasm MRI. The largest area of green was the anterior cingulate, which Irene Tracy has found it is the bit that responds to unpleasantness so if you're feeling a bit chilly it lights up so this must be a key...

We're talking again about the art of medicine. It's a difficult to define but powerful area and it's to do with the language that we use and the depth and quality of listening that we do, and what kind of therapists we are in this mutual relationship –

the power of a healer or therapist. I have found that over the years I have had to pick that up by doing it and thinking about it, but there is no specific teaching or any works you could gain access to in a comprehensive way. There is Michael Balint's early book about it, but not much since.

We're still in a scenario where our junior doctors are being ticked off: they can do this or that procedure; they have certain competencies – but we don't have a competency for healing!

* (page 45) Notcutt WG. The Tao of pain. Pain Reviews 1998; 5; 203-15. This was the main inspiration for the first meeting of this group [Ed.]

The (cost) effectiveness of pain clinics: Who are we kidding?

Ian Yellowlees

“I think there is probably little ethical justification for claiming that that our little speciality should have any priority for resources over others.”

I'm feeling rather uncomfortable here today, and I'm rather hoping to make you feel uncomfortable as well, and I will judge the success of this talk by whether it does so at the end. I'm going to talk about philosophy and ethics but, as I started life as an engineer, in a very simplistic way.

How long can we ignore the dark side? The programme asks if rationing of pain services is necessary and I thought the answer to this is so obviously YES that I wouldn't actually talk about it much. Rather I'm going to talk about life – yours – what are you going to do with what's left of it. Does it matter? You might say it doesn't much provided you don't do harm to others. It might be better if you actually do some good, and a lot of people in medicine think that's what they are doing, perhaps misguidedly. Volunteers of ten think that. My son has been working in Zanzibar. That sounds like a nice island with amazing coral beaches, which it is, but the he lived for eight months in a shed in a mud hut village with no running water, trying to teach physics to a class of 65 with nothing but a piece of chalk. Why do people volunteer or go into medicine? I would suggest that they do it to a large extent for themselves and if they do a little bit of good that's the icing on the cake.

Who decides things – us or 'them'?

I would suggest that in the NHS where most of us work there is a difference: you are paid by the rest of us to do good for some of us. That's what you are supposed to do for those of us who need it. There is an implied imperative to try to maximise per pound spent. But this is where it starts to get tricky: how do we do that? Who decides how to maximise the public good? Maybe you think it's the job of managers; certainly it's what they are paid for. It's what politicians are elected for too. So maybe this is OK and we don't need to follow this train of thought any further. Perhaps we can safely assume that if someone has created a job as a pain specialist or pain nurse or whatever, that implies that it has been through this process, and somebody has thought through whether this is a good thing for the NHS and the money.

So who does see the big picture?

Theoretically it's the politicians because they are the representatives of the people... but...

[Referring to newspaper picture of stalker at Twickenham being arrested] This reminded me that if you take the attitude that politicians and therefore managers are responsible for thinking about the big picture: how is this money going to be spent in an ethical way the that's good because everything becomes somebody else's problem. The crowd were enjoying this hugely and it was someone else's problem. So let's follow this through: if you think that it's all the responsibility of the politicians and the managers you have to accept that their other decisions have some validity. So if they decide to reduce your budget that's fine. If they decide that your service is not affordable you shouldn't argue. And what other physicians do isn't your problem

either and if they decide to fund lots of dorsal column stimulators (or the Childhood Immunology Trust which recently spent half a million pounds on one child) – fine, not your problem.

What about whistle-blowing? If we are going to follow a logical thought-path through this: management and politicians are going to make decisions about how we're going to spend the money, and we are supposed to be doing good, how do we handle it when things go wrong? How do we work out what we are going to do about situations that get out of control because of politicians and managers? What if they are going against professional standards such as the GMC's Code of Practice?

What about military managers and politicians whose decisions can lead to atrocities and places like Auschwitz? I don't think it is actually possible to stand back and say yes, managers and politicians have the ultimate say.

So there has to be a line somewhere. On the one hand we are paying managers to decide how money should be spent in the NHS. On the other we are saying actually we want to hold back a bit on that power. Where are we going to draw that line? We are happy to let managers take decisions because can't make all of them or we would become politicians, which we're not prepared for. We could draw the line at a basic human rights level; we have had discussions in this Group as to whether pain relief should be a human right. But even there we run into trouble. Apparently votes for people in prison are a basic human right – this has turned out to be a hot potato. We approve of freedom of speech, but what about freedom of speech that causes upset to others, or incites violence? Maybe its how you see your patients are being treated that that should decide whether you should stand up to managers who are trying to govern your service. Perhaps it should be the GMC or the National Institute for Health and Clinical Excellence (NICE)? Perhaps it comes down to how good the managers are.

Are we kidding ourselves?

But who is going to decide this? It has to be you. How do you make these decisions? This is where I think we probably kid ourselves. You can kid yourself that you are doing it for all sorts of good reasons but maybe actually you are just like the volunteers, and you personally have a lot invested in what you are doing (in much more than the financial sense). So following our train of thought from our obligation to do good for some and our agreement that we didn't want all the decisions to be made by managers and politicians, we seem to have ended up with the suspicion that maybe it's really just all about us. It doesn't feel very comfortable, and perhaps we'd rather not think about it too much. But it gets worse.

Why are we involved in pain? One of the nice things about these meetings is that we get away from these practical issues and talk about philosophy and ethics. I remember at that first meeting, Mary Midgely getting up and talking and I felt – help, my poor brain can't keep up with all this – and that's why I have kept coming to the group. (I like to try to get my head round some of these difficult concepts and it was one of the things I liked about engineering; in medicine, at least at the undergraduate level you've just got to remember stuff, but in engineering you've got to understand it). I was slightly distressed to see on the front page of the programme the suggestion that people in pain medicine need to be involved heart and soul, as well as expertise. Well...um... er! You think we're in it to do good? Do we actually know that? Well, no. Quite a lot of what we do is actually harmful for patients but we like to ignore that bit. But presumably you enjoy what you are doing and think it worthwhile and you would stand up and defend your budget in the face of cuts. That means that you really

believe that your work should have priority over some other aspect of clinical spending – whose? Have you really thought about this? [*Murmur of general assent*]
Perhaps you believe that there shouldn't be any restrictions of resources anyway?
[*Murmur of disagreement*]

So let's see if we can come up with some justification for what we are doing. This is pretty difficult. It's relatively cheap for a start. Is it? I reckon this meeting must be costing the NHS about £20,000 pounds in study leave and cancelled appointments. Is this a good use of money? And this is tiny – what about the Pain Society's annual jamboree? ...

This is an argument as to whether professional development is important ...

... That's accepted but it is part of our cost. At a very rough estimate, the total cost of pain services in the UK is about £6 million per annum. That would pay for Childline, for example, for about four years, or about 11,000 hip replacements. What about the perception that there's a lot of it out there? If you look at epidemiological studies of pain you find and incidence of pain between two and 40 per cent depending on how you define it. An Australian study found that 20 per cent had suffered pain every day for three out of the last six months, and a much quoted big European study found that 19 per cent had suffered pain for six months; had experienced pain in the last month and several times during the last week. But they only needed to have had it in the last month and a few times in the last week, so the six month claim is a bit dodgy, and 46 per cent refused to respond at all! Note that this includes all causes of pain, including osteoarthritis, hip, cancer etc. and not only people who come to pain clinics. All sorts of people like orthopaedic surgeons and rheumatologists do lots of useful thing for pain. We actually see somewhere around two per thousand (0.2 per cent) of the population in most pain clinics. That implies that if those studies are right and there are about 20 per cent of the population who need us, 99 out of a hundred are not presenting. Are we really suggesting that we have to provide for all of these and that lack of resources is preventing 99 out of 100 people coming to a pain clinic?

Are we effective?

We kid ourselves if we think we are. We do a lot of good for a few individuals, but overall? Not really.

“The outcome literature suggests that only a minority of patients with chronic non cancer pain show measurable benefit from ANY of the treatments commonly given for this condition”

(IASP news Jan 2011)

But let's be generous. If we think about Numbers Needed to Treat (NNTs), well maybe about five is quite good for a pain therapy, and this might provide 50 per cent pain relief for a while (for about 0.04 per cent of the population) The cost per patient helped works out at about £7500.00 – about the same as a hip replacement. Alternatively that would buy a nice holiday for the patient which might be much more effective!

I once gave a talk at the Pain Society about Pain Management Programmes (PMPs). The average time that people had pain before going on one then was *eight years*. The follow-up time for most PMP's was, if people were lucky, about 6 months. I had a piece of rope that was marked as lengths representing periods of time. It was rather

dramatic as the time people had been in pain stretched way across the stage and the time they spent in pain services was relatively tiny.

Are you still feeling good? I'm not. I hope you can defend your treatments but I doubt that I can. I think there is probably little ethical justification for claiming that that our little speciality should have any priority for resources over others. What are we competing with? Take breast screening: there is little evidence that breast screening works and it's incredibly expensive, but no politician is going to dare to touch it. We know obesity causes huge trouble and alcohol huge costs to the NHS. Few doubt the value of education and dementia care.

Rationing

So we're back to rationing. All that I've said applies to most branches of medicine. It seems to me that the only way forward, if you've got limited funds that are getting smaller, is to ration across the board. We all think we are doing good for patients but no-one can stand up and say our speciality deserves priority. Although we all know we are doing good for individual patients, maybe managers should say we're cutting all of you by 20 per cent because there isn't really much to choose between you. Maybe we should consider ourselves lucky if we're not shut down.

I'm just as guilty as you as I'm a pain doctor; I don't like this conclusion and I didn't really want to do this talk. But if we are really honest with ourselves we would have to concede that the real reason why we do what we do, like the volunteers, is that it is mainly about us, and if we get some benefit for some patients some of the time that's icing on the cake. So I suggest we face up to this and then like most people in most walks of life we get on with business as usual.

Discussion

I would take issue with this. Most of us are altruistic or at least philanthropic. We all labour under a very inefficient health service, and the reason we're not very successful may be related not so much to what we do or try to do as to how health is organised, certainly in the community. A lot of patients we fix up send them back into the world where they encounter the 'revolving door syndrome', instead of being picked up before they get ill again. We need better pain services which are broader in application, and better relations with the community.

So we're saying it's someone else's problem because they haven't given us enough resources ...

...We should be working together to try to improve them and being more cost-effective. NICE only looked at intervention – not at the multidisciplinary multimodal approach. And there is very little outcome data available.

And alongside the outcome data in a way we are missing the point. If we accept that there is a limited pot for healthcare, somebody has to decide how that is to be spent. NICE looks at cost effectiveness of treatment A versus treatment B etc. but does it look at cost-effectiveness of that versus putting our money into reducing our [inaudible] – no, of course it doesn't. Not only do we not know if what we do is terribly effective but we have no concept of how this really impacts on what we are supposed to do.

There is a way you can do that... [using an aspect of] information theory which allows you to assess the value of one thing against something completely different, but it hasn't hit NICE yet.

One element is missing here; as well as talking about how to run the NHS but also [we need to reflect that] these meetings are sometimes sponsored by the pharmaceutical industry... I think we want to get away from support from third parties who have vested interests. A huge problem is that those people are very successful and have loads of resources to target the health service to make it expensive when they can make money for themselves. If for example you look at the number of people you don't see in the pain clinic and are dealt with by GP practices, it is interesting that there are some practices whose patients you see more often and others less. This tells you something about the background these patients are coming from, and fragmentation with less continuity of care seems to have a great impact. We need more research but that needs to come out of the same budget that we are treating our patients with because we don't want any third party influence. The important thing for me will be to go home with this and think about it every day at work and ask myself the question: do I get my money and have I done some good work for it?

Before we talk about budget we have to ask a philosophical question, because that's going to determine how look at it. What you have presented is absolutely appropriate for this meeting on Virtue Ethics. You have presented a kind of utilitarian model of ethics, firstly because you are obliged to do this as part of your professional code, and also because you are doing it for yourself. To ask the question from an Aristotelian point of view: for antiquity the development of the individual was the first thing. It was absolutely important to bring forth who you are with your own voice. That was Athenian democracy at its height, but it was implicated instantly in the development of the whole society. So in actualising your potentiality you were contributing to the development of the society. You couldn't even dream of this model civilisation without having a concept of educating individual people to their fullest potential. They go hand in hand as a reciprocal relationship: as I develop myself and develop virtues, which include generosity and concern for other people I am implicating them. So it's not the either/or disjunction: either I am completely in your corner and I annihilate my voice because I am volunteering and serving you but not contaminating myself, or I am doing it for me under the pretext of doing it for you. I am saying that's a false dichotomy. I am really pursuing virtue if I am really concerned about developing myself, if as Aristotle says the purpose of life is becoming more alive, then I'm going to have an impact on you as a physician when you are telling me where it hurts and I am really with you, going to the edge with you, I'm not only developing me and getting something out of it, but I'm with you all the way as part of my professional practice. Yours is a disjunctive model ...

