

JOURNAL OF
holistic
healthcare

Medicine as if People Matter



Shadows in Wonderland
– a hospital odyssey

Can doctors and
patients work together?

Radical ordinariness: the
women's service in
Purley

Medicine and the healing
vocation

Homeopathy – all in the
talking?

Coronary heart disease

Plus

- News
- Reviews
- Events
- Research summaries
- From the frontline

holistic healthcare

The core purpose of the BHMA is to promote holistic practice in healthcare and its organisation.

Holistic approaches to practice and self-care and more holistic ways of organising health and social care are urgently needed because healthcare faces a four-fold crisis. Its costs are rocketing and, though hoped-for cures for chronic disease are slow in coming, medicine's over-emphasis on the parts at the expense of the whole has created the illusion that caring for people and commitment to the arts of healing is less relevant and unscientific. They are not: frontline science now views the human body-mind as a complex self-organising open system intimately linked with other humans and the world; body, mind, spirit and environment are inseparably involved in illness (some of it inevitable) and health. So while medicine cannot ignore advancing gene-science and nanotechnology, neither must it fail to tap our growing understanding of the mind-body and its healing processes, nor the resources of compassion, mindfulness and the therapeutic relationship. Science may rediscover that they can represent 21st century healthcare's greatest potential.

The core purpose of the BHMA is to promote holistic practice in UK healthcare.

Holistic healthcare means

- A revolution in our understanding of healthcare practice
- Creating health and well-being – not merely countering disease processes
- Thinking in terms of whole systems, not just component parts
- Empowering individuals, healthcare organisations and communities to take responsibility for creating health
- Health care workers who can understand and provide for their own needs and wellbeing
- Emphasizing relationship and context more than separateness
- Working with the grain of nature, not against it

These core values underpin holistic practice

- Compassion – being considerate and caring towards others
- Respect – for ourselves, our patients or clients, our community, our culture and our place in nature
- Open-mindedness – healthcare needs many good ways of being and doing,

- Competence – committed to ongoing professional and personal development
- Self-care – looking after ourselves so we are healthy individuals and effective practitioners
- Engagement – doing what we can to change the systems we live and work in for the better

The BHMA will

- Champion the BHMA core values – especially within the NHS
- Foster the exchange of knowledge and skills necessary for holistic practice
- Support healthcare workers' health and well-being
- Advocate practical ways of incorporating holistic practice into healthcare organisations
- Promote awareness of our self-healing capacity and its relevance to health care
- Work with like-minded organisations to help individuals, healthcare organisations and communities create health for themselves and protect the environment
- Encourage research that seeks to understand health, illness and healing more holistically
- Encourage diversity and creativity in healthcare practice and planning

What the BHMA is doing

- Providing a natural home for holistic values in healthcare
- Forming alliances that promote holistic practice
- Shaping holistic policies for education, practice and
- Maintaining a BHMA website and creating products
- Injecting inspiration into the system through the *Journal of Holistic Healthcare*
- Developing BHMA seminars, courses and conferences
- Providing networking opportunities and retreats

BHMA members

- Are part of a movement promoting more holistic practice in healthcare
- Contribute actively to the *Journal of Holistic Healthcare*
- Join together to create local groups
- Support BHMA campaigns for holism in healthcare
- Spread the word about the BHMA
- Use the BHMA to exchange knowledge and skills

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British Holistic Medical Association
PO Box 371
Bridgwater
Somerset TA6 9BG
Tel: 01278 722000
Email: admin@bhma.org
www.bhma.org

Reg. Charity No. 289459

Editor-in-chief

David Peters
petersd@westminster.ac.uk

Editorial Board

Jan Alcoe, Richard James,
William House

Editor

Edwina Rowling
erowling@tiscali.co.uk

Administrator

Di Brown
admin@bhma.org

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Editorial

David Peters

Editor-in-chief



‘Energy medicine’ and the gulf between body and spirit

We have reached the tenth year of the 21st century. It badly needs to be a turning point towards a more connected world. As old certainties collapse holists must rise to the challenge of showing the world a new way. A good place to start is our familiar mantra of ‘mind, body and spirit’ – a unity disguised as a trinity. Neuroscience and psychotherapy are bridging the gap between mind and body, yet the gulf separating body and spirit yawns as wide as ever. Is ‘energy medicine’ trying to jump that divide and blur that boundary?

From birth to death the body can be a source of pleasure. It subjects us to its drives and its suffering too. As we grow up, everyday life confirms just how tricky the body can be. We soon discover that ancient survival instincts live on there, alongside traumatic body-memories that trigger feelings the conscious mind can’t always comprehend or control. Then, as we grow older we learn that the body is limited, unreliable, vulnerable, impermanent; bodies break down, wear out, dis-able us, die.

And so the great religions – whose task is to seek what’s eternal – distrust the body, and its instincts. They warn us against enslavement to its anger, sloth, gluttony, lust. The spirit, they remind us is willing, but the flesh is often weak. Spirit and flesh: the north and south poles of dualistic religions that view spirit as definitively non-material. This basic assumption might explain humankind’s age-old bewilderment over the body’s spirituality. If Freud’s Id – human nature red in tooth and claw – resides there, then can the body also be spiritual? Christianity’s story reflects this confusion. Should we infer from it that the human body fell from grace (body bad) or, that because spirit took human form we should celebrate our embodiment (body good). Or might it mean that the body is treacherous until sanctified (body bad but can be made good). Parallels between sin and sickness, cure and redemption, ‘vital energy’ and spirit are obviously there to be drawn. The argument about body and spirit is a version of the long-running ‘nature or nurture’ debate that surfaces in many spiritual traditions: the body may be a temple they say, but only after purification through self-denial and abstinence.

But not all spiritual paths are pessimistic about human nature. In older cultures where the cosmos wasn’t split into either spirit or matter, spirit didn’t get a divorce from nature. This is a world alive and sacred, where the body is spirit manifested. Not so long ago our society declared such ‘primitive’ views ignorant and misguided. Yet naïve though these traditions might seem, their take on Mother Earth and Father Sky seems more valid since science has glimpsed the vast complexity of the cosmos, and the staggeringly intricate web of life the human form emerges from. With a little imagination we may get a hint of this inter-connectedness, and the eternity of organisation out

of which stars and planets evolve, and biospheres spawn life and consciousness. With a little imagination the existence of the body starts to look miraculous! Curious though it seems that stories told by mystics and scientists should resonate and evoke similar awe and wonder, it might help explain why we so often hear the words ‘spirit’ and ‘energy’ used as though they were interchangeable.

The blurring of these and other time-honoured distinctions – for instance between mind and body, or biology and belief – is in the spirit of our time. Since the prose of science can’t comprehend these ambiguities, the development of integrative medicine will call for more poetry. In which case notions like ‘vital energy’ will have important symbolic value, especially when we are called on to explain how it feels to fall ill, or where disease comes from, and how it goes away; sometimes despite all expectations. Normal healing processes are something medicine takes for granted. And most doctors would acknowledge that recovery from chronic illness usually entails effort and personal change. Spontaneous remission from catastrophic disease, however, must make us wonder about the way human bodies entangle flesh, mind and spirit. Although such extraordinary cures are not the rule with energy therapies, there have been many documented cases where spiritual healing provoked a ‘spontaneous remission’. Yet given that energy therapies involve a powerful blend of beliefs about that entangling, it would be odd if (just as with the mysterious placebo response) they didn’t sometimes trigger profound healing processes. While we wait for science to provide answers, the ‘energy’ language serves to remind us of all that remains mysterious and intangible in healthcare, and of the unfathomable interweaving of mind, body and spirit.

Slowly, our culture is waking up from modern life’s dream of individuality and dominion, into a world whose survival may depend on shared visions of connectedness and inter-dependence. With so many of our basic assumptions in flux, we shouldn’t be surprised at the popularity of treatments based on the notion of ‘life forces’ flowing in nature and through living organisms. We must judge for ourselves whether to interpret terms like ‘vital energy’, and ‘spiritual body’ literally, for hard science is bound to deny the existence of chakras, energy channelling, and auras as superstitious fantasies. Far more important for medicine to accept that the body is imbued with mind; and for our society to realise – as ‘primitive cultures do – that because mind-body co-evolved with nature, they are intimately inter-connected. If these ideas take deep root then techno-industrial medicine may learn to respect human adaptability and connectedness, and chart a more sustainable course.

The developing of an integrative vision of body, mind and spirit is central to holistic endeavour: genes do not shape our destiny, nor can our wellbeing long depend on heroic medical advances, and healthcare thrives best when it values human worth and nurtures the indomitable human spirit.

News review

Stress and health blog

JHH board member James Hawkins has launched an evidence-based blog on stress, health and wellbeing to share information he gathers on emerging research.

He brings more than 30 years of experience as a medical doctor and psychotherapist to this 'sifting-out-what's-valuable' task and sharing it as a free resource.

There are three strands to the blog – handouts, research updates, and more general writing. During November he posted three sets of downloadable handouts (information sheets and assessment questionnaires) on social anxiety, wellbeing and time management, and problem solving and behavioural activation.

He has also posted four recent research updates on fish and n-3 fatty acids, egosystem and ecosystem (an introduction to fascinating work on the effects on oneself of being more caring for others – complete with link to a brief Beatles youtube video!), half a dozen studies on cognitive therapy (demonstrating both one of the major strengths of CBT – its ongoingly active research underpinning – and a caution – at times CBT approaches are not automatically the best way to go), and seven studies on diet, supplements and smoking. The third strand to the blog is more general writing.

www.goodmedicine.org.uk is the overall website address, and the blog is at www.stressedtozest.com. If you would like monthly email alerts about new posts, contact James at james.hawkins@blueyonder.co.uk.

Medical hypnosis body formed to encourage more clinical trials

A new organisation has been formed to help medical students and professionals explore the use of

hypnotherapy. The chair is hypnotherapist Ursula James and the aim is to encourage new research which will put hypnotherapy on a stronger medical footing.

'The use of hypnotherapy on the stage doesn't help the image', she says. 'The field also suffers from the same problem as 'talking' therapies: drug companies have no incentive to carry out the expensive trials required.'

For further information and to receive their newsletter, visit www.msha.org.uk.

Energy therapy and its prevalence in the NHS

Estimates suggest that there are approximately 12,000 registered healers in the UK, belonging to a number of organisations. Energy therapies are popular, especially for those with chronic disease, long-term conditions and receiving end-of-life care. Such therapies are known by various names, for example: reiki, healing, and touch therapy.

Research conducted on energy healing has demonstrated positive and beneficial outcomes, such as improvements in perceived quality of life for people living with cancer (see for example Vaghela C, Robinson N, Gore J, Peace B and Lorenc A *et al* [2007] Evaluating healing for cancer in a community setting from the perspective of clients and healers: a pilot study. *Complementary Therapies in Clinical Practice* 2007; 13: 240–249).

A team of researchers from Thames Valley University and registered UK healers is now conducting a survey to identify where healing is available within NHS healthcare provision such as day care centres and hospices. They hope the study will provide important statistics as to where energy therapists are working, especially in cancer care. This will provide a framework for

future research into this area and improve information on and access to this service.

Their aim is to make these services more widely available and this data will facilitate that by quantifying the scope of range of current provision.

If you are an energy therapist working in the any of the following sites, they would like to hear from you and seek your views via their questionnaire.

- Therapist working in NHS premises. This could be either on a voluntary basis or funded by the NHS, and in either primary or secondary care, or both.
- Therapist working in premises in private hospitals, GP practices or care homes.
- Therapist working in hospices in the UK.
- Therapist working in day care centres in the UK eg elderly care centres, nursing homes.

Please contact the team at ava.lorenc@tvu.ac.uk. Your help is conducting this research is much appreciated.

More CAM professions to be regulated

The Health Professions Council has recommended the statutory regulation of three complementary healthcare professions.

A steering group set up by the Department of Health has recommended that the Council should regulate medical herbalists, acupuncturists and traditional Chinese medicine practitioners. The Health Professions Council has discussed this report and has recommended statutory regulation to Ben Bradshaw, the Secretary of State for Health.

For further information email the Health Professions Council's Policy and Standards at policy@hpc-uk.org.

Web health information leads to distress

Health information online can cause unnecessary fear and distress, as surfers fear the worst of simple symptoms.

A team at Microsoft studied health-related web searches on popular search engines and surveyed 515 employees about their health-related searching.

The researchers found web searches for common symptoms such as headache and chest pain were just as likely or more likely to lead people to pages describing serious conditions as benign ones, even though the serious illnesses are much more rare.

Searching for 'chest pain' or 'muscle twitches' returned terrifying results with the same frequency as less serious ailments, even though the chances of having a heart attack or a fatal neuro-degenerative condition is far lower than having simple indigestion or muscle strain, for example.

About a third of the 515 Microsoft employees who answered the survey on their medical search habits 'escalated' their follow-up searches to explore serious, rarer illnesses.

CAM enshrined in Switzerland

Switzerland is close to allowing complementary medicine to be integrated into the national health system by a special change in its constitution. Three years of intensive lobbying by a grassroots movement called 'YES to Complementary Medicine' has resulted in high acceptance for a national people's vote on integration.

This unusual process, known as a popular initiative, allows Swiss voters to decide on an amendment to the Swiss Federal Constitution. Earlier this year both chambers of parliament approved an amendment to the constitution saying: 'The Federal

government and cantons shall ensure that, within the scope of their jurisdiction, complementary medicine is taken into consideration.' The public will vote on this change to the Constitution in 2009, and it is strongly anticipated that the voting will be in favour.

The Swiss initiative comes on the back of a recent decision in Switzerland to eliminate reimbursement for CAM medications, despite the fact that a five-year research assessment by international researchers had confirmed the usefulness and effectiveness of five of the CAM disciplines: homeopathy, anthroposophic medicine, phytotherapy, neural therapy and traditional Chinese medicine.

Switzerland would be the first country to have complementary medicine enshrined in its constitution and would therefore take on a pioneering role in Europe. A constitutional article would make it fundamentally clear that complementary medicine not only has a right to exist, but is becoming an integral part of the public health service.

Integrated medicine first for UK

A new college is set to train a new generation of doctors and post-graduate nurses in all aspects of integrated healthcare. The British College of Integrated Medicine's Diploma in Integrated Medicine will be accredited by the University of Buckingham, a first for this medical speciality in the UK.

The British College of Integrated Medicine will open in May 2009.

The college is offering a two-year part-time diploma. Students can continue their study for an additional 1–2 years part-time to gain an MSc in Integrated Medicine enabling them to forge career pathways within the areas of highest need such as cancer treatment, care and prevention.