...but I would suggest that it's a more real world. I agree with what you are saying but ... my personal stance is not necessarily what I'm saying ...

[Unfortunately the recording was cut off at this point.]

Being human and in pain

Kate Maguire

“As humans we usually try to avoid pain, but sometimes we precipitate it to feel more alive...to try to counteract the numbness of a greater inaccessible pain.”

You might see me as a visitor to your island but although I am not a Pain Therapist but a Psychotherapist, what we share is that we work in pain. I learnt from the earlier speakers that we are all fighting for the relational dimension in treatment and almost everything that we are doing, almost as if we sense a paradigm coming our way of managerialism and instrumentalisation and competition and all those issues.

I was interested in what Ian saying about doing something for yourself, because working for Médecins sans Frontières (MSF, which over the next two years is going to call itself Doctors without Borders), I've had the privilege of working with many people returning from the field and asking them why they went there, and why they keep going back. The answers are varied, and they are all individual narratives (and an individual narrative is what you are going to get from me today – not an expert's voice, just my narrative.) And in those narratives, what comes through is not about having an illusion or being deluded, but it's all about meaning-making. This is fundamentally what they are telling me. It goes from stories like “I went there really because I had a terribly difficult time in a relationship, and when I went off I found some meaning; I began to see that I was of some use in the world.” They come back to the NHS and hate it so they go out again. Why do they hate it? “Because in the NHS I don't feel that I matter, I feel I'm separated from my own creativity. There, if I'm working, I think I and my skills *make a difference*. I don't seem to be able to do that in the NHS.” I was also interested when we were talking about humanity, neurobiology and the human dimension. Alan Shore, a Psychiatrist and Neuroscientist, has done a lot of work in the US demonstrating the value of therapy in creating neural pathways. The kind of therapy that did this was not cognitive or analytical but relational.

Being human

I worked with survivors of torture for several years so my narrative has become tied up with the narrative of the people I have worked with. I want to share some of what I have learnt *being human* is from this experience.

The centre of life is pain, and pain is life. But for some the pain is excessive. For others it is redundant and useless. For some it is chronic and never-ending. There is pain in being born, living and dying. It has life-saving elements and life destroying elements. Humans try to make meaning not just of life but the pain of life through philosophy, religion and art. A lot of people come into psychotherapy to try to make meaning of pain. They are aware that they are not going to get rid of it: it's very difficult when you have been tortured to actually get rid of it, and maybe that's not even such a good idea. But one can try to find a place for it, to make meaning from it. Medicine and healing try to cure pain or control it through external intervention.

‘The psychological evidence strongly supports the view of pain as a perceptual experience whose quality and intensity are influenced by the unique past history of the individual, by the meaning he/she gives to the pain producing situation and by the state of mind at the time.

We believe that all these factors play a role in determining the actual patterns of nerve impulses that ascend from the body to the brain and travel within the brain itself. In this way pain becomes a function of the whole individual, including his/her present thoughts and fears as well as his/her hopes for the future.'

Melzack, R. and Wall, P., (1996), *The Challenge of Pain*, London: Penguin Books

Melzack and Wall's understanding of pain, for me, still stands when it talks about an accumulation of things: the individual's experiences, their past, and what situation they are in at the time. It is really a very *human* definition and that is what I have come across in my work.

Psychotherapy and psychological interventions often try to make meaning of it for the individual so that the individual can feel they have more control over it and even heal it. I have worked for some time with anorexia, which is very challenging because it's all about control. Controlling pain, for the anorexic, is extremely complicated, but it still goes back to making meaning. Belief systems also try to make meaning of it for the individual and the collective to make it more acceptable. Look at Christian belief and the issues of sacrifice, Islam and issues of duty, of Hinduism and Buddhism with incarnation: grappling with questions of pain and life: what is it for, and why is it very unequal?

As humans we usually try to avoid pain, but sometimes we precipitate it to feel more alive, as with self-harm, to try to counteract the numbness of a greater inaccessible pain. To feel nothing may be the greater pain. Sometimes we anaesthetise it through substances and coping or maladaptive behaviours. We did a study on sexual abuse in Ireland and its relation to alcoholism. In the generation of the 1950's who were put into industrial schools the incidence of alcoholism was extremely high later in life.

Most behaviours are a response to pain or an avoidance of pain. Power dynamics are based on pain. State sanctioned torture is all based on pain: the fear of it, or the threat of it. Organisational structures from businesses to religion are based on it, or at least discomfort: what will happen if you lose your job? That's a form of pain.

The inhumanity of pain

I have been long aware of the inhumanity of pain and what it does to the individual. Pain, particularly redundant pain can be inhuman, and requires being human to alleviate it. Pain separates you from yourself (one of the stories I have been told.) It separates you from others: you stop wanting to talk about your pain ('I don't want to hear about that again – I can't do anything about it - don't remind me of my powerlessness.'). It shifts your locus of control. This is a theory of looking at the world and seeing your relationship with it and whether you can get it to respond to you positively. So if you have an internal locus of control it means that anything you do will make a difference – you have confidence, you are out there doing it. If you have an external locus you're going: what's the point? – Why bother? Or: it's in God's hands. You feel powerless. Pain makes you feel 'chosen' in a very awful way: 'why me?' 'Why have I got this pain?' 'Why did I lose my wife?' 'Why was my child killed?' Often people who have experienced extreme pain change from being internally focused to externally focused. This is very important to us as therapists, because if the locus of control has changed for a person in pain where has it gone? Who are you? Yes – *you* are the external locus - the power is going to be located in

you. You are the one who is going to make them better or not and if you don't they can be very angry with you. Pain makes you aggressive or withdrawn and depressed, and it causes fear and anxiety and irritation in others. I'm sure you have all heard stories from people who don't want to talk about their pain any more: 'it's boring everybody – people don't believe me.' Pain can be said to apparently cause deafness in others and dumbness in oneself. The families of people with chronic pain stop hearing, so after a while they stop talking.

There was a wonderful man who had been tortured very severely and his feet were badly damaged. He was treated at a very good clinic in Norway and he used to go around giving talks about surviving torture. One day the Norwegian doctors came to him and said "we have found the best surgeon for you; we can help you to walk." But he said: "no". Why, when otherwise he would be a cripple the rest of his life? Because he was being *heard*. His feet were the witness to what was done to him so he would be believed. He thought two things would happen to him if his feet were repaired: one that he would not be believed, and nobody would understand that he still felt his pain. The other, he said, was that it would reduce what torture is, because if people think you can recover from torture it can't be that bad.

If you have not read the remarkable book *The Body and Pain* by Elaine Scarry, I strongly recommend it. She has some really interesting things to say about the notion of pain and society. It touches the deep seated avoidance in all of us not to have to live with it.

What do we do as practitioners? (What about our own pain? I once had some excruciating pain which I don't know how I survived; I was terrified. I went through a period of a few years when my children were young when I was terrified someone would snatch them because I had become so sensitised to pain and torture and what can happen.) So as pain practitioners we try to make it go away: what with, and who for? This was the important question Ian brought up this morning. I come from the island of psychotherapy. Psychotherapists have time; we see patients for an hour or sometimes two hours every week, or even three. But what can we exchange about our knowledge to manage extreme pain or psychological pain? Can we adapt some things to time limited contact?

The haunted house of pain

I want to bring you some experiences to see if they make any sense on your islands. Most of my clients who are either survivors of torture or who have come back from conflict zones in Médecins sans Frontières use a lot of metaphors. One of these is 'entering a house of pain': like approaching a haunted house. I worked with somebody for seven years and it took me all that time to work out that perhaps he had been psychotic before he had been tortured.

There is also something about wanting to deliver a letter or fix the meter, not wanting to be kept there, and hearing that the person has other stories like they can't pay the bills and their partner has just died. Often you're not wanting to get further than the front door hoping the meter is outside or that it is a letter you are delivering and not a parcel – oh my goodness you might need to have a conversation. So you knock, like a delivery person, and an exchange takes place.

But what if you get invited in? What if you have a strong instinct to go into the haunted house? What might be in there? You might find the whimpering animal in the corner of the room who bites your hand off. Extreme experiences like sexual abuse

and torture internalise the abuser so people who have been severely traumatised in that way have a lot of anger and aggression within them. Someone asked me: how do you know the outcome of your work with a particular client? The answer was that he had stopped beating up his children.

You might find the ghosts of someone's past life; like the mother I worked with who managed to get three of her daughters out of Afghanistan but lost three sons. I thought she meant they had died, but no, she had lost them. She sent them out before her and she didn't know where they went. She was now in the UK, extremely ill and nothing could work for her, no pain killers, nothing, because she didn't know what to do about her sons. A terrible pain – it might have been easier for me as a practitioner if her sons had been dead. I had to do something with this information and after many months we succeeded in tracking down her sons and she was reunited...

Did it help her pain..?

It did indeed.

You might find shattered fragments that don't seem to be able to be put back together again or make any sense – it can be frightening. You may find someone you wish you had never met! You might find a time eater.

If you stay long enough, you might find that all is not as it seems to you - or it may be exactly as it seems. I'm reminded of the story of the well-dressed chap who rushes into a bar saying "help – someone's stolen my wallet – I need a fiver for a taxi to get home – I'll pay you back" - and everyone gets out their money. Then a tramp wanders in and mumbles "anyone got a fiver?" – And no-one is looking. Why do people give money to the man in the business suit and not the tramp?

Because he looks like us – we can identify with him

Because you imagine it's a one-off occurrence

Yes – you can give freely because this person is not going to become dependent on you. If you give it to the tramp he might think you're a soft touch and come back every day for life.

What do we need to bring into the encounter? What language do we need?

Are you going in there with the right gear? Because if you're not you might feel even more powerless. You may disappoint them – you're not this great doctor. You may become depended on them. You might get trapped by a time eater. You might feel quite deskilled, and none of us likes to feel like that. It may trigger off your own fears of pain in yourself or those close to you; you begin to see what it's like to be in that house of pain and to wonder whether you could cope.

Do you need to be an Exorcist? In a way that is what seems to be expected but is of course not always realistic. But do we sometimes act that way, with our potions and so on.

The kind of pain I work can defy verbal language. I told you at my last visit to this group about the man who came to me that could tell me everything about his torture. Over a period of sessions he had told me that story with no feelings attached to it – it

was dissociated. He said “I can tell this story because I have to. If I want to live in this country, if I want my children to have a roof over their heads and go to school, I have to tell that story. *I have prostituted my pain* for the safety of my family.” We often get people saying: “Oh, refugees always tell the same story”. Of course they are going to tell it but it doesn’t mean it’s not true.

Words do not reflect the complexity, the experience and the impact of redundant pain, but verbal language can keep it all cognitive and safe. If we keep to just talking we keep the exchange in a very cognitive place, but as human beings we are not just cognitive, we are emotional and empathic as well.

If we allow people to draw or write about their pain we may encounter metaphors that they might never reveal just by talking. People with eating disorders, for instance, sometimes portray a horrible monkey sitting on their shoulder.

How do I explain how we might help? Maybe we need to be a *Hermeneut* – an interpreter – rather than an Exorcist. Hermeneutics is the study of understanding. It originally came from the wonderful Egyptian god Thoth – the god of interpretation, who was taken on by the Greeks as Hermes, messenger of the gods. Hermeneutics study how we understand one another and how we build bridges into each other in a kind of common humanity (Hermeneutics were originally used to interpret religious texts, between the two very different realms of experience of the gods and of mortals.) If you are a pain practitioner you might be in pain, and maybe you can manage your pain, but maybe the person that comes to you is in a different realm of experience. So how do you build the bridge? – And it’s not just one way. A pain Hermeneut needs to be a very good listener and a good translator for both the patient and themselves. Often pain has separated parts of the individuals from themselves, and you as the human practitioner can help to make these connections. Basic to hermeneutics both ancient and modern is that idea that there is no making sense at a distance; one must always work out some kind of internal connection with what one seeks to understand.

You have to be a story teller – somebody who uses metaphors. A few years ago, the last time I came to a meeting of this group, I met Joanna Zakrzewska, whose main interest at the time was trigeminal neuralgia. She invited me to her hospital: I went and she opened a cupboard in her office which was literally full of pictures and poetry provided by people in pain. She asked me what she should do with them. She decided to compare analogue measures of pain with pictures, and the two came out almost the same, in terms of measurement, but the difference was that the patient felt much better after working with the pictures*.

Perhaps you have to be a trickster, but find something positive to replace ‘crumbling spine’ language, by using something out of your bag of metaphors, such as culturally appropriate and enhancing storytelling and visual imagery.

I am also an Anthropologist, and have never forgotten the value of observation and learning. An Anthropologist needs to evolve from the ‘observer’, trying to bracket off their own experience, to the ‘participant observer’ recognising the reflexivity required to fully comprehend human impact on each other and the world, to the ‘advocate’ who can no longer separate themselves from what they have encountered once they have uncovered the internal connection which is a prerequisite for understanding.