The courses will be run by IM consultants Dr Rosy Daniel and Dr

Mark Atkinson and other leaders in the field, and will be professionally validated by academic partner Professor Karol Sikora, Dean of the School of Medicine and his team at the University of Buckingham.

Information about the college is available online at www.integratedmedicine.org.uk

Doctors' health matters

The BHMA has been talking about self care for health professionals for 25 years and now it seems that the medical establishment has woken up to the idea. 'Doctors' health matters' was the title of a BMA international conference in November in London, and the subject of doctors' health was a lead editorial in the *BMJ*.¹

It was a very good conference, and truly international with presentations from North America, Australia, New Zealand, Europe and South America. The problems of burnout, drug and alcohol dependence, and depression amongst doctors are similar in most countries. There are some good programmes of support, counselling and mentoring in the profession.

Of particular interest are the preventative programmes for newly qualified doctors and medical students. Exposing students to information on the problems doctors face and simple measures for dealing with them seems to make a difference. Yet how many medical schools will give space in their busy programmes to teach stress reduction? Many still feel that this is not a priority despite the growing evidence of the impact that sick doctors can have on patient care.

This kind of conference, which produced a wealth of research not only on the problems but on some innovative solutions, should go some way to convince those that are responsible for educational programmes that doctors wellbeing is central for good patient care.

1 Brewster JM. Doctors health. *BMJ* 2008; 337: 1121–1122.

Shadows in Wonderland – a hospital odyssey

Staff

Colin Ludlow

Summary

When television producer Colin Ludlow was admitted to hospital for an operation, he expected to be home in 10 days. In the event, he ended up staying for five months, nearly died on several occasions, contracted MRSA, and was still recovering from his experiences more than three years later. In **Shadows in Wonderland** he tells his story, and takes a fascinating philosophical journey through chronic illness as he explores its wider significance. Here we reproduce the chapter **Staff**.

I wrote articles and reviews for *New Society*, the *TLS*, Alan Ross's *London Magazine* and *Plays & Players* before embarking on a career in television drama. I worked for the BBC and in the independent sector, firstly as a script editor, and subsequently as a producer (*The Scarlet Pimpernel*, *An Unsuitable Job for a Woman*, and a number of award-winning TV films). I went into hospital for what I thought would be a short stay. This book is the story of my experience.

'The Hospitals of London are, in many respects, noble Institutions; in others, very defective. I think it not the least among the instances of their mismanagement, that Ms Betsey Prig is a fair specimen of a Hospital Nurse.'

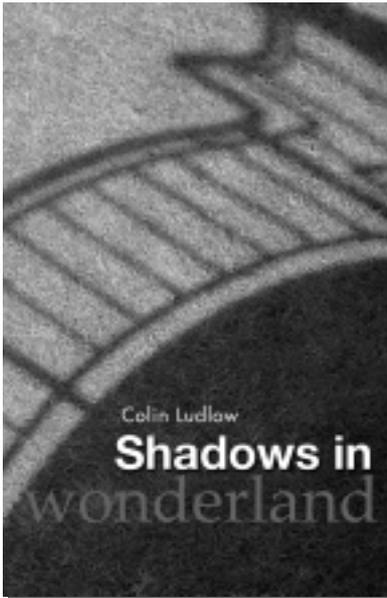
Charles Dickens, *Martin Chuzzlewit*,
Preface to the Cheap Edition (1850)

As the titles of Peter Nichols' stage play *The National Health* and GF Newman's television serial *The Nation's Health* suggest, the condition of hospitals and the health service has often been viewed as a reflection of the state of the nation. If the metaphor is a useful one, and hospitals do offer a microcosmic image of society at large, then my recent experience of the Royal Free suggests that the age of multi-culturalism and a globalised labour force has most emphatically arrived. Without its extraordinary, eclectic mix of staff from different parts of the world, the hospital would simply implode. It functions as a multiracial institution or not at all.

The nurses who have looked after me include innumerable women of

black African and Afro-Caribbean origin, many Irish girls in their 20s and 30s, a wide selection of carers from the Philippines and the Far East, and even the occasional one from Egypt, Mauritius, Finland, Poland and the Czech Republic. However, during all my time in hospital, I do not think I have been attended by more than a handful of 'white British' women. The small number of UK born and bred Caucasians among the nursing staff tend to be male and often gay. For some reason, there seems to be a high proportion of Australian nurses – both male and female – in ITU (while the x-ray department depends on a plethora of radiographers from New Zealand).

This international quality is not confined to London. In a recent television programme, the film director Ken Russell discussed his time in Southampton General Hospital (where he caught MRSA), and commented on the paucity of nurses there whose first language was English. This perhaps reflects not just the United Kingdom's current 'open door' policy on foreign labour, but also the relatively shallow roots



of nursing as a profession here. For while nursing in Catholic countries is historically linked to the charitable work of religious orders, in Protestant Britain its traditions are less long-established and austere. Only with the innovations of Elizabeth Fry and Florence Nightingale in the mid-19th century

did nursing acquire a vocational flavour. Until then it was more associated with the working class disreputableness of characters like Sarah Gamp and Betsey Prig in Charles Dickens' *Martin Chuzzlewit* (and it is perhaps not irrelevant that Dickens' charitable work extended to being an active supporter of the Royal Free).

With the changing role of women over the past 30 years, and the erosion of the ideal of public service that has taken place during the same period, nursing in this country appears to have undergone a further mutation. The idealised 'angel' of popular tradition, who selflessly devotes her life to the care of others, is no longer to be found on the wards. For most of those staffing them now, one suspects that nursing is no longer a stern social duty or quasi-religious calling. While it still requires qualities of dedication and compassion, it has become more and more like other careers, chosen from a greatly expanded range of options for the particular combination of emotional challenge, job satisfaction and financial recompense that it offers; a way of earning a living that is better rewarded in America, Australia or much of the Middle East, but, equally, is better paid in Britain than where many of the nurses working in this country were born and grew up.

The change is vividly marked in the passage from the 1970s nurses' drama *Angels* to the recent Channel 4 series *No Angels*. 'Nothing special' might be an alternative wording for the updated title, and that is certainly the premise that underlies the drama's portrayal of the nursing profession. The group of flatmates on which it centres happen to work in a hospital, but they are just like any other collection of 20-something females: more concerned with boyfriends and relationships than the substance of their jobs, constantly jockeying for power and position the same as people do in any workplace. The medical setting is incidental to their lives rather than defining.

Working conditions for nurses in London are far from attractive: apart from having to contend with the capital's property prices and its sclerotic transport system, ward staff are scheduled in exhausting 12-hour shifts with regular night duties. And if the buildings are often unsympathetic environments for patients, they are no more congenial for those who work there. Concern has been expressed recently that hospital nurses take more time off sick (an average of nearly 17 days a year) than other public sector workers – who in turn take off significantly more time than private sector employees. This may be the result of greater exposure to infection, but it also seems to reflect the increasing pressure under which nurses are working, with inflated expectations from patients and their families, poor management, and cash-strapped NHS trusts trying to save money by leaving vacancies unfilled all contributing to the problem.