*Deborah Padfield who is now the resident photographer and ‘pain artist’ at the Eastman Dental hospital has produced the remarkable book *Perceptions of Pain* recording people’s expressions of pain.

What you need to know to keep you and them safe

Maslow's hierarchy of needs:



This is the model used for systematic torture. It was used in South America in particular as a model of deprivation. First you deny the prisoner their physiological needs: food, water, clothing, (we have our clothes on because we feel safe in them; they protect us from shame and all kinds of things) Then you deny them safety, their social needs and so on. Systematic torture is about the deconstruction of an individual so you can't put them back together again; they are no use to anybody and least of all to themselves.

So if you have people coming to you who are refugees or survivors of torture or of sexual abuse with a pain you can't explain, their pain may be compounded by some of these layers. You might not be able to get through unless you do something... We have to work in this area with refugees, and it is very difficult if they don't have somewhere to stay or are going to be deported. Restoring social needs (which are replaced in some models by love and belonging needs) is something we have a really good chance with: the human in us meeting – or trying to find or re-engage, or helping them to re-engage – with the human in themselves.

Quality of listening

In true listening one enters not simply into another's subjectivity but into what is said... It matters to Heidegger that in German the word for listening and hearing is also the word for belonging. "We have heard (gehört)," Heidegger says, "when we belong (gehören) to what is said." When one listens one steps out of the aggressive mode of grasping and knowing into the mode of belonging.

Bruno, G. (1984), *Hermeneutics Ancient and Modern*, Yale University Press: New Haven and London

In our society, if we listen in the way Heidegger says, we stop being an 'I' and become a 'we'. But when you become a 'we' you take on responsibilities of being a fellow human being. This ties in with Carl Roger's view:

This listening is tuned into what is not said as much as to what is said through an attitude of observation, respect and engagement of the heart and mind, which Bettelheim believed was at the core of understanding of what we do and why we do it.

These forms of listening begin to access implicit or tacit knowledge and the trickster encourages, among other things, various forms of metaphor enabling the articulation of what is implicit.

Maguire, K. (2012) *Translating in complexity: The skills of the hermeneut.* (forthcoming)

If you're not sure what your patient has said reflect back to them what you think you have understood – this is a non-intrusive way of listening. If you listen well you'll get into the rooms of the haunted house, and even just that interest alleviates pain.

Authority dynamics

In torture, all the activity takes place between the torturer and the victim. The person who is the authority stands back from this, so the victim thinks: if I can get to the authority, they will be more reasonable than the torturer and will be able to knock some sense into him. It's like a game being played out between the torturer and the victim. The authority says 'it's really nothing to do with me – I'll have a word'. It's actually designed that way because the torturer is also tortured. Torturers are not, on the whole, psychopaths. They are part of this awful system. In South America, the torturer was initiated through ways too awful to describe and therefore if they weren't a torturer, they would be a victim. A story I shall never forget, and have used many times as it involved an implicit understanding of this, was told me by a Chilean mother and daughter who had been tortured. I found out from someone else that their brother was also in London, working in a bank, and that he had been a torturer. I asked the women why they didn't denounce the brother and they said "*because he is also a victim*". He had been arrested and tortured, and then they got hold of his little son. From that point he broke and went over to them. So the Chilean community would never turn him in, because there was a recognition of the shared pain. It is always the authority that gets away with it.

Torture relationship dynamic

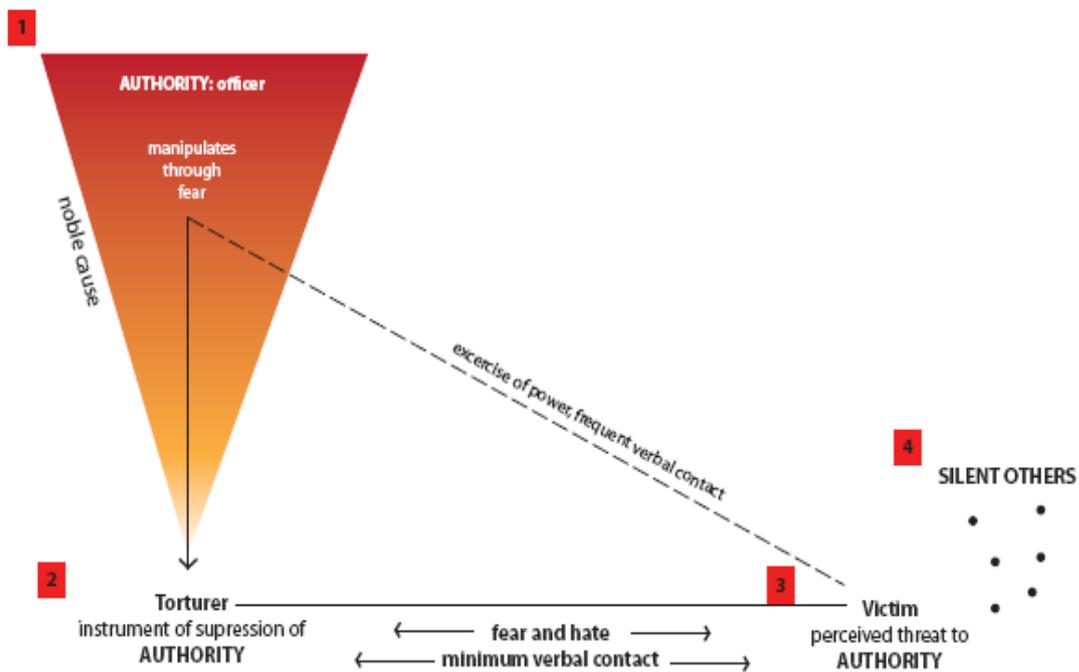


Figure 1: Kate Maguire © 2002

You can discern the same dynamic in many other situations. If you look at the way my university works the managers are the authority and the lecturers the victims – they're not tortured, they're just disappeared! Another form of torture. All our time is tied up with bureaucracy; we're fighting each other and the managers sit there and do nothing.

Possession and identity formation

Many of the people I work with tell me that pain is like a torturer: a possession by extreme pain. So they feel the victim of their torture. So in that way you become the authority that can do something about this torture: you have the skill to take away their pain. We may need to challenge that dynamic with which they might come of the pain torturing them.

Our experience of pain in childhood plays a significant role in coping behaviours in relational development and hence in identity formation and how we cope later. We can take ten people from a project in a conflict zone, involved in the same incident, and they all respond differently.

So you are the practitioner, and you can give that a human quality or not. There are times when you might not want to be drawn in.

MSF developed a mentoring system and a lot of their returning field workers, although they know all about analgesics, found that through talking to others and psychosocial therapists they could make meaning of pain, and thereby it was alleviated.

This was a song that was a favourite among their field workers:

*When you try your best, but you don't succeed
 When you get what you want, but not what you need
 When you feel so tired, but you can't sleep
 Stuck in reverse
 And the tears come streaming down your face
 When you lose something you can't replace
 When you love someone, but it goes to waste
 Could it be worse?*

*Lights will guide you home
 And ignite your bones
 And I will try to fix you
 (Fix You, Coldplay)*

This is the story of one young field worker. He had been in Sierra Leone during the 'epidemic' of limb-hacking. He went to university, and something happened to make him walk out of a lecture and just be drunk for three days, and his friends brought him to see us. This is something of the dialogue that took place between him and the therapist.

'What are you staring at? Would you rather I hurt you or some poor kid in the street or some drunken old man?'
'I would rather you didn't hurt anyone, especially yourself.'
'And what would you know about hurting, about this terrible pain that gnaws away at your very being. How can you learn when there aren't the words? How can you hear anything when the words you use silence the scream of it? Here. I've tried.'
(He drew his other hand out of his pocket and threw neatly folded pieces of paper in her face. She opened one and flushed with shame at suddenly penetrating this man so intimately. She put it down...)
'Don't start pretending you understand. You sit here safe in your middle class office thinking you know how to help people like me. Then you read something in the newspaper about dying babies in Romania and over breakfast you shed a tear, then it's gone out of your existence, banished to its limbo, to the graveyard of used up media sensations. Gripped the heart for a bit, made the nation feel for a moment, glad they are not there, give something to a charity, salve a conscience keep it all distant, then bin it.'
His mounting voice at last came down to rest and gathered itself calmly for a purpose.
'You see you won't really understand unless you feel it. Like this.'
He picked up the open fountain pen from the small table between them and stabbed it into her hand. In that one moment of that one day she knew that pain had robbed her of her carefully constructed, articulate facade of words that held civilisation together as she fell back in time to a period before words, to the choking. And in that falling she knew no one would ever understand what she was experiencing, what complexities of thought lay diminished as she hurtled back through thousands of years of evolution to be left only with a scream. And through that scream, sonorous, undulating, nauseating, she heard him say:
'The bastard lecturer was talking about the severing of hands in Sierra Leone being an act of frustrated creativity. Fucking frustrated creativity'

This was a guy tortured not only by his experiences but the way they were interpreted by others.

Being human and the inhumanity of pain

For Being Human to reduce the inhumanity of pain requires meeting the sufferer and the suffering with openness. It recognizes the necessity of providing emotional and empathic support as well as the cognitive and prescription interventions which may not heal pain but can alleviate it. It is to recognise that a rupture to one's humanity is healed by the mirroring of humanity in another's face; to be met as a human who is more than their pain.

I did a lot of research in pain clinics some years ago. So many of the patients said they wanted to be met as a human who was more than their pain. When they asked if that had happened they replied: 'with individuals – yes'.

Ethical obligations

If I am a pain practitioner I may need to enter the house of pain; I am not sure I can live with myself if I don't. But I should not enter if I am not equipped. I have a duty of care to myself as well as to my patient.

Pain is another form of difference. I need to connect to that difference as I would to any other through knowledge, respect and finding a solution in the context of the patient.

The monkey and the fish story illustrates the need to acknowledge difference and to find the patient's solution; not your solution. A writer is walking along a road and he sees a monkey jump out of a tree, jump into the river, pull out a fish and put it on a branch of the tree. The writer asks: "What did you do that for?" The monkey replies "I was saving the fish from drowning."

Research

If our knowledge of pain intervention is to increase we must be prepared to explore our practice relationally with patients, and not try to manage it without them. There is so much research we can do with patients which would involve them relationally: qualitative research, not just surveys and questionnaires. We can get better at what we do – we have a lot to learn, and I think everything I have learnt has been from my clients.

Humanity and understanding

Hermeneutics is not about prescribing a procedure of understanding but to clarify the conditions in which understanding takes place.
(Gadamer)

So working with pain requires getting the conditions right and one of the conditions is being human and relating, and being equipped to enter that house and providing that humanity; and then I think understanding begins to take care of itself.

Discussion

Listening to the three talks this morning has convinced me that we have to throw out this paradigm that we developed from the eighteenth or nineteenth century: we do the autopsy and say there is the disease and we want to inject something

into the disease to fix it. In the work we do we have to have an understanding of quantum mechanics, which says with me as an observer, seeing the thing observed is a merger and interaction so the two are no longer independent. So the observed experience is different from the unobserved experience and what is knowable is different if there is an observer. When you [Ian Yellowlees] said that a scale – using the engineering model, used to measure something – has a therapeutic impact, that is saying that there is this relation between the observer and the observed. Going beyond the engineering model, we can't go in as self-interested, objective – here are my instruments and I'm going to do something to you. The commitment is that we have to make is to go in with our heart and soul and say we are going to be, in some way, one with the person we are working with and trying to heal.

As Howard Brody says (of hermeneutics) the story has to become part of me. The stories you have heard about so much torture have made you a different person you so you are not walking away, like someone who has injected A,B and C so everything is fine – it's a completely different experience with a different physics and philosophy. And that's where we need to be and what the calling is.

The problem is, especially for GP's, is that this takes time which they may not have.

Working in general practice I have learnt that the relationship between time and empathy is absolutely crucial. You can spend huge amounts of time with no empathy and achieve nothing more than if you did what you normally do in five minutes; but you can spend relatively short periods of time with true empathy and the kind of listening you have described and achieve quite a lot of healing. Stewart Mercer [Professor of Primary Care in Glasgow] has done a lot of work on this.

I can talk from the experience of torture: one of the basic ruptures is of the illusion that people are good – a huge relational rupture. I am entering the house knowing that is there, so whatever happens in the house, if it is informed by the relational: I want to be there but I'm scared, so this person is my guide. This already begins to repair something of the relational. That's what I'm interested in – not the objective realities of what one might see because narrative changes all the time; we change every time we meet each other. It's a wonderful synthesis that happens if we're looking for it

...If the outcome is good you don't necessarily need to understand how it happens...

...Nor to have an outcome idea of what it is you want to happen. What the possibilities are ...

Someone mentioned authenticity: this is just who I am and I make mistakes – this is just being human. Bosnian survivors told us at our unit that they could live with the gravel in their stomachs which they were eating because they had no food; they could live with the beatings and even their houses being dynamited, but what they couldn't live with was that this had been done to them by their neighbours. That was the rupture they couldn't repair – this terrible betrayal. And betrayal is the same in all cultures and languages – nobody likes it. Bruno Wettelheim, writing about the experience of the concentration camps, said the hardest thing to live with was to know that they had not behaved in a way they did not approve of in themselves.