There is also evidence to suggest that nursing has become less attractive and fulfilling as a result of the enlarged administrative burden that staff now face, with up to 40 per cent of their time taken up with form-filling and other non-clinical work. I myself have been repeatedly baffled and irritated on my frequent return visits to hospital for one- or two-night stays by having to spend half an hour or more with a nurse while she takes down my extensive 'patient history'. Since the past never changes, the vast bulk of it is always the same as on the previous occasion, and its many convolutions have already been thoroughly documented in my ever-expanding notes, which are now the thickness of several telephone directories.

Despite the problems, however, what is remarkable about the Royal Free is the relative stability of the nursing staff. Many of the faces on the wards remain the same as when I first visited Anna there more than five years ago. Those who have left generally seem to have done so for reasons of career advancement, to return abroad, or to have children, not because they were disaffected and could no longer take the stress. From the patient's point of view, this continuity is immensely desirable. Not just because of the warmth with which you are greeted if you are unfortunate enough to have to be re-admitted, but because a nurse who knows the ward well is more efficient and provides better care.

I used to dread the nights when agency staff were allocated to look after me. Not knowing where things were stored, they would be much slower in responding to requests for banal but vital things such as urine bottles. Not knowing me or much of my history, they would also tend to be inflexible and suspicious, doggedly insisting that I should be given drugs that I hadn't taken for days because 'you're still written up for them on your chart', or getting panicky and rushing to send for a doctor when my temperature was slightly raised although it was doing no more than follow a well-established pattern.

Although the hospital's blue-uniformed nurses can sometimes seem a little mechanical in the way they go about their tasks, they are nevertheless unsurprisingly zealous when set alongside the green-clad domestic staff. These are mostly middle-aged women of colour who give the impression of being wearied by life and go about their work with matter-of-fact economy of effort. Cleaning other people's mess is hardly a job to set the pulse racing, and the cleaners in particular often seem bored and verging on disaffection. Patients and visitors who obstruct their work are clearly an irritant, and the job is doubtless unfulfilling and poorly paid. Predictably therefore, the standard to which it is so laboriously completed is seldom more than adequate.

At the other end of the hospital hierarchy are the doctors, with the consultants representing the visible power in the system. Their ward rounds are a reminder of how structured and deferential the medical profession remains, with teams of registrars and housemen nervously responding to cross-examination about the patients' progress, and the ward sister or lead nurse earnestly transcribing the care commands from the white-coated gods on high. At the Royal Free, there are more white faces among the doctors than among the other staff, with the consultants in particular continuing to be predominantly white British men with a slightly patrician air. But the ranks of junior surgeons and other physicians now conform to the general pattern of the hospital and have a strongly international flavour. I have been treated by Russian, Italian, Indian, Greek, Egyptian and Pakistani doctors, a fair proportion of whom have been women, as well as operated upon by a consultant surgeon of African descent.

The consultants may appear to be 'top of the ant heap', with all the other categories of staff scurrying around below, but in fact their power is circumscribed – 'cog-like not God-like' as frustrated senior doctor Raymond Tallis has described them when writing about the NHS. While consultants have absolute hegemony over matters under their direct control like operating lists, they are subject as much as anyone to the constraints of the system and there is much that eludes their grasp. The imperious commands of one day's ward round are often met with a litany of excuses and failed responses the next. The junior doctors grimly confess that they are still waiting for x-ray to come up with a time for the ultrasound, haven't received the results of the blood test, or remain unable to find the missing notes. I have sometimes noticed an air of weary bemusement in my consultants as they apologise for x-rays having disappeared, or express surprise at clinic appointments having been postponed without their being informed and through no desire or fault of their own. Despite the deference of the nursing staff and junior doctors, their carefully cultivated surface of

authority often seems wafer-thin as they struggle to make the hospital machinery work.

That machinery is a vast and complex structure. It embraces a posse of polo-shirted physiotherapists – predominantly white Britons who seem to spend much of their time flirting with the nurses, if male; or cultivating a strict no-nonsense manner (which might alternatively be described as bullying), if female. It includes multiple phlebotomists, who circulate the wards taking blood samples with wondrous, painless efficiency, and for some reason seem mostly to come from eastern Europe. There are pharmacists and dieticians – usually women and frequently of Asian origin – whose tasks are to organise patients' medication or advise on nutrition and recommend food supplements. Ferrying beds and wheelchairs to and from the operating theatres or the x-ray department are the hospital porters – all men, mostly in their 20s and 30s, and from a wide variety of ethnic backgrounds, but with the unifying characteristic of all seeming to be slightly anarchic 'chancers'. On a recent stay, I was particularly enchanted by one who was unable to speak, but communicated through an extraordinary combination of whistles, hand gestures and vividly expressive eyes.

The happiest staff often appear to be those on the fringes of the system or occupying very specific niches within it: Keith, the complementary therapies co-ordinator, and his team of volunteers who clearly enjoy giving massages to patients; the stoma nurses; or those overseeing chemotherapy treatments. These reveal the human face of the system, often working well beyond their allotted hours and making space to accommodate patients' needs with an attitude of 'we'll slot you in somewhere'.

Less at ease are the clinic clerks and receptionists, many of whom seem harassed and anxious, presumably from constant exposure to fretful and frustrated patients. Although doing no more than 'obeying orders' that emanate from elsewhere, they represent the machine at work, unable and sometimes also unwilling to respond to the anxiety and individual circumstances of those with whom they are dealing.

With no seeming awareness of contradiction or inconsistency, the hospital also employs a team of counsellors – in the case of the one I saw, a sympathetic Jewish woman with immense dark eyes and a strong hint of mittel-Europe in her accent and manner. There are also Catholic and Anglican chaplains who stalk the building with portable Eucharist kits in their bags. One of these is a young-ish female priest who, it transpires, has become a minor television personality.

It is an immense plethora of staff that inhabits the building – a bewildering network of different skills and human types which gives the impression that all of life is to be found there; a country in its own right, even before the patients are admitted, which readily explains

why hospitals are often seen as metaphors for the society from which they emanate. So how does this 'Little Britain' function? What is its organising principle, and does it work?

In terms of its multicultural composition, which is perhaps its most defining characteristic, the answer is emphatically yes. People of all colours and backgrounds rub along and work together in a way that seems largely free of racial tension or prejudice. That may be found among some of the patients, and there may be legitimate criticisms across the health service as a whole concerning equality in the pace of career advancement, but on a day-to-day basis, the Royal Free seems a remarkably harmonious environment, particularly given the stressful nature of the work that goes on there.

Whether, or how well, the hospital functions as a caring institution – whether it represents a benign, humane and well-ordered society – is a more difficult question to answer. The institution is reasonably well-resourced, but looking at the issue in terms of staff, it has to be said that the overall impression is less one of tightly-knit organisation, than of tolerably functioning muddle. The individuals who work there inevitably comprise the good, the bad and the ugly. The booking clerk who sought to dissuade a friend of mine from cancelling an appointment by officiously and irrelevantly informing him that 'this procedure costs £1,000, you know' goes about his tasks alongside Mr Thomas who 'popped in' every day over the Easter holiday weekend

when I was there to ensure that his patients were all right. Collectively, however, one has the feeling that the commitment and professionalism of the staff are often compromised by working in an environment that controls them rather than vice versa. It seems to frustrate them with its inadequacies rather than excite them with its possibilities. The result is a hospital in which the employees are generally positive and motivated, but of which they are perhaps less than wholly proud; a place where the struggle of getting the job done often seems to eclipse the reason for doing it. Not a callous institution, but a pushed and therefore inward-looking and sometimes careless one.