That's a question for us; I'm very anti-managerialist – my measure is that if I don't keep my job my son doesn't stay at university, and I can't live where I do. I

hope my university won't force me to behave in a way I would disapprove of. So what I do is to work every weekend to make sure my students are OK because that's important to me. I don't give a shit what the university's ideas are; I have students who have paid their money and trust me to see them through. I can't live with doing what the managers tell me.

How do you justify your work in terms of outcome to your employers?

With the clinic in the NHS which is now dispersed into all the mental health units, actually I was very lucky because the patients that were sent to me all came from psychiatry and the choice was either coming to our unit or being put into mental health wards because they were behaving psychotically or trying to commit suicide or whatever. So what they were looking at was what happened to each of these people after they had been in the unit: if they were no longer psychotic or dependent on the NHS or getting a job ... there was a whole team including social workers. And we were allowed to see people for a very long time if we wanted to.

I have occasionally been into the house of pain and I find it quite damaging to me and it takes me into my own house of pain. How do you protect yourself against that? It must be a huge issue in your job.

One thing is how you work when you are there. When you work with metaphor it keeps you and your patients safe, because any time either of you can withdraw. So for example dreams are very good metaphors to work with and I learn a lot from them. All therapists have supervisors. You can go and talk it out with them, or you have group supervision.

There are issues around the voyeuristic element – you get drawn in. I reached a point about four years ago when I couldn't practice any more with survivors of torture. Going into that house so often was beginning to make me lose the very thin existential thread I had about my own meaning-making. Here I was trying to work with people to see if they could make meaning of their pain, and I was thinking – I can't make meaning of it, or even of my own existence. I have asked people who have come from quite religious cultures what impact that had on their belief system. Some have said: 'I hate it – God... get rid of him!' And yet when you read their poetry it is among the most spiritual you will ever see.

What's happening there? They are denying God but it he is in their poetry...

What they are denying is the man-made construct that this is what God does ... Torture is about ripping off the mask of illusion about civilisation and everything. But they still have this notion of God within oneself. Their experience has connected them to something that was beyond the human construct of God. When I sit with these people I can scarce believe their desire to still want to relate. But that also gives me hope.

The last chapter in Erich Fromm's book *The Anatomy of Human Destructiveness* is about the ambiguity of hope, and the distinction between expectation and hope. I worked with the story of Pandora with one of my clients who told me years later how helpful it had been because Pandora opened the box and all the ills of the world flew out. I asked her if she knew what was left in the box – she said "no" – it was Hope. Pandora asked why it didn't fly out with the others and Hope said: "it's your choice." So she released it into the world. And this client said: "I thank her for that". Your patient comes into you with expectation, which in

life often just leads to disappointment. But its hope that one works with; it transcends expectation. Erich Fromm put it this way: “you are told that the Messiah is coming at the expected hour, but he doesn’t come at the expected hour – what will you do? Will you wait?”

The Gift of Knowledge

Michael Bavidge

“There is no objective understanding of the world without a community of enquirers... There is no community of enquirers unless they are embedded in a shared environment, a common world.”

I want to take up a position which is very similar to almost all the contributions we have had over the last couple of days, but there is a difference. The other papers have been looking forward to the clinic and problems you have dealing with patients, whereas I am standing here, I hope with the same sort of commitments, but I am looking backwards, away from the practical engagement. I can feel the hot breath of hard-nosed empiricists and positivists down my neck and saying this is all very nice but it's rubbish; I see myself as addressing those problems. So what I want to do is to have another look at the difference between what I want to call, as simply as possible, knowledge of persons – ourselves and others – and knowledge of the non-personal world. My interest in the distinction is not just, as it were, academic. It comes from a concern – paranoia even - that the distinction is frequently denied, in fact its denial seems to be embedded in some scientific disciplines and in general cultural attitudes that are thought to be at the cutting edge of things.

One of my earliest memories of being philosophically outraged was a long time ago, in a public library in Carlisle. I was reading an article by what must have been one of the first artificial intelligence people, and they were proudly announcing that they had built a machine that had a nervous breakdown! It was a robot that could follow a light source, but when its batteries ran low it was programmed to go and plug itself in. So what they did, when its batteries were running low, was to raise the intensity of the light and the thing blew a fuse. So their claim was: at last we have a genuine scientific understanding of a nervous breakdown! It wasn't a joke! I thought this was rubbish and haven't changed my mind since. Of course the machines are more sophisticated but they are playing the same game.

I want to give a couple of more recent examples. Last month in a review in *The Guardian* Dorothy Rowe wrote:

“We can never know precisely what another person is thinking or feeling. As Neuroscientists have established, we cannot see reality directly. All we can ever do is to create theories or guesses about what is going on in the human-sized world in which we appear to live.”

Dorothy is widely published and I don't want to be rude about her, but in those three sentences she announces, as if it was too obvious to be worth saying, first that we, the most communicative of animals cannot know (or know precisely) what others are thinking and feeling. One could ask what the word 'precisely' is doing there. Secondly she claims that we, the only animals who have embarked on a journey to understand the nature of the world and ourselves objectively, cannot know reality directly. (What is 'directly' doing there?)

I think there is something really odd going on in our culture when this becomes an easy thing to say, an odd form of intellectual masochism, that people who make these sceptical remarks about communication pride themselves on being hyper - communicative and sensitive to the least raising of an eyebrow or hardening of the

eyes. They often work in communication industries. They go to theatres and get a buzz out of sharing sentiments expressed by Shakespeare centuries ago, or Sophocles millennia ago, and yet allege that we can't know what another person is thinking. My second worry is that the best we can do from the point of view of knowledge is guess about what is going on in the human-sized world in which we appear to live. So perhaps we agree with that and then we go home and watch television and see Professor Al-Khalali explaining how cosmologists have arrived at objectively based but truly mind-boggling conclusions about the real dimensions of the cosmos: it's much, much bigger than you think!

Another quotation, this one from the distinguished academic Colin Blakemore, the Professor of Neuroscience at Oxford:

“Increasingly, those who study the human brain see our experiences and even our own intentions as being an illusionary commentary on what our brains have already decided to do. Perhaps we humans come with a false model of ourselves which works well as a means of predicting the behaviour of other people; a belief that actions are the result of conscious intentions. Then could the pervasive human belief in supernatural forces and spiritual agents controlling the physical world and influencing our moral judgements be an extension of that false logic: a misconception no more significant than a visual illusion?”

‘Science is just one gene away from defeating religion’, Colin Blakemore (The Observer, 22 February 2009)

So what he is asking is: could supernatural beliefs be an extension of that false logic? That seems to me to be a whopping mistake, to say that even if you are a five-star atheist, it's not an extension of that false logic – but it might be a false extension of that logic, which is a completely different point.

But the point I really object to is his assertion that our experiences and even our own intentions are an illusionary commentary on what our brains have already decided to do. (I have been hearing here about neurological experiments that have suggested that before we decide to do something there is some sort of brain event, which raises problems about free will and so on). I think a professor of neuroscience should display a bit more respect for the truth of what he says. The ordinary way, he says, in which we talk out of and about our experience relates to what is really going on, namely brain events, as John Motson's commentary relates to play; in other words it's *epiphenomenal*. But worse than that, he says it's an illusionary commentary. Not only is Motson's commentary not a working part of what's happening on the pitch or making any difference to it, but it's a mis-description of what is happening there. But worse still, it's not a mis-description of the game in the sense that he reports that Rooney has scored when he hasn't, but in the sense that he's got the wrong sort of game altogether, as if Motson having only the distinctive lingo of a football commentator was called on to commentate on a cricket match. He will talk of goals when there aren't such things in the game. Similarly Blakemore suggests, and I think we are meant to take him seriously, that when we talk about intentions we are really talking about something that doesn't exist in reality at all.

I really think we ought to take these claims with some degree of seriousness, as they are affecting the way we think about ourselves and other people and the world. If we take Rowe and Blakemore together at their word, we get a triad of denials. We do not know the world directly; we know other people only in the sense that we can predict their behaviour on the basis of fictions, and we are seriously deluded about ourselves.

The nature of knowledge

It seems to me that this depressing story must be based on a narrow idea of what knowledge must be. It's hard not to feel that we are fighting a rear guard action against the more outrageous assertions of science, and we have to pluck up courage and go on the offensive. We can defend the distinction between different sorts of knowledge, and show that they need to be and are different, and that they are interdependent. There is no objective understanding of the world without a community of enquirers: people who understand, sometimes precisely, what each other are thinking. There is no community of enquirers unless they are embedded in a shared environment, a common world, in which they co-operate intelligently. There is a big difference between personal knowledge: the thoughts, experience intentions of others and ourselves, and non-personal knowledge. (I'm not saying that there are only two types of knowledge – there may be many more – but I want to make this important distinction, which affects the structure of knowledge in a very fundamental way)

There are obvious distinctions to be made between the data on which our knowledge is based: where it comes from; the processing: what we do to the data, and what is an appropriate way of handling the sort of data; and finally the outcome: what completes the process and gives us reasonable grounds that we have arrived at something called knowledge. There isn't time to deal adequately with all of this and I want to concentrate on the data, but first a little about the other two. I think processing of the data is what we have been discussing in our previous sessions: the common theme of the conference of what is involved in understanding people, listening and being sensitive to their situations. And this involves not just the personal qualities of therapists but also institutions and practices that do not force sufferers into silence. No doubt a physical scientist needs to be more than a number-cruncher; he needs imagination and creative thinking, but he doesn't have to take into account the sense and sensibilities of his subject-matter.

As regards outcomes we should wean ourselves off concerns with certainty and proof. We can know something without being able to put QED and the end of a long sequence of thought. Personal knowledge does not issue in putting a tick next to a proposition, but in mutual understanding, getting along with someone; building with another person the basis on which an honest relationship can be continued into the future, sometimes with what he have come to call closure: being able to draw a line under a distressing episode and move on.

Back to the data. I can make my point by distinguishing two senses of data. Data has come to mean a group of known or assumed facts, from which, by calculation or theoretical interpretation, conclusions are drawn. But etymologically data is the past participle of the Latin verb *dare*, to give. Data then means given, in the sense of a gift. It is in the second sense that the data on which we build personal knowledge is something that we have to be given. Hence my title of 'knowledge as gift'. This is a synecdoche which as you know is a form of autonomy, meaning using the part as the whole (as in *there were 31 hands on the ship*, which doesn't mean a crew of 15 commanded by Captain Hook!) I could have used other words like transaction or participatory which other speakers have used, and it is the second that best conveys my meaning. Last year there was a giant hoarding outside the British Library which carried a quotation from Dr Johnson which read: "Knowledge is of two kinds: we know a subject ourselves, or we know where we can find information upon it." Johnson made this remark to a Mr Cambridge who had commented upon his habit of

reading the titles in a library, meaning it's useful to know what books are available on a subject even if you haven't read them. But taken seriously it really embodies an error or an imbalance - a typical Enlightenment remark - that still causes us trouble today: knowing is a matter of making your own mind up on evidence you have collected. You've either done this or know how to go about doing it. Acquiring knowledge is a proactive business, the core of personal autonomy. I think it was Kate [Maguire] who quoted Heidegger complaining about knowledge thought of as an aggressive form of grasping.

There is a third form of knowledge to add to Johnson's two: the sort of knowledge that in terms of human life is absolutely fundamental, and without which other forms of knowledge would not be possible: our knowledge of the thoughts and feelings of others. We haven't got knowledge of other minds ourselves by relying on our own resources. Nor can we find it ourselves. It can only be acquired by waiting upon the intervention of others and of their ability and willingness to communicate with us on their expressions, avowals and disclosures. The idea runs counter to some quite deep assumptions. We live, we are told, in the information age. Information is all; it is equal - it doesn't matter where it comes from or who discloses it. We don't always feel comfortable about this. For example we think people have a right to privacy. There are difficulties about how far that right should be extended, as the current row about super-injunctions shows. But people have the right that certain facts about them should not be common knowledge: their medical history, for example. One's medical history consists of information: personal and sensitive, but facts all the same. There may be information about me that is not even personal or intimate but only I have a right to put into the public sphere - how much money I have in the bank, for example. It's my business. There are plenty of things you could not try to find out unless someone is prepared to tell you. Outing (of gay people) seems to share the character of the medical history and the bank account. A person's sexual orientation may be for them a personal matter which they do not want to be common knowledge, or even if they do not feel particularly sensitive about it, they many think it is an item of information over which they hold a proprietary right. So their objection to outing is that other people have no right to put such an intrinsically personal matter into the public domain.

These things can have moral and legal implications, but there is a more epistemologically interesting set of cases. Sometimes the method of disclosure materially affects what is disclosed. It's not just a matter of offending someone's sensibilities or breaching their proprietary rights. We are no longer dealing just with information or facts, even sensitive facts, but with facts insofar as they relate to the person's broader feelings, intentions and interests. It may be possible to regard someone's sexual orientation to be fact about them, but what we may well want to know, if it is our business, and it may be our business, is what they make of their sexuality, and that is what we want to know. We have to wait for them to tell us. Personal knowledge can be thought of as a gift as we can only acquire it through the good offices of others.

The disclosure of personal knowledge: A gift?

The basic point that John Loeser makes in his foreword to the book *Pain Suffering and Healing* (which we are shortly about to publish) supports this view of personal knowledge. 'Suffering,' he writes, 'can only be addressed through the patient's narrative ... [it] cannot be found in a laboratory test or imaging study; it is only observable by communicating with the sufferer.' That's what I meant when I said personal knowledge is based on data in the sense of gift. But there is a philosophical trap waiting for us. Loeser emphasises our dependence, when it comes to

understanding suffering, on the patient's own account. But there is a problem: what confidence should we place in the patient's version of events? He writes: 'we also know that eyewitnesses' accounts are notoriously unreliable and the patient is the epitome of the eyewitness.' This suggests to me that the reason why we need the patient's own narrative is that they have exclusive access to the information we are after, so we have to wait for them to pass it on to us. The situation is not as desperate as that idea of inner privacy suggests. Our inner states are not as private as we have come to think, and our access to other people's inner states is not through their witness reports but through their direct communicative talk and behaviour. We need personal disclosure, but not because each individual is the only eyewitness of events in their own inner life but because we are not in the first instance eyewitnesses at all. We speak out of our experiences before we speak about them. We express our inner states; we do not observe and then report on them. People suffer and they express their suffering; later they may report, describe or tell the story of their suffering. Wittgenstein started an influential line of thought when he argued that descriptive language is not required to mediate between experience and expression. Reports and narratives do not get between our experience and its expression. Imagine someone asking: "but isn't the beginning the sensation – the pain – which I have described?" He answers - no, expression comes first. He writes: 'How can I go so far as to use language to get between pain and its expression? – as if for example I could prise the person undergoing the pain from the pain itself', and insists that before he gives expression to the pain by crying or in words he takes note of the fact that he is in pain.

The difference between description and expression is important but there is an instability between them. In the rough and tumble of life we move between them, sometimes easily, sometimes with difficulty and sometimes in anguish. We see it in domestic comedies and the groaning and pathetic voice I use when I am under the weather and ask my wife to make me a cup of tea and the voice I use at the surgery, not wishing to underplay my hand because I want the tablets (but anxious not to overplay it because I don't want to appear a difficult patient!). In real suffering we are caught between anguished expressions and the narrative that is of dragged or enticed out of us, both threatened by the silences of suppression or despair. (People have spoken to me about this instability between expression and description; one of you said "when you go to the doctor and say 'I'm in pain' it's learned behaviour".) It's that move from the directness and spontaneity of expression which seems to me to be the point of access we have to other minds, and the shift from a narrative (someone today described how when a patient and a doctor come together they create a narrative between them). I am surprised that doctors don't feel more uncomfortable about that gestalt shift; it's almost the difference, when you're having a conversation with somebody, between taking them seriously – taking what they say directly – or taking what they say as a symptom of something.

The shaping of our in-experience by externals

So personal knowledge depends on the generosity of people, on their capacity and willingness to make themselves available, through spontaneous expressions of their thoughts and feelings. But in the argument against those who have lost confidence in their power to communicate another idea is just as important. We should show how our in-experience isn't as inner as all that. It is shaped by aspects of the world around us. (There is a whole branch of philosophy now called externalism). That seems easy enough when we are talking about mental states like beliefs or intentions that have a high cognitive content. (You say that I believe that or I intend to do this and something follows.) For instance my opinion that Mrs Thatcher was the best prime

minister since Disraeli depends on all sorts of facts about the world outside my head. I couldn't formulate the intention of going for a drink this evening unless there were a world out there with pubs and so on. But it is equally true of those states that sensations like pain that seem to have little or no intellectual content and would seem to fit perfectly into our inner world without any overspill. I have a domestic anecdote to illustrate this point. When he was about five years old my son Colin was stung on the lip by a wasp. He screamed and screamed and nothing we could do would console him or lessen the pain. My elder brother who is a doctor arrived unexpectedly. He got the boy's attention and the first thing he did was to agree with him that it really, really hurt. Then he pointed to a clock on the mantelpiece and said when the big hand gets to the three it would still hurt but not quite as much. When it got to half past the pain would still be there but much less, at quarter too hardly there at all and when big hand pointed to 12 the pain would be completely gone. Colin went over this with his uncle and went out to play. Sometime during that exchange he had stopped crying. So far so good. The philosophically interesting bit is that every few minutes he ran back into the room to check where the minute hand had got to check how bad his pain was! He told us that he could indeed feel it at quarter to, and we acknowledged his authority to say that. When the hour came round he announced, as if he had passed an exam, that the pain had completely gone. So my brother gets full marks for therapeutic technique and we wryly note how suggestible we are and how our experience of pain is conditioned by all sorts of psychological factors.

Perhaps we can see the episode as a good illustration of another of Loeser's remarks in his foreword: "What we experience is coloured by our past experiences and the anticipated consequences. The placebo response demonstrates this with clarity". We have no problem with that but we still think there is something humorous about the little boy looking at the clock to find out how bad his pain is. Surely he knows already how bad it is just by having it? Or you might say, in philosophical mode, he knows how bad the pain is by introspection. What my brother did was to con him into distorting his own perception and experience. But is that right? In his book *Zettel*, Wittgenstein imagines his opponent saying "I may know that he is in pain but I may never know the exact degree of his pain" (that word exact again). Here is something that he knows but his expression of pain does not tell me. It is something purely private. He knows exactly how severe his pain is. Then Wittgenstein says "isn't that much as if one were to say he always knows exactly where he is, namely here". My brother was not just using a diversionary tactic to help his young nephew through an unpleasant experience, he was communicating something about a concept of pain. It is something of which you can take an overview; you can stand back from: something to be endured or managed; something with degrees; something that comes and goes; something that you the patient can speak authoritatively about. In particular he related it to time objectively realised: the hands on the face of the clock. He was not explaining the meaning of the word pain; he was sharing a view of where pain fits in with the woof and warp of life.

Every mother does the same when she kisses the baby better or tells the child to count to ten. When we interact with infants in this way we give shape to their experience, just as we give shape to the world they live in when we communicate concepts like dog or dinner or teach them to count. We wake in the morning to a world of alarm clocks and curtains and bedside tables, but also to our own feelings of tiredness or toothache or depression. We organise our experience as well as the world using concepts we learnt at our mother's knee and other transactional joints.

Discussion

I was intrigued by your discussion of witness and I wonder how you'd respond to the distinction Arthur Frank makes in his book 'The Wounded Storyteller' that when you are listening to somebody's story of pain you listen as a witness. What he means is that as in a courtroom where the witness is the person who was there at the time of the accident or whatever, so witnessing the pain, the story, requires the listener to be there for the gift that comes across. It's a very different kind of listening from ordinary listening which can be kind of impatient – 'hurry up and finish, get to the point etc.'

I suppose I was using the term critically and worrying about the metaphor that was used in the preface to the book that we are 'the epitome of eyewitnesses' of our own experiences, and I don't like that. We are already going to go down a path that's going to end in some dualistic mess if we start thinking of ourselves as being the eyewitnesses of our own experience. But that's not what you are talking about – you're talking about being a witness to someone else's experience, but even then it's not quite, in a hard-nosed sense, it's not being an eyewitness like being a witness to a crash. This may sound pedantic, but Loeser's analogy does depend explicitly on this – he says we depend upon the narrative of the patient, but the patient is the epitome of the eyewitness and we all know that eyewitnesses can be very unreliable. Now they are unreliable, but they are precisely not what I think you mean about being present, because we are not present to a car crash. If I walk down the street and see an accident slightly to one side of me I am not present in it (in your sense) but nonetheless I will be dragged in but goodness knows what I am going to say. I was reading recently about some research into the reliability of eyewitnesses and there results were very depressing. They showed subjects a video of a car crash, and when they asked the question 'did you see a dog' some said 'yes' and some 'no'. But if they asked 'did you see *the* dog' (there was no dog) the number who said yes went up amazingly, just because using the definite article implies that the thing was there. That's the sense of witness that I worry about. But I liked your point and I would like to look into the preconditions of receiving gifts ...

We say 'pain is what the patient says it is'; this means that you have to accept what the patient is saying to you but you can't assume they are right. You have to put yourself in a place where you accept what they say but you need to check their stories.

It's not quite like that – we are only making an assumption that they aren't being deliberately mendacious, and we are running the risk of falling into that dualistic mess because on the one hand we are talking about being an eyewitness – where exactly were you when you saw the crash – measurable stuff – and on the other – like Dorothy Rowe – when my patient speaks to me and those words are out there those words spoken create the reality and I think that we are trying to compare apples and pears.

I'm not sure if I agree or disagree with that. Even our sensations like pain aren't as private as we take them to be. Not because they are affected from outside extrinsically but because they are moulded; they are made to be what they are as items of experience by what other people and the environment do to us. So I think it's out there in a sense but on the other hand we mustn't put it so much out there that we have some sort of behaviourist stuff going on ...

Some of this relates to the subject of trust, which we have discussed before, and the extent to which we trust what the other person is saying. I think that varies enormously and I was very struck by your story of the different way you present your cough and cold to your wife or your doctor, and we all do that, but then when it comes to other aspects of ourselves like how much do we drink we go a bit further and we actually lie. A lot of the understanding of the other person's reality depends on whether you really trust what they are saying when you get to the point of actually being really honest.

That seems again to do with presence; it's not the blatant lie but more about self - deceit or where you are in a position where I am repressed in some way. Those things mean that it's kind of impossible for me – I mean at the present, not absolutely - to make myself present to the other person. I'm happy to take your experience to fill out what I have been trying to say. I have written a paper called 'Against empathy' because I am reaching for a presence rather than a notion of empathy which I have come across in psychotherapy textbooks where it is seen as a rickety imaginative bridge between my inner world and yours, which I build. That's the sort of thing I want to get away from; of course you can't be against empathy but I want it to be understood as finding common ground out there in the 'community' or between people.

... There is a neurological basis for empathy seen with functional magnetic resonance imaging fMRI ...

That gets me to Colin Blakemore who can be stunningly annoying on occasions and I wonder why he says and writes what he does. I can only attribute it to territorialism. You speak out of your territory and the only people who listen to you are neuroscientists. (He is for ever having to defend his territory from anti-animal experiment people and others) You said you feared we were going in this direction where all the rest is fantasy and illusion, and this is hard fact. It is really quite extraordinary to think that in the twenty-first century after all that has been written about the nature of scientific hypothesis etc. that somebody of his eminence could write such absolute rubbish.

I liked your concept of gift and recognising data as something given and the possibility of that kind of knowledge opening a very rich territory. (I am not suggesting it could replace scientific enquiry) It does raise problems: scientific enquiry is nice and simple and you can know for certain about some things; and it does depend on relationship.

Philosophers have a lot to answer for in this regard. Since Descartes certainty has been given such an overblown place in our epistemology, and it doesn't make sense to put it there, and part of the strategy in dealing with problems is that we must deflate that notion. I really recommend Raymond Tallis; his latest book is called *Aping Mankind*. * He is a doctor and very productive on the scientific side of medicine and an all-round renaissance man, but he is also a philosopher and has the self-confidence and the knowledge to really take these attacks into the enemy's citadel which I can't do because I don't know enough about neurology.

On another point which I have alluded to a couple of times: before we speak about our experience we speak out of it. The Blakemore problem arises from saying, look: we've got two accounts. On the one hand here's me rabbiting on that I want to go for a drink and I've got toothache and I'm feeling depressed and this is my first person talk about my own experience, it's a report of how I feel and what I intend using 'folk psychology'. Over here on the other hand I've got a scientific description of what's actually going on in my brain. The question is how do these two languages relate: the

two narratives, the two reports of the same event? Now we're beginning to get into difficult territory. But I want to object before we even get there. I want to say that this hand here is the one that is 'Me', that does the 'I' talking: it isn't a report at all – it's not a report that has to be aligned with this report. It's an expression, a speaking out of but not about, and so the whole way the problem is set up wrong from the start.

Regarding the detection of brain events before you have decided to do something and what this says about our actions: on the one hand we have the description of the brain event, and on the other my account of my intention to do this or that. But now we ask ourselves: how do we identify an action, because this problem doesn't become acute till you think you've got on this hand a description of something, X, in the middle, and over here another description of X and how do I relate them? How can I identify my action?

Here I have spoken for nearly an hour. How many actions have I completed? I've given the paper, and I will ring my wife and she will ask how it went and say well done. That's one thing out of the way. But have I done one thing or 99 things or 199 or even 10 million things if you count every little thing. If we are in such a mess that I can't say when my actions start and finish, what is this dreaded correlation supposed to be?