Is that a reflection of the country at large? A fair image of Britain under new Labour in the early years of the 21st century? It seems curiously appropriate that the abortive terrorist attacks in Glasgow and London during the early summer of 2007 were organised by staff working in the NHS. For with its chaotic mix of cost imperatives, elusive sources of responsibility, bureaucratic structures and social concern, the modern super-hospital certainly embodies the messy and sometimes contradictory goals of a multi-racial society working to maintain its position and preserve its humanity in a divided, shifting and increasingly competitive world.

Shadows in Wonderland – a hospital odyssey
First published in 2008 by Hammersmith Press Limited
www.Hammersmithpress.co.uk
See Reviews p35.

EVENTS



JANUARY

- 27 **Westminster Health Forum keynote seminar Dementia and Elderly Care** *with* Phil Hope MP, Minister for Care Services, Professor Sube Banerjee, Senior Professional Advisor, Older People's Mental Health, Department of Health, Neil Hunt, Chief Executive, Alzheimer's Society. See www.westminsterforumprojects.co.uk/dietandhealthforum/bookdementia.html
- 28 **The Mummy Diaries: supporting children when someone in the family has a life-threatening illness.** A St Christopher's Hospice education centre workshop, London. See www.stchristophers.org.uk.

FEBRUARY

- 7 **The art of wellbeing:** seven tools for coping with the ups and downs of life, Hove, Sussex. Details at j.alcoe@ntlworld.com.

- 24 **Dementia and spirituality.** A St Christopher's Hospice education centre workshop, London. See www.stchristophers.org.uk.

MARCH

- 17 **Bereavement support: help or harm?** A St Christopher's Hospice education centre workshop, London. See www.stchristophers.org.uk.
- 19 **The power of soul esteem.** A Penny Brohn Cancer Care event. See www.pennybrohncancercare.org or tel 01275 370110.

To publicise your event send details to Edwina Rowling at erowling@tiscali.co.uk. Deadline for next issue: 28 Feb 2009

Just what the doctor ordered?

Donald Watson

Author, ex-cancer patient and patient representative

Laryngeal cancer brought my work as a university lecturer to an end in 2003, just as the second edition of my *Dictionary of Mind and Body* (André Deutsch) was about to be published. I resisted suggestions that I should have a laryngectomy, and five years later with my voice restored I was declared 'hopefully cured'. I now work on many health committees as a patient representative, including the Royal College of Physicians Integrated Health Committee, for whose encouragement and support in writing this article I am very grateful.

Summary

How happy are patients with medical consultations? What do they like about the way their doctors interact with them? Have their priorities changed in recent decades? How has the success of modern medicine affected both the way doctors behave towards patients and what patients want from doctors? What do patients perceive as still lacking, and how can doctor and patient work together to form a more effective partnership and achieve better healthcare? And where does integrated healthcare fit into all this?

'The doctor knows best' versus personal responsibility

There was a time when western doctors, like all healers down the centuries, were surrounded by an aura of mystery and authority and were held in awe by those they served. Consequently, patients carried out their physician's instructions unquestioningly. Today the dictum 'the doctor knows best' is starting to sound decidedly old-fashioned. More and more patients want to know all the details of any prescribed treatment, and they want to know what options there might be for their particular conditions. Many words used in a medical context such as 'patient', 'prescription' and 'compliance' seem slightly inappropriate nowadays, suggesting that a passive individual (the patient) is told what they absolutely must do (prescription) and they are somehow expected to obey (compliance). Some people do still take their body along to the GP's surgery in much the same way as they might take their car to a garage, expecting the mechanic to fix it and without wanting any personal involvement in the process or understanding of it, but this 'just fix it for me' attitude is becoming less common. Despite the enormous successes of modern

medicine, doctors are no longer seen as all-powerful: they are experts like any other from whom we seek advice and guidance with the hope of some thoughtful discussion. We recognise that they are human and fallible, and that medicine is an increasingly difficult tool to use safely, as the rise in iatrogenic illness has shown. Many informed people have started to think that it would be far better to do what we can to avoid becoming ill in the first place. How can more people be encouraged to think like this and what can doctors do to help?

As patients, we are encouraged to take more responsibility for our own health, and both the medical profession and the government talk a great deal about 'healthy lifestyles'. It is as yet unclear to what extent this might signify a new approach to healthcare. What would our GP say today if we requested a consultation simply to discuss how to maximise our health and wellbeing without being able to present any specific symptoms other than perhaps feeling slightly below par? This is how some of us already take responsibility for our own health by, among other things, regularly consulting complementary practitioners, often avoiding the need to see our GP for many years. Indeed the maintenance of good health is usually seen as a prime purpose of many

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complementary medical practices, at least equal in importance to remedial treatment when illness occurs. (We are told that in some societies such as ancient China medical practitioners were paid for as long as the people in their care remained healthy, and whenever illness intervened they went without remuneration until health was restored.)

The medical profession identifies two possible motivations in patients who consult complementary practitioners: one originates in our need to have an existing condition treated; the other stems from a desire to feel good. Put crudely, these alternatives mean that sometimes we expect real treatment, and sometimes we go just for a treat. The ‘treat’ category seems to deny the preventive potential of why we might consult a CAM practitioner: is it just to feel good, or is it rather to achieve actual greater physical fitness or wellbeing – something more than just a feeling? There is perhaps a third motivational factor to be acknowledged: the actual maintenance of health. One of the things patients do like about CAM is that it aims not simply to treat an existing condition, but to maximise the individual’s ability to avoid illness, whether by advising on diet and physical fitness, identifying innate weaknesses or tendencies, promoting emotional wellbeing, or ‘recharging the batteries’ in some less tangible way.

One of the things patients like about CAM is that it maximises the individual’s ability to avoid illness.

It is generally acknowledged in medical circles – in the 60 years since the World Health Organization definition of health – that health comprises physical, mental and social elements, to which the spiritual domain is also increasingly added. These four areas are routinely addressed in consultations with many complementary practitioners and brought to awareness and discussed. Even if the practitioner is in no position to affect all the aspects of a patient’s life which could be affecting their state of health, by considering them and relating them to each other a patient may be encouraged to take more responsibility for trying to change some of the key factors which may impact unfavourably on their health. The significant point here is that as patients we clearly value this approach and believe that we benefit from it. Otherwise we would not be paying for consultations of this kind in such numbers. (This is not to suggest that all is perfect in the practice of CAM, but if patients are willing to pay for what they perceive to be ‘successful’ CAM consultations and treatment, then there is probably something worthwhile in the way these practitioners engage with their patients, and conventional doctors could perhaps take a leaf out of

CAM’s book in order to provide patients with consultations which they truly value, thus building an improved relationship – a genuine partnership, which would form a sound basis for the delivery of more effective healthcare.)

It would probably be unrealistic to propose a routine of ‘maintenance consultations’ in the NHS, but we already have the so-called MOT check-up for the elderly. Perhaps the principle could be extended to include a visit to the GP at other key moments in life, for example when significant life-changing events have occurred, when we know that we are more likely to be susceptible to illness. It might be worth looking for manageable ways to achieve a greater degree of health monitoring within the NHS, which could lead to earlier diagnosis of some diseases where the UK lags behind other European countries.