Let me just try this: I like that distinction about personal knowledge, but if I'm talking to you and sharing first-person knowledge but I'm selecting from the stream of events so in a sense I'm fictionalising that experience and using language in order to describe something, but it's selective. I could have framed it. I could have done the story at a different point. I could have said this is the sequence I want to share with you... It's the moment before I gave the presentation rather than the moment after. So there is an element even in personal knowledge of fictionalising inevitably because it is language and it is helping to construct reality. As anthropologist Clifford Geertz says, reality is a story about a story about a story about as story, ad infinitum. In other words, Geertz argues that we never arrive at a pure reality that is not embedded in a narrative. It's compelling.

Does phenomenology play a part in this: the recognition of the other?

The Phenomenologists have been strong on this side of things. I'm not always happy with phenomenology as a methodology – I tend to think that there is more to be said on the analytic side than is often allowed because some of the problems we get into are really conceptual rather than failure to get to grips with the flow of our experience. The analytical philosophers have rather overdone it; even Wittgenstein who has influenced me most can be rather annoying sometimes, but I think the problems we face are mainly conceptual.

A fiction is going to encourage us to think in a particular kind of way, but as a cure to some sort of gross naïve realism, then that's fine. But I much prefer the other story about how you have a sort of negotiated –not only with the doctor but with yourself – before I go to see the doctor I negotiate what I am going to say.

What I'm getting out of this is that the words actually create and define the reality and they may not be precise truth, but you are saying ... I'm thinking about non-verbal communication as one thing, but that is open to imprecision as well. I'm thinking about different cultures ... even when words aren't used. If I'm faced with a Turkish client, especially for the first time, their behaviour, which may well be a precise expression of their experience, may not arrive in that way at my doorstep. What can we do with this?

I'm looking backwards – not forward as you would have to create the conditions in which you can be present to your patient and achieve a genuine understanding. So that's for you to sort out. But this is why I want to be iffy about words like fiction. I'm kind of in favour of reality – I think it's a good thing! – At all levels, and that includes the gross physical – let's get the physics and chemistry right and all that stuff. But I don't want to say realism is OK with physics and chemistry but when it comes to people – oh well, that's not the case. Which is why I want to make a little song and dance about the word exact. It may sound as I'm missing your point but sometimes I know exactly what my wife is thinking; she is a very reliable person and if she says she is going to be back from work at twenty past six she will be back then. The word precision – can I know precisely what you are thinking – makes sense in certain contexts but not in others. Suppose we all enjoyed listening to the readings from King Lear - do I know precisely what you (or I) meant or made of that? What is the word precise doing there...?

... *Does it matter?* ...

My question is, is there any content to the suggestion that there is something precise there at all? And that not because everything is imprecise, but the distinction precise/imprecise doesn't operate in that way. It does if you are talking about buses or a child getting sum right ...

It sounds like we have a delay in our own awareness – our own reality. If we take the driver applying the footbrake but he's not aware of actually thinking about it before his foot has already moved, that's almost a sense of not being aware of your own awareness...a delayed response.

These are difficult problems but I must repeat the point that Tallis makes, although my argument is not quite the same. He wanted to ask about the experiment where they detect the difference in time: at what point do the subject's actions start? Did it start three months ago when they agreed to participate or when they put their coat on to come to the laboratory? The person who is unaware of putting his foot on the brake: does that mean he did something deliberately or you could blame him if he didn't do it? This assumes ... when he got in the car, when you turn the key and start moving, that's when you take responsibility for braking. I think we've got to get away from this idea that there are events going on inside our head and some are conscious and some unconscious – our language about other people and about ourselves is much more subtle.

* [For anyone with insufficient time – or inclination – to read the book, may I recommend the excellent review by Andrew Brown to be found at <http://www.guardian.co.uk/books/2011/sep/16/aping-mankind-raymond-tallis-review> For those with time it may whet your appetite to read the book! – Ed.]

Reductionism revisited

Diana Brighthouse

“So what is the comfort of reductionism for medics and a lot of other people? Certainty offers security. That’s part of the human condition.”

I’m not going to revisit the talk I gave at the very first meeting in 2001 because a lot has happened in eleven years, both in the world of medicine and in my world, and also although I do lay claim to being a Doctor, a Psychotherapist and a fine arts graduate I do not pretend to be a Philosopher! So I hope the Philosophers in the audience will excuse me as what I have to say comes from the paradigm of medicine and art rather than philosophy. I want to look back on these eleven years partly reflecting on my own journey, partly on the political journey of the health service, and sort of look at it through a reductionist lens, and how reductionism might apply.

The backgrounds of my slides are deliberately chosen artworks*

Listening to the talks thus far, serendipitously everything I am going to talk about fits in quite well, and I’m not sure if this is going to be a resume of what has been said or a deconstruction.

My very simplistic definition of reductionism is: an understanding that the nature of complex things can be understood by reducing them to more fundamental things, or a philosophical position that a complex system is only the sum of its parts.

I came across this quotation from Giles Fraser, the Canon Chancellor of St Paul’s Cathedral written the day after the royal wedding:

“The night before I got married I went out for a drink with a mate. I tried to make a rational analysis of reasons for and reasons against getting married. But it was a stupid exercise because no equation of reasons could begin to describe the situation. How is love to be reduced to a series of propositions. In truth what binds people together as a couple or as society always exceeds the reach of a purely rational analysis.”

I would ask how can medicine, and certainly pain medicine and mental health medicine (which in my experience are often intertwined) be reduced to a series of propositions.

On the other hand, about a week earlier an article appeared in the Observer, quoting an economist as saying:

“Capitalism wishes to see the maximum return from its investments. To that extent it exerts great pressure to turn both human beings and nature into commodities. Viewing people as commodities promotes hierarchies of worth and discourages communication”.

I rather feel that what we have had a tendency to do in medicine in the last decade or so is to turn human beings into commodities. I recommend very good article from the British Journal of Psychiatry 2009 by a very large group of Psychiatrists from across the country. This proposes that:

Reductionist policies have impoverished the health services. Providing high quality care is reduced to meeting targets. (I think this applies in large part to chronic pain, and indeed most chronic services) Professionalism is reduced to competences. Diagnostic assessment is reduced to assessing needs and risk. Clinician- patient relationships are reduced to an assembly line model where functional teams provide 'client-centred' but fragmented and impersonal care. The current emphasis on health rather than illness and on recovery rather than treatment represents magical thinking, (a lot of this in chronic pain) in attempts to deny the existence of madness (chronic pain) These manoeuvres also help to tidy away the suffering and emotional pain of mentally ill persons (chronic pain patient)

Lean and NICE

Evidence-based medicine is very much something to appeal to managers, health service economists and people who want to measure things and deliver reports, rather than practicing clinicians. 'Lean' is a model of care which has been adopted by the Department of Health (DOH) if not further down the chain which actually originated with Henry Ford but has been taken up in Japan by Toyota as a model of efficiency: if you can streamline and become more efficient and save money you can improve outcome. [Slide showing various models from Lean that have been taken up by health authorities, and a model of a computer system, suggesting a visual similarity] Lean is medicine for healthcare. 'Healthcare is full of committed, highly trained and motivated staff who struggle daily with broken and wasteful systems and processes. Lean techniques have many of the solutions to sort out, repair and align these processes to organisational objectives. The solutions themselves come from within the teams working in the systems and processes' (From Lean Healthcare Academy's website). You will notice that patients aren't mentioned. I trawled through several pages of this and patients weren't mentioned once. John Seddon who was an Occupational Psychologist and is now a Management Consultant, and has been giving advice at a parliamentary level writes:

"Instead of changing it, unfortunately Lean has actually reinforced the current management paradigm. As such it represents the further industrialisation of the service with effects that can only be deleterious."
(because we can't industrialise people)

He says that:

"Focus on relationships in service organisations can deliver levels of performance that most people wouldn't dare dream of – something far beyond the capacity of any commercial toolkit to deliver, even one that calls itself 'lean'."

NICE 'works with the experts as well as the carers'. They claim to make 'independent decisions in an open and transparent way, based on the best available evidence and including input from experts and interested parties.' They don't say how they obtained this evidence, so I looked further and found 'NHS evidence provides access to a wealth of quality information and best practice.' They still don't say how that information was obtained, so I actually e-mailed NICE. They did reply, but didn't tell me, and more or less repeated what they say on their website. So a body which purports to be highly reductionist in producing quantitative evidence can't tell you how they got it.

This is from a Centre for Evidence Based Medicine (EBM) in Oxford: 'The first step for EBM is to translate an uncertainty into an answerable question'. Think about this for a moment: your pain patient has hundreds of uncertainties, at least about why they've got chronic pain. Your duty, according to EBM, is to change that uncertainty into an answerable question. So quite often we randomly pick a question which we think we might be able to answer. It might not be terribly relevant to what the patient is bringing in the first place. They say that the whole point of getting a question is that it should be one that will facilitate a precise answer. EBM 'doesn't always involve RCT's' but they do go on to say that ecological studies (which means qualitative rather than quantitative) 'ranked C2 in a hierarchy of evidence' (which runs from A1, 2, 3 B1, 2, 3 and so on.)

Research: Quantitative vs. qualitative

Simplistically, quantitative research is about numbers; discrete entities and variables. Qualitative research is about continuous variables and less numerically measurable things. The null hypothesis* is an essential part of any research design. We accept that as a given, don't we? It's always tested even indirectly. The first time I remember being challenged on that I thought the person challenging me didn't know anything.

Alternative terms for the traditional research paradigm are quantitative, scientific, experimental, hard, reductionist, prescriptive and psychometric. Traditional research paradigms rely on quantitative data and mathematical treatment of that data. The 'truth', real and incontestable because it's been tested by numbers, that is uncovered, is grounded in mathematical logic. This is absolutely fundamental to the reductionist paradigm in medicine: that we can somehow uncover the truth if we can only find the right questions to answer and measure it in the right way. Patricia Greenhalgh, writing in the BMJ in 1997 observed that 'most of us are happy to accept uncritically simplified, reductionist and blatantly incorrect statements so long as they contain at least one number.' In an article in a medical journal it was announced that in the last 50 years, cancer 'generally' has increased by 55 per cent; breast cancer up 65 per cent, prostate 100 per cent, testicular 300 per cent and brain cancer 80 per cent. What does that mean? 80 per cent of us are going to get brain cancer? Of course not, but what do the public or politicians think if they have access to this?

On the other hand qualitative research aims to gather an in depth understanding of human behaviour, and the reasons that govern such behaviour. That's awfully difficult so maybe not so appealing. In quantitative research the possibility of a researcher taking a neutral position is seen as normal whereas in qualitative research we accept that the phenomenon we have been talking about of the observed and the observer changing one another means that there is really no such thing as a neutral position for the researcher.

A reductionist approach isolates variables and establishes relationships between them. A qualitative method starts to look at systems which can't be understood by looking only at the sum of its parts.

In the latest edition of the Medical Research Council's (MRC) good practice guide there is not one mention of qualitative research, but:

"There is ample evidence that the legitimacy and usefulness of qualitative research is no longer questioned by most prominent scholars in administrative and organisational science."

Stanford University School of Education, January 2011

“Researchers who use qualitative methods look for a deeper truth. They attempt to make sense of the meanings people bring to them, adapting a holistic perspective which preserves the complexities of human behaviour”

Patricia Greenhalgh, BMJ 1997

So as in chronic pain we have long abandoned the simplistic notion that we can abolish pain by cutting nerves etc., we try and make sense of, and try and interpret what is happening in terms of the meanings our patients bring to us.

“Qualitative researchers aim to gather an in-depth understanding of human behaviour and the reasons that govern human behaviour. Various aspects of behaviour could be based on deeply held values, personal perspectives, experiences and conceptual circumstances.”

John Hopkins School of Medicine

We all know this. So why is it not getting out there? Here are a few suggested questions in emergency medicine:

- Should we allow relatives to witness emergency resuscitation?
- Are patients reassured by negative tests?
- What makes working in emergency medicine stressful?
- Are patients satisfied with the emergency care they receive?
- What is the effect of having a consultant on the shop floor?

These seem quite enlightened questions, and the source, which I find fascinating, is a set of guidelines published by the College of Emergency Medicine. They carry on:

“These questions cannot be answered very satisfactorily by our familiar quantitative methods. They require a deeper understanding of attitudes, experiences and behaviour. Therefore we have to use a different research methodology”.

I looked at the Pain Faculty of the Royal College of Anaesthetists to see if they had anything comparable: nothing. The Royal College of Surgeons: of course not. The Royal College of Psychiatrists: yes, but you might expect that. Perhaps we might think of doing something similar for our trainees?

Positivism and reductionism

I hope the Philosophers will forgive me as I know they are not the same but I'm pretty much going to equate positivism and reductionism – at least for the purposes of what I'm saying I think they are near enough. Positivism, then, is the view that all true knowledge is scientific and that all things are ultimately measurable. (I do think that drives a lot of people in medicine.) It avers that entities of one kind are reducible to another, and processes are reducible to physiological, physical and chemical events. There is a strong strand in psychiatric research that all mental health problems will be reducible to biological events. Social questions are said to be reducible to relations between and actions of individuals.

So is there a philosophical difference between qualitative and quantitative research? Are we talking about the philosophical difference between reductionism and anti-reductionism or constructivism? These are some of the differences:

- Positivism is a single tangible reality which is broken up into variables, whereas constructivism involves multiple constructed realities.

(We have been talking about constructed realities: the realities we and our patients or their partners bring into the consulting room, and the phenomenon of multiple eyewitness accounts of the same event.)

- The idea that with reductionism you can separate the observer and the observed versus the recognition that they are inseparable.
- The implication of reductionism that cause and action are described by one another against the constructivist perception that they are interlinked.

And most importantly:

- The positivist belief that inquiry is value free – the holy grail of evidence-based medicine – versus the understanding that it should be value-bound.

Positivists argue that if you can't measure it it's not worth studying. The problem is that if it's so simplified it's probably not 'It'.

In a paper in April's BMJ on qualitative research, Paley and Lindfield say:

It is impossible without further inquiry to rely on what people say about themselves.

So when your patient comes to the pain clinic and tells you something you don't believe them until you have made your own inquiries. Their assumption is that there is a single verifiable truth – if you gather enough versions you will find The Truth. That is highly reductionist.

Understanding the context in which people live is essential. Qualitative researchers need to identify their own contexts so that they understand how their own views and beliefs may influence the interactions they have with participants. If you're eating steak and salad every night and your patient exists on burgers and chips you're already a world apart and you have a huge communication gulf. Your views will be coloured: if you see someone in front of you weighing 20 stone [280 lbs.] and you know that's what they live on, you've made a value judgement already. People understand the world differently, and that informs their beliefs and their intentions. Understanding these differences is sometimes a matter of listening rather than counting, which is why history-taking is still so important.

Fitness to work is a reductionist paradigm, as a result of which, (as revealed in a recent BMJ article) many people with serious health problems including Multiple Sclerosis, terminal cancer, bipolar disorder, serious depression and agoraphobia have been found fit to work, because the questions that are asked are highly circumscribed, and if you've managed to book an appointment and walk up the stairs you're fit to work. I have over-simplified but the people who do it are trained to work strictly within a simplistic paradigm.

So what is the comfort of reductionism for medics and a lot of other people? Certainty offers security. That's part of the human condition. As doctors we like to have some illusion of truth: we might accept our short fallings and admit to patients that we can't quite get there but we can send them to someone who

might find that absolute truth. This is particularly a problem in chronic pain; we've all met someone who has been passed from person to person, with the often unspoken hope that the next doctor will find the right X-ray or the right test to find out The Thing which if removed will make everything better. One day we will know 'It' all and will have all the answers.

Descartes said:

"Divide each difficulty into as many parts as is feasible and necessary to resolve it."

But I would prefer Aristotle:

"The whole is more than the sum of its parts"

And Edmund Simpson:

"The love of complexity without reductionism makes art. The love of complexity with reductionism makes science".

Discussion

You mentioned Patricia Greenhalgh and she doesn't study single neurons but complex clumps of neurons and the way they behave together rather than singly – she's a bit anti-reductionist in this sense.

Going back to Descartes: I think many people misunderstand his philosophical position. No physically-determinable system can be more information-extensive than what is obtained after fully accounting for the sum of all internal information, both as objects and information exchanges, given its interaction environment. If the informational output of a system appears greater, it means that the accounting methodology is faulty. The concept of 'philosophical emergence' is faulty and is disallowed by both physics and Gödel's Axiom. The most parsimonious explanation for how the concept of philosophical emergence arose is that it is difficult, in many cases, to decide how to reduce a functioning system to a complete set of meaningful elements and information exchanges since we lack fundamental information about the system as a whole. Subsequently, the investigator fails to account for all the information by allocating it to its parts. Descartes position was similar to what I am saying since if you do arrive at an explanation of the whole based upon understanding all of its parts – the reduction – synthesis was successful and the problem is solved.

If you can't reassemble the reductionist set so to reproduce the whole, the most parsimonious explanation is that you have overlooked one or more parts rather than postulating 'a mysterious force or energy'. However, if one continues to study the system and its parts using all known information and the synthesis continues to fall the, one must postulate a 'missing factor', currently unknown to science. After this factor is included, the system can be reproduced by synthesis of its elements, completely and fully. Emergence is simply ignorance.

You are assuming the truth of your statement that nothing can be more than the sum of its parts – I think it can. I don't want to go back to the explanatory gap that we talked about eleven years ago, but it is possible that it could be. (I realise I have quoted selectively from Descartes)

I am saying that the whole is only the sum of its parts is not a simplistic explanation, but, a fact of the universe and all of its systems. Everything we can measure – everything that we do – can always be added up so to create a well-defined system, given complete knowledge. I call this the theory of convergence which I see as not understood as yet. For example, for years people have claimed that it is impossible to predict the properties of water given only the quantum mechanical properties of the elements hydrogen and oxygen. A few years back, some chemists actually succeed in this endeavour, disproving emergence.

The problem with reductionism is that it assumes that it is really simple to reduce a system to its parts, particularly a living one, while, ignoring many things. You cannot make it simple, because life is never simple; we can make simpler models, but, we must make sure they really work. If a model doesn't work we have to redo it, again and again, until we understand it.

So you're still taking a reductionist view – you're breaking it down ...

That's true; everything we do every day is reductionist which explains our daily problems.

The problem is when you study complex organisms or complex states they are more than the sum of the parts. If you take them apart you may not know how to put them together.

My point is, just as you said, we do not know how to put Humpty Dumpty back together again.

So how do you explain synergy? That's more than the sum of the two...

... That's because you do not understand the internal functionality; synergy is lack of information most of the time.

... You take two molecules that work better than additively together than separately – how do you explain that?

Phenomenologically, it is the free energy – the useful work you get out of it.

Again you're looking for a simple explanation, and that's not a simple explanation – there's more to it. The problem with too much reductionism, however you take it, is that it is over-simplified. When I see complex pain patients because no-one else will see them I find them fascinating because I like working out all the issues. You have to work it out as a whole. My colleagues, who are interventionists, take the simple route; they say I can burn that nerve and it will fix your pain and then they are flummoxed because it hasn't.

I say that's not true reductionism; it's a misconception. The problem is too big for me, so let us oversimplify the problem so to simplify the treatment; the surgical, 'when it doubt, cut it out'. It's foolishness – that's not scientific reductionism.

It's a type of reductionism.

Yes, you're right, but this kind of reductionism should be banished from medicine - and I might add, the churches.

A very helpful way [of resolving this] is to make the distinction between complicated and complex. A good example of a complicated problem is getting a man on the moon: it's got lots of bits to it but you can take it apart, put it back together and do it again next year.

There is a linguistic model that some people have developed based on the physics of light – is it a particle or a wave? They say when you are thinking well you're actually looking at something from a particle, a wave and also a field perspective. A field perspective is the systemic perspective, the particle is the analytical perspective if you take it apart, and the wave is the dimensional change. So you ask the question: how much can this phenomenon I'm looking at change and still be the same? And so you're looking at something but moving around it to look at it from these three different perspectives. They make this arrogant assertion that when you are really thinking well you are engaging all three so you do the breakdown in the separate parts, but that's only one perspective. Then you've got to look at the dimension of change and then you find the systemic perspective so it might be ... they do move into complexity and dealing with complex systems and processes.

You mustn't forget Heisenberg's uncertainty principle. There was a great experiment shown on Horizon a few weeks ago: if you shine wavelengths of light through a slit and have a beam on a screen and a camera looking at the wave going through the slit they all go through. If you turn the camera off and see what's on the screen some of them don't go through. Just by observing it you're changing it. Even quantitative research involves uncertainty.

The political thing: you were talking about capitalism instrumentalising people. Are you suggesting there is another system – that it's possible to be in a utopia and not instrumentalise people?

No – if I could I would be in politics!

I am slightly worried on a personal level: I find what you have been saying immensely appealing but I just wonder to what extent that's because I am the sort of person I am, because I am pretty lazy: I like to see the whole of the picture and cannot be bothered with detail – a bit like George W Bush who was reputed never to read briefing papers and only wanted to look at a few salient points provided by his assistants. I suspect some of the interventionists are equally guilty of mental laziness. We do need reductionists with that sort of mind-set who like detail – otherwise ...

Of course we do – we wouldn't want to be in a sort of monochrome society. All I am saying is that perhaps the pendulum has swung too far - I was saying to someone only yesterday that in our grandfathers' time medicine was an art and by the time I went to medical school it was half an art and half a science, and now it is a science. So perhaps the pendulum needs to swing back to some sort of middle position. One part of my remit was to come down for or against reductionism; I will never be a reductionist person. But I think that in the UK, at least, reductionism is the prevailing model in medicine. The scientific method prevails in the hierarchy of academe, and in the public's eye. I think we need to redress the balance.

In a way we've been let down by scientific academia which has insisted that the BMJ only publish gold standard randomised controlled trials (RCT). I've sat there with gold standard RCTs and realised that we've nearly got to the primary objective. But look at all the other stuff we've got! No we can't, we've just got to

look at the primary objective. The other group you didn't mention is the lawyers who insist everything has to be black or white: was it negligence or not, was it due to this or that...

You remember the Tony Bland case (he was in a persistent vegetative state and virtually starved to death)? The judges' report was a beautiful piece of English prose I recommend anyone to read. Their logic was also irreproachable but you realise it was based on the premise that his brain was liquid which is what they had been told by one scientist. At his post-mortem his brain was perfectly OK. The lawyers are only as good as what they are told.

One problem we have with qualitative research is because we have no training in, nor understanding of it we tend to dismiss it, and those who employ it, as inferior to those who use 'proper' quantitative research. I think we sometimes don't grasp the fact that qualitative research is quite a rigorous process and requires training.

I agree. From personal experience I can remember being introduced to qualitative research methodologies during my Spirituality MA and feeling an almost reflex response of 'they don't know what 'real' research methodologies are'. When we have only ever been taught one way of doing things, in whatever sphere, our natural tendency is to see that as the right way. We need secure but flexible boundaries of our own - if we have these then we can safely explore different ways of seeing and doing things without fear of ending up in a sea of uncertainty.

I don't think you need to feel nervous in the presence of Philosophers! One way of approaching what you're trying to say would be to talk about meaning and languages, and to ask the question: does there have to be only one language that is meaningful. Logical positivism – the Vienna School – made the famous statement that the meaning of a statement is so what you get from there is that any statement that is not verifiable by scientific method is literally meaningless. That's a slightly different flavour from reductionism. You might say reductionism is also in this group in the sense that it is demanding what it believes to be the only scientific method as the only meaningful explanation. It seems to me that an awful lot of both the direct and the indirect communication of your talk was to say that there are many ways of communicating and therefore of understanding, and some of these are analytical, and others are the artworks behind your print. It's another way of understanding or communicating which is neither better nor worse but equally valid. I think that in medicine what we have to defend is plurality of languages.

I would utterly agree with that – I think therein lies the problem. But once you start to talk about pluralities people will say: well – what about this absolute verifiable truth. People want a hierarchy – they aren't happy to accept that your way is as valid as mine– they want an answer, a certainty – that's human nature. And it's certainly professional territorialism.

[This takes us back to] the splendid quote [from Giles Fraser] about love and marriage, which suggests that it isn't possible to disassemble some of the things we know to be true...

We probably need to synthesise a language that incorporates the different languages so if we tell a patient the resultant of all the different ways of looking at [his problem] that may be a way forward.

Maybe it's more than just language and to do with intention. Regarding your example of fitness to work, I think something very serious has been happening. You may not be aware that it is not the Department of Health doing the assessments, but a private

company that is paid to assess patients' fitness to work so the state is removing itself from the judgement. The firm only gets paid to do the job, which is to find the patient 'guilty', so to speak, so that people with twenty years of serious disability find themselves fit for work. That is really perverse; is there a dark side working in the background? It's how you look at it and use what you have got so with the best intention ...

It's how you do that – perspective is key. This reminds me of many years' endless conversations with my husband who is a very interventionist, rational thinking Surgeon and manager in which he has said “don't harangue me with all these questions – you never give me any answers!” And I haven't got any answers ...

In our hospital we depend on relatives and volunteers because they are in there doing something that was traditionally a very important part of nursing – attending to nutrition and hydration.

Or its cultural. We were talking the other day to a Spanish doctor friend about Severiano Ballasteros and how well he had done and how in Spain the state is still churning out high quality healthcare. He said you have to think of it as cultural because in Spain when you go into hospital it is accepted that your relatives will come and change your sheets and feed you etc. – that is the norm and employers give people time off work to do it.

In his book Pain the Gift Nobody Wants Paul Brand describes how they very rarely had to use morphine after orthopaedic operations because the family would be camped round the bed, looking after the patient and caressing them and giving them a completely different kind of care...