The focus in a health service

Our National Health Service could more accurately be described today as a national disease service, with the purpose primarily of dealing with disease rather than promoting and maintaining health. Its prime aim seems to be to treat existing disease rather than cultivate wellbeing and avoid disease. This notion is revealed by the use of phrases such as ‘payment by results’, since the only results taken into account are outcomes following treatment; disease prevention and the maintenance of good health are not regarded as ‘results’ worth measuring – or paying for. Modern medicine has become very successful at keeping people alive and extending life expectancy; it has been less effective when managing chronic conditions and keeping people healthy. The increasing need for advanced care planning and ‘living wills’ has arisen in part because the traditional injunction ‘to do no harm’ seems to many to have changed to ‘keep your patient alive at all costs’. Quality of life from the patient’s viewpoint must be given a higher priority than it often is. With an incurable disease, part of the treatment must be enabling the patient to live a good life; dealing with the disease alone is not enough.

A tendency to focus on the disease rather than the individual, while being an understandable consequence of strained logistics and not a conscious choice on the part of any doctor, is still the overriding impression reported by many patients. This is not new, having been remarked upon for well over a century as medical schools have produced professionally qualified physicians. ‘Care more for the individual patient than for the special features of the disease,’ was Sir William Osler’s exhortation to physicians (1849–1919). Likewise Sir William Gull (1816–1890): ‘Never forget that it is not a pneumonia, but a pneumonic man who is your patient.’

In today's age of technological medicine the risk of that impression being given is even greater. In its extreme form, a disease is attacked with apparently little thought for the actual person, whose body resembles a battleground on which the medical profession wages war on the enemy – the disease. So it can seem to the beleaguered patient.

Doctors have to work harder than ever to avoid patients leaving a consultation feeling that they have not been treated as an individual. They have to convey an interest in the patient as a person, finding out what is important to them, asking not just how they feel physically, but how they feel about their situation. As patients we are more satisfied with a consultation and feel that greater rapport has been achieved with the doctor, when any references we might make to our personal circumstances, emotional life, or the context in which the troublesome symptoms first arose are followed up with some discussion of these seemingly peripheral issues. Then whatever is on our mind does not become an obstacle to the investigation of what the doctor really wants to find out, and the consultation is both clinically more successful and (perhaps surprisingly) less time-consuming.

These 'peripheral issues' are more often recognised as crucial by complementary practitioners. While the first question a GP asks will probably be a variant of 'what's wrong?', the complementary therapist is more likely to start with questions which help to characterise the patient in terms of type, tendencies, predilections, susceptibilities etc – information that GPs may not have – before exploring the current situation and events leading up to it. Many patients feel that true preventive medicine becomes more feasible after a fairly general yet personal holistic assessment of this kind. The age-related health check sometimes provided by a GP is one small step in this direction, but that is still focused narrowly on a few very specific conditions, looking for something that has already started to go wrong, rather than helping the patient to balance their innate strengths and weaknesses.

Another consequence of the complexities of modern medicine concerns how doctors decide what treatment is appropriate for a particular patient with a particular condition. There was perhaps once a time when we could say that if you suffer from this disease then the best treatment is X, and another disease will always be treated with Y. Today we can consider ourselves relatively fortunate if we find ourselves in such a clear-cut situation. We can no longer rely on the simple correlation between this disease and that treatment. With many conditions we are faced with an increasing range of treatment options, and one doctor's recommendation will not necessarily coincide with another's. Patients cannot then be expected automatically to adopt the 'doctor knows best' attitude, and the directive approach of many doctors

of the past becomes even less justifiable. And only when doctors regard patients as true partners in the task of healthcare, can they justifiably expect us all to take more responsibility for maintaining and monitoring our own health.

Characteristics of a successful consultation

When does a patient feel that they have had a 'good' consultation? It is when we feel we have been treated as a person; we have had a dialogue with our doctor, without feeling rushed; and we are assured that we are involved as partners with the doctor in managing and treating our condition? The doctor has not used language such as 'This is what I want you to do' (unless we have clearly indicated that this directive approach is preferred, as it still may be by some). As a patient we are recognised as an active participant in our treatment, not a passive and obedient observer, and we are encouraged to take on that responsibility with understanding. (Greater compliance with medication would surely follow if this practice were more widespread.) As a patient we then feel empowered and informed, not passive and ignorant.

Possible treatments are explained and discussed without prejudice and all options are given, without the patient being made to feel that the doctor has an agenda in pushing one particular treatment. There is no 'one size fits all' where treatments are concerned, just as there is often no obvious reason why one person succumbed to a disease and another did not. Where treatments involve risks and side effects, these are realistically explained to us, but at the same time the doctor explains the maximum benefits, describing, say, what can be achieved in the top 10 or 20 per cent, rather than simply referring to averages. As patients we always want to aim high, and statistics about 'the typical patient' are not really very helpful to us: none of us feels that we are 'typical'; each of us is a special case. Averages can be very discouraging, effectively destroying the potential for hope through the placebo effect. Most of us will welcome being encouraged to adopt the positive attitude which realistic hope engenders.

Only the patient can accurately assess their own quality of life, as affected by a disease and by possible treatments; the health professional cannot assume that their values are identical to ours. We need to be treated as individuals and to feel that we have been heard: we need to be allowed to say what is important to us. At all times the health professional must be conscious of the fact that they cannot know how the patient feels, both emotionally and physically. It is very frustrating for us as patients if a doctor refuses to take our subjective report of a new kind of pain seriously until it has been confirmed by a clinical test. In some respects we know

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our own bodies best; we are the experts, and a sensitive doctor recognises this. And on our part, as patients we take far more responsibility for our own health than perhaps the majority of us have in recent decades.

Integrated healthcare

At some point in a consultation, reference may be made to other treatments which the patient may be accessing independently. Ideally there should be open discussion of any complementary or alternative therapy the patient wishes to engage in, but unfortunately most patients who use such therapies are still reluctant to volunteer this information. The reason for this is that in the past the doctor's response has often been a dismissive 'well, it won't do you any harm', or a condescending 'all right, if you believe it will help'. If we suspect that our doctor regards us as a gullible fool with regard to complementary therapies, it is not surprising that we choose to keep quiet about using them, even if our personal experience has shown them to be helpful. Any risks involved in complementary therapies have been well rehearsed and are best avoided by open discussion of them between doctor and patient, rather than implied criticism. What we are hoping for now is an attitudinal change in the medical profession, and it has already begun. It should be recognised that a growing number of hospitals already offer complementary therapies ranging from acupuncture and aromatherapy to meditation and healing. We do not want our doctors merely to tolerate their patients' desire to use complementary therapies; we want them to accept it and co-operate with it, so that an integrated approach to health and health maintenance

can emerge within the NHS. Judicious use of complementary therapies can safely and usefully be integrated into conventional healthcare.

With a rapidly aging population we are now entering a time when chronic conditions demand more attention than ever before, and this is an area where the full range of therapies available can be used to maximum effect. In this situation people often find complementary therapies far more congenial than drugs, in part because they avoid unwanted side effects.

Conclusion

Integrated healthcare means, among other things, that every practitioner consulted by an individual is aware of the full range of therapies that their patient uses. They respect the patient's right to choose how they take care of their health, and they co-operate with the patient in tackling any problems that arise, giving guidance where necessary, rather than assuming that it is their duty to take charge of the situation and expecting the patient simply to follow their instructions. The patient is an active participant in their treatment, in partnership with their physicians, dealing with a unique case. All this is a natural consequence of the emphasis now being placed on patient empowerment, patient responsibility and personalisation of care, and without it the whole concept of preventive medicine and a genuine 'health service' can have no future.

Donald Watson is grateful for the encouragement and support provided by members of the Royal College of Physicians Integrated Healthcare Committee in writing this paper.

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Radical ordinariness: the women's service in Purley

Foxley Lane Women's Service staff

Summary

The Women's Service in Purley, London, is radically different from the stereotype of mental hospitals as frightening impersonal places. A large 1930s house is home for up to eight women at a time who are going through a mental health crisis. Inside, there are bundles of NHS leaflets on the windowsills and the odd reminder of smoking regulations, but otherwise it's an ordinary house offering a unique service.

Introduction

Foxley Lane Women's Service in Purley, Surrey, is part of the South London and Maudsley NHS Foundation Trust (SLAM). It provides an alternative to informal hospital admission for women in the London Borough of Croydon who are experiencing a mental health crisis. The unit, which has been open 10 years, is run by an all woman staff and provides 24 hour care in a safe and therapeutic environment. It was set up in response to the fact that women have unique mental health needs which stem from the fact *'that women beset by a lifetime of social and psychological disadvantage, coupled with long years of child-bearing and neglect, often end up experiencing poverty, isolation and chronic psychological disability'*.¹ From its inception, it has striven to deliver care in a non-institutionalised way and has focused on developing innovative approaches to working with women in mental health crisis. It has been cited as an example of good practice at both local and national levels.

Brief history of the unit

Although Foxley Lane was opened in January 1999, the idea of a women-only inpatient unit, run on non-

traditional lines, had been discussed and planned within the then Croydon mental health services as far back as 1994. Croydon was looking at its mental health service provision in the light of the proposed closure of Warlingham Park Hospital, Surrey, which provided the bulk of inpatient services for the borough. At the same time as this review, there was a move from national government towards providing single sex environments for mental health inpatient units, as it began to be acknowledged that mixed sex wards were detrimental to women patients.² MIND ran its 'Stress on Women' campaign in 1992³ which highlighted some of the difficulties faced by women in mixed sex wards.

A working party consisting of professionals and women mental health services users was set up, led by the women's service lead for Croydon. This planned the shape of the service and searched for a suitable property. An innovative research project² with women services users, explored their experiences of inpatient admission and what they would like to see as an alternative. Service users suggested the following would be helpful during an inpatient admission following mental health crisis:

- being listened to when stating their needs

- having a space to talk
- time for groups
- creative activities
- access to complementary therapies
- a small women-only service in a pleasant environment.

Environment

The unit is set in an old 1920s style detached house, with an extensive garden. It is decorated in a way that is non-institutionalised, with attractive colour schemes and good quality furnishings. Downstairs there is a large



kitchen where food is prepared, a comfortable client lounge, creative arts room and visitors room. There is an ensuite bedroom with fully accessible walk-in shower and on the ground floor the house is fully accessible for women with disabilities. The creative arts space where most of the group work occurs has an induction loop.

Upstairs there are a further seven bedrooms, providing necessary private space for women – there are no 'spy holes' in the doors. The house throughout is decorated with artwork done by clients who have stayed over the years, as well as artefacts from around the world celebrating the cultural diversity of the women and staff group who use and work in Foxley Lane. Names of rooms were chosen in the beginning by the women to reflect and celebrate women figures from different cultures rather than obscure medical personnel. For example the name Tara was chosen for the visits room after the Tibetan goddess of healing.

The décor at Foxley Lane is often commented on – women have said it makes them feel valued to have a nice place to be in when unwell. The staff firmly believe in the healing power of the environment at Foxley Lane and make great efforts to maintain and improve it.

The large garden has been well used over the years. After starting out as a vast expanse of tarmac and weeds, it has been developed by women service users and staff, with funding from SLAM Trust, into a relaxing space offering sanctuary and peace. There are two raised vegetable beds, accessible to wheelchair users, which have produced a variety of crops. This year, organic maize, runner beans, broad beans, strawberries, courgettes and potatoes were grown and enjoyed by the women.

In line with research by MIND⁴ it has been found that being in the garden, especially getting women involved in work to improve the environment, improves mood and can be an enjoyable activity. There is always something to be done in the garden whether it be planting bulbs for the spring or harvesting home-grown vegetables. The garden has gazebos and a summer house which provide quiet spaces for women to relax in. Natural light is known to boost mood⁵ and women often comment on how much they enjoy the garden, especially as many live in places where access to green space is severely limited.



What the service offers

The aims of the unit are best summed up by the Philosophy of Care statement, developed after many hours of lively debate and argument about how to encapsulate what was being offered at Foxley Lane. It seemed central to the philosophy that *how* care was delivered and the *way* staff wanted to interact with service users was explicitly stated in the statement. The service wished to acknowledge the strengths and abilities of the women rather than just seeing them through the lens of a mental health diagnosis.

Philosophy of Care Foxley Lane Women's Service

We believe that the nursing team are here to provide holistic care for women experiencing a mental health crisis. We aim to help women grow and learn from their crisis by helping them develop existing strengths and learn new skills.

We aim, through an individualised approach, to provide a safe, supportive environment which will enable women to discover their own path to mental wellbeing.

We are committed to working in ways which demonstrate respect, sensitivity, honesty and the acknowledgment and valuing of differences amongst women users and staff.

We aim to offer an alternative to traditional psychiatric treatment, working in a women-centred way, helping women find creative ways to express and manage their distress.

Accessing the service

The service is suitable for adult women aged 18 and over who are experiencing mental health crisis and who would normally be admitted informally to hospital.

Women can access the service in a variety of ways.

- Self referral: this has been possible from the opening of the unit, as there is a strong belief in the ability of service users to recognise the signs that they are becoming unwell and to have a choice about the type of care they would like to help them manage their crisis.
- Referral from professionals and family/friends.
- Referral from the main inpatient wards at Bethelm Royal hospital.

Initial contact is by telephone, when a short screening assessment with the woman is done. This is to ascertain whether or not what the service offers is suitable to meet her needs at this present moment, what her current needs actually are, and whether there are any child protection issues which urgently need addressing prior to possible admission. After this, the woman is usually asked to come for a more detailed assessment, done with a qualified mental health nurse at Foxley Lane.

Her crisis and current situation are discussed and the services offered by Foxley Lane explored to see if what is offered here matches her mental health needs.

Care given

The care given at Foxley Lane is based on this initial assessment of the woman's needs. All women have an allocated nursing team, consisting of primary nurse and three associate nurses, one of whom is a designated night nurse. Medical care at Foxley Lane is provided by



two job-sharing female consultants with a special interest in women's mental health care. Each woman's care is reviewed by the consultants and nursing team weekly at clinical review meetings.

The primary nurse works closely with the client, and is responsible for devising an individualised plan of care for her stay and evaluating its effectiveness with her. Initial work nearly always concentrates on helping the woman feel more safe and contained. The very structured programme of groups and individual activities, developed over the years, help to facilitate this sense of psychological containment. The unit has found over the years that the most important means of enabling safety is to spend time building up a therapeutic relationship with each woman. In this way even very suicidal women can be helped to manage feelings that initially have felt overwhelming.