Science is a methodology for understanding everything. Scientific materialism is a very small subset that takes the scientific method beyond science. I would argue that being scientific – studying everything, qualitative, psychology – is about making models and seeing if they fit the situation. Scientific materialism is based on the premise that everything is out of the brain, everything is molecules; and the data does not suggest that scientific materialism is true. We all ought to be scientific in the truest sense of the word but ...

I liked Willy's talk yesterday describing the billions and billions of neurones in the brain, and how on earth we expect one molecule to have an effect. How can you have a reductionist approach to such a complex organ?

Doesn't this all seem a bit left brain/right brain? All of it is true but looking at it with a completely different perceiving and understanding, and all of it is part of our nature: we like the left brain stuff because it gives us that nice number at the bottom right hand corner of the sheet but we also need meaning and metaphors and stories and all the wonderful art stuff.

*The slideshow can be obtained on request either from Diana at dbrighthouse@aol.com or the Editor at jandpgorman@btinternet.com

*Null hypothesis (page 88): (in a statistical test) the hypothesis that there is no significant difference between species populations, any observed difference being due to sampling or experimental error.

Mindfulness – the art of presence

Andy Graydon

“We may never get into it totally – at least not until death, but why wait till then when we can enjoy so much in the present moment?”

In a way I'm going to bring things together a little bit but I'm not going to give you any information or any more stuff for your heads. We keep on wanting more and more but you've had enough this week. I want to appeal more to your hearts. You won't need to write anything down – perhaps you won't even have to think much. Just let things ride for a little bit. That's what 'presence' is all about.

When the Pope came to England lots of people wanted to see him and when a fellow priest wanted to go and asked me if I minded saying Mass for him and I said “that's OK – seen one Pope seen them all!” So I went over to Barnsley to say Mass and he'd left me a list of instructions and one of them was to read out the list of first communion candidates for the following week. As I read out each name there was the loud response “present!” One was missing so I asked where he was and the reply was “he's not here – he's not present!” I was thinking of starting this talk by trying the same exercise with you and I'm sure you will all answer 'present' ... but perhaps you're not present? Your body is here but your mind might be somewhere else.

Already I've seen people getting ready to go and thinking of taxis and all that stuff I've got to do when I get back; your minds are moving on somewhere. We're not always really *present*. That's a big problem in our society today: we want to keep one step ahead of things; we feel we'd never get anything done otherwise. And if it's not preparing for the future we find ourselves kind of being pulled back into the past ... I should have done it that way, I could have done it better, I'll have sort that out ...

So very little goes on in the present. We live in an insane society but it's become so insane we think it's normal to think that a future moment is more important than a present one. We're so stretched – I've got so much to do, so many deadlines, so much to prepare for, the next patient is waiting, I've got to get rid of this one – and the past problems are stretching in the opposite direction. And it hurts. But people get so used to it they believe they can't be anything else, they take it for granted that this is how we should be. People even start feeling guilty if they don't feel stressed: I'm not doing my job properly; people will think I'm lazy.

I used to work in a secure mental hospital. There was a newly appointed Modern Matron whose job was to attend meetings. I didn't realise what was going on in his (sic!) life until I was at a meeting at which he arrived late and rather breathlessly apologised that he had just come from an important meeting – and left half an hour early because he had another one to go to! So the meeting he was coming from and the meeting he had to get to was always more important than the one he was at. He was never really present at any meeting. The guy had a breakdown two years later.

So I want to offer you a few simple ways to get into this presence. The first is walking. That's great as long as it doesn't become a quantitative thing! : “I've walked 20 miles today and I'm going for 25 tomorrow”. We think of walking as a means of getting from A to B. But some people never seem to walk anywhere. They never feel the earth under their feet. People say “I'm so busy my feet hardly touch the ground” No wonder they can't be present. So I'm suggesting walking for no other purpose but for walking. It might seem a bit slow, thinking of every step, one step at a time...but

remember the first step climbing the mountain is as important as the last at the top. Each step has its own meaning, helping you to become present.

The second thing to think about is nature. We've got so much beauty around here; I see people just walking around just taking it all in. Sometimes when we do appreciate nature, when we see a beautiful scene, it might be a stupendous one like the Niagara Falls or the Grand Canyon, we just stop in awe. And for a moment you are totally present; almost at one with that.

Being here is great, but when you are back into your daily life, you might just try and still it and hardly notice it. But when we don't notice it we're not present. Even in your own place nature is around us in every sense; just feeling the wind in your face – even rain, even 'bad' nature – be present to it, don't be judging it, don't be doing a commentary on it, don't be wishing this bloody rain would stop, when it's cold don't be wishing it were summer again. Be at one, be at peace with it. Just take it on board for what it is. Nature is what we call 'pre-mind' – it just is. And when we are giving presence to nature we're actually giving something back. It's like what we have been talking about: transactional communication with each other. You are adding something to nature when you become present to it, because you are not separate, and when you appreciate the trees and the scenery you are actually enabling nature itself to express itself – nature becoming aware of itself through you. Some people get so busy they can go round in circles trying to get things done and never be at peace with nature. Jesus said look at the flowers in the field and the birds in the air; some translations say 'consider' – think about – but they don't need thinking about; just look! – notice – see.

Pets, too, can be a great help to us. My dog used to be my spiritual director. He just seemed to accept me as I am. When I came home late he wouldn't say 'where the hell have you been – where's my food?' – He'd just love me. It's the one moment of true presence they have in their day. There is a lovely prayer: "Dear God, help me to become the sort of person my dog thinks I am".

The third way of finding presence is 'Simple Actions'. A Zen master was asked: "what is Zen all about?" His reply was "chopping wood and fetching water". "And if I do this for a long time what does it lead to?" "Chopping wood and fetching water". Of course in our society very few people fetch water and chop wood, but a few hundred years ago that's all people did. Now we just turn a tap for water or press a button for warmth, but yet, simple actions is where it's at: discovering the extraordinary in the ordinary. Most of the time we want to escape the ordinary – I'll get the simple actions out of the way and do something more interesting. There's no presence in that. When food has been cooked without presence it doesn't taste as good. Another Zen saying is 'Do one thing at a time'. I still get this wrong - I still think I can have a pee, clean my teeth and brush my hair at the same time! Imagine bringing mind into the simple scenario of chopping wood or fetching water; you get to a stage of saying I've been chopping this bloody wood and fetching this bloody water for 25 years – why can't someone else do it? Or projected into the future: how much longer am I going to be doing this? – Another 25 years? I can't stand it anymore! That's if you do it without presence. Putting your foot into your shoe and tying the laces is just as important as going off to do something else. To think that there is a more important future act to prepare for than the present moment is ludicrous. But it's so normal to us; if you get this done then you can get that done ... no. So bring presence into buttoning up your shirt – it's as important as walking through the door. By that I mean, being attentive, being alive to it. Seeing if a deeper, fresher moment – it's a new moment, it's never been done. If you bring the past into it: you've always done it ... but if it's never been done it's always got depth.

Amazing things can happen. You are widening a field of presence around you, and this leads into other people. They've got something to teach us. Simple actions have something to teach me. And it affects our relationships; bringing presence into them can only bring presence into our lives. Sometimes we see couples doing a lot of shouting and talking at each other and yet they are hardly ever present. You remember the Terminator? Arnold Schwarzenegger was the Terminator and a robot. Sometimes on the camera you saw how he saw things; his vision would pan around and when it saw a figure it would identify it as 'man, six foot, 200lbs, carrying machete, danger level nine, eliminate'. Imagine us doing something like that every time we looked at somebody. In fact we do it, at super speed: is-this- person-going-to-affect-me-be-someone-I-can-understand-or-going-to-make-me-look-foolish-going-to-be-comfortable-look-good-next-to-me-yes-I-think-she-will-I think-I'll-marry-her! And she's doing the same thing. Minds are meeting but nothing else. Sometimes they get together for about two weeks and then it's 'goodbye'. There has been no real presence.

Real presence between people involves attentiveness, real listening. I remember talking to someone who had been estranged from their parents for a while. I suggested that they go to them and instead of getting involved in the old arguments and shouting just be present; just listen. There was no change for a while and then the father began to ask questions that were not argumentative and slowly things began to change. Once I went to Maltby, a rough area in South Yorkshire, to see a patient at home. It was a nice summer evening and there was a crowd of teenagers I had to pass through who made me very nervous. I heard one voice say "grey-haired old git"; my first reaction was anger and then I thought "well, fair comment!" so I said "lovely evening guys" – just being present. They let me pass peaceably and the same thing happened when I came out – and they waved me off! I could have threatened to call the police but you can't change peoples' behaviour with external stuff – it has to be internal.

We are constantly wanting to change things in our lives, addictions; too much food, alcohol, cigarettes. None of them can be changed just by willpower. It might work for a while but if you don't bring presence into it, it won't work. Being present opens a field of energy which affects those kids, other people, nature, life. There's a sort of primordial instinct to want more and more: more stuff, more information, and more interest. But instead of eating that sandwich and being cross with ourselves just be aware of that impulse – be present to it. It might not stop you eating the sandwich but you'll know the feeling before you get to the fridge. In the end it won't matter whether you fail or not because presence has been alerted, and it will widen to make a difference.

You see these people in your surgeries and clinics who come in and pick up a magazine; they don't really look at it, they're just turning pages. It's part of the hunger for stuff. Bringing presence into that will make a difference to life in general, to your own being. *[Andy handed round a diagram which appeared to show several interlocking triangles and asked the audience how many there were; counts ranged from two to eleven. In reality there were no complete three-sided figures. The most apparently prominent triangle simply didn't exist.]* That's what presence is –in the middle of all the stuff we're doing, at the centre we can have presence, and we can begin to bring it into everything we do. We may never get into it totally – at least not until death, but why wait till then when we can enjoy so much in the present moment?

A comment on whether society copes with, or doesn't, people who are present: my younger son has Asperger's syndrome and part of that is an exquisite focus on what

he is doing – he is exquisitely present. These presences are in the moment, they are very communicative and direct and that's what make them quite difficult in schooling and so forth, and society has unusual ways to cope with people who are actually extremely present.

Yes – society works against it much of the time ...

What is fascinating about this meeting is that we all demonstrate our constant presence here in real terms because people get so much out of it that they are very present, whereas if you're at a boring meeting your mind is miles away.

There are different forms of presence so we are present with each other in this room: we can see or touch each other. There is also the presence where you might pick up the phone and talk to somebody the other side of the world and you can be present with them even though they are thousands of miles away. And then there is also the presence beyond death in that you can remember somebody or bring them to mind and they can affect the way you are now; even though they are dead so you may walk into a house thinking they are there but of course they are dead. They are present with you even beyond death. It's working at very different levels and we need to recognise which level of presence we are working with as well as being present.

Is there a reductionist view?!

Actually there is! [Name inaudible due to laughter] came to a conference in New York ...he is a very good teacher and focussed on being present and doing one thing at a time. On the last day of the conference he was seen sitting by himself in the restaurant, smoking a cigarette drinking a cup of coffee and reading the newspaper all at the same time. He was asked: "Sensei [teacher] - how can you do this – you're only supposed to do one thing at a time". He replied "one is a very interesting number!"

I deal with a lot of people with anxiety or depression and frequently both. When they look back they select all the miserable horrible things that have happened, and when they look forward they think of all the terrible things that might happen. If they can be in the present moment that switches all that off.

In that situation I often say to people: just feel that chair – feel that presence with me. Some people can't do it...

Part of the problem for a lot of people is that they imagine the worst case scenario so if we were to put a plank of wood on the floor and ask them to walk up and down on it they'd be fine, but if you put it one hundred feet up nobody will because they imagine falling off it. So their imagination takes over and it's almost a matter of enabling people to re-imagine the future as well as to re-remember their memories of the past in a different way, so you are 'now' instead of worrying about what might happen or has happens and the guilt and concerns the carry round about the past.

As an Anaesthetist I am trained to always expect the worst: if something can go wrong it will – and prepare for it. It makes you a very good anaesthetist but it might make you a depressive nihilist...

It might be an idea to begin these meetings with some sort of mindfulness experiential thing...

...perhaps two minutes of silence before we start? ...

... the Tai Chi helps in this way...

Some people may have wondered what a yoga teacher is doing at a meeting like this. Mindfulness – being present in the moment – is what I bring my students. I can help them to release themselves for one moment from their past which is full of pain and suffering and a future which they know is full of pain, suffering and death. For one moment they are free ... and that puts them in a space in which they can cope much more easily with their lives which are – well, shit, actually, to be honest. The last few days I have listened to the brilliant speakers and have thought: what I have to give is of no value compared with wonderful specialists and drugs and regimes. But Andy reminded me that what I have to give, although it may not be supported by experimental evidence and so on, is of real value. The philosophers told us that there are two wings to wisdom: the knowledge we come to by logical reasoning, and from experience. Like learning the piano: we can be told how to do it but can't actually do it until we actually do it over and over again. And you can give them birth. I can only give them one thing which is to feel, to feel, to be; to experience a sensation which it feels like - like sitting in a chair which you have done thousands of times but what does it actually feel like, what is your body experiencing right now? Do you know how to feel that? And that's what people like me and Andy can bring to the party.