Each woman will have an opportunity to have an individual session with a nurse at least once a day to discuss her care plan; usually two sessions are offered. As has been stated, care plans are tailored to the unique needs of each client. For some women, their care focuses on opportunities to talk about what led up to their crisis, how to manage stress more creatively and to regain confidence in their own coping skills. For others, the time to have a safe space to talk about their needs is of most help. Many women who use the service struggle with anxiety; for them, learning anxiety management techniques is most beneficial.

The Recovery Model⁶ which grew out of the experience of mental health service user Mary Anne Copeland has been used with clients from the beginning. This model emphasises the skills of the service user and acknowledges that she often has the inner wisdom and coping skills needed to deal with her mental health crisis; often what is required is helping her regain confidence. Each woman leaves the service with a Wellness Recovery Action Plan (WRAP) which sets out what helps maintain wellness, the warning signs of illness, and what to do in a crisis. WRAPs are based on Copeland's work and are now used in many mental health services countrywide.⁷ Recovery as a pathway to mental wellness is being promoted now by the DoH⁸ as part of its strategy for developing the skills of mental health nurses to improve care delivery.

Support and creative groups

The morning support group provides a safe facilitated space for women to explore what led up to their crisis and how they are feeling at present. Most women at first find this group challenging, often because they have never had the opportunity to share how their mental health difficulties have impacted on their lives, or because it can take courage to share in a group of other women. It is emphasised that the group is not necessarily about getting answers to problems, but about having a space to be listened to – often, the most supportive thing that can be done for another is to hear their story with respect. By the end of their stay, most women say being in the group has helped them feel less alone in their mental health difficulties and that they have appreciated the space to be heard. Feeling connected to other people has been highlighted recently⁹ as one of the five main ways to stay mentally healthy. Isolation is one of the main difficulties women in mental health crisis face, partly due to the general lack of understanding and stigma surrounding mental illness.¹⁰ Women are much more likely to experience poverty¹¹ which in itself can be isolating as it limits opportunities. The support group can help to start addressing these issues.

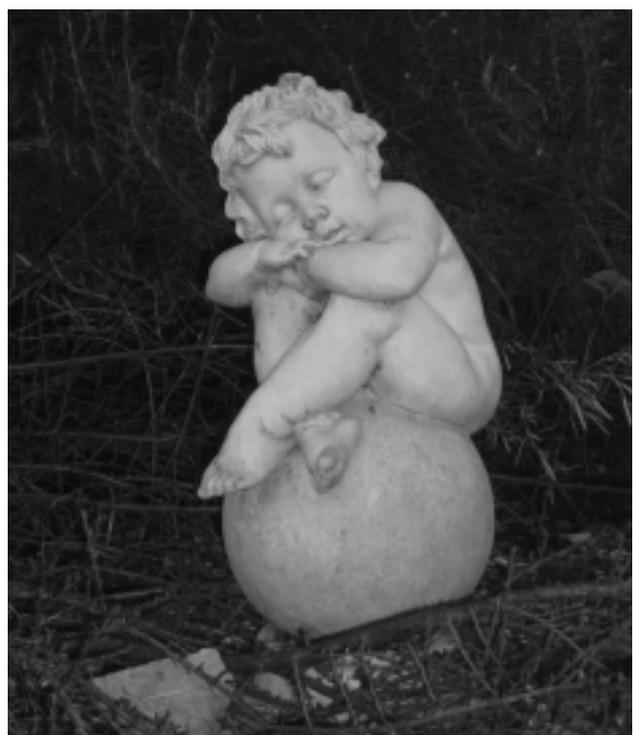
The afternoon creative group is an opportunity to explore some of the topics raised in the morning support group and to take them further. This can be in the form of a creative arts session such as clay work, collage, and creative writing. Other groups are based on discussions and input on relevant topics such as anxiety management, assertiveness and bereavement care. Sometimes more 'fun' groups such as cake baking, circle dancing and karaoke happen in this space. Recently, for example, the clients raised money for Children in Need by using the creative group to bake cakes to sell to visitors. Quality control in the form of tasting the results of the session was much enjoyed.

Managing stress

Women are encouraged to learn different ways of managing stress while at the service. Emphasis is placed on practising different relaxation methods and there are two opportunities a day for women to participate in relaxation groups. Snozelen,¹² a method of gentle sensory stimulation developed in the Netherlands more than 30 years ago, has been used since the house opened as a way of creating a calming environment in the relaxation room.

Sandtray therapy¹³ has also been used as a way of promoting relaxation – many women find working with the sand helps to relieve tensions and agitation and can help distract intrusive thoughts. All nurses are trained in hand massage with lavender oil¹⁴ as a way of helping women relax and sessions with a qualified reflexologist are offered regularly and much appreciated. In line with current research on depression the unit encourages gentle exercise as a means of boosting mood.¹⁵ This mainly takes the form of walking, initially in the garden if the woman is very unwell, then in the surrounding quiet roads and parks. As well as helping fitness, it can help women feel better about themselves.

Many women find the concept of self care and nurturing very difficult, even though this is known to be essential for good mental health.¹⁶ The unit runs a nurturing group at least once a week, to help the women look at the ways in which they can care for themselves without feeling guilty. Women have often commented how hard they find it to take time out for themselves, as they can be left feeling selfish, particularly if they are in situations where they are the main carer



for children or other relatives. Clients report they enjoy the nurturing group, particularly if pampering activities in the form of foot spas and hand massages are offered.

Physical care

In line with the philosophy of looking at women holistically, the physical health of women using the unit is taken into consideration when planning care. Women are given an extensive healthcare screen; the impact on mental health of specific health issues for women such as those associated with childcare, menstrual cycle and menopause are discussed.

Healthy eating is an extremely important part of the care offered; care is taken to plan the menu for each week with the women, making sure those foods known to be beneficial to mental health such as oily fish and fresh fruit and vegetables¹⁷ are included. Sessions on healthy eating are offered regularly, and the difficulties of shopping for healthy food on a low budget are addressed. Service users and staff sit together for each meal as it has been found to be a good way of discreetly assessing the amount of food women, particularly those who struggle with food, eat.

Sleep

The unit recognises that sleep difficulties occur as a result of stress and illness in nearly all of the women who use the service. The night staff at Foxley Lane have developed a degree of expertise in managing difficulties in sleep and in helping the clients develop better sleep hygiene.¹⁸ This takes the form of:

- using non caffeine based drinks at night
- the use of exercise and relaxation during the day
- getting into a good routine for sleep
- not watching TV immediately before going to bed, and using the Snozelen room for a short period before retiring.

Client-centred projects and awards

The service has been involved in several projects with clients over the years. It produced its own relaxation CD in 2004 (which won an award from the trust) with the music and script jointly composed by clients and staff, and devised a calendar with recipes from clients and staff for healthy eating which was distributed throughout the trust. The latest project is the production of a self-help book with clients, detailing interventions which had helped them stay well. This won a highly commended award from the Trust's Excellence in Practice Group.

Foxley Lane has been cited as an area of good practice in several DoH documents such as *Women's mental health: into the mainstream*.¹⁹

The unit was 2007 joint runner up in the Foundation for Integrated Health good practice awards.

Linking with other services

Foxley Lane is not a stand-alone service, but part of the wider adult mental health services for Croydon. As such, the unit works closely with community mental health teams in the borough, particularly when women are nearing discharge. All clients have a pre-discharge care programme approach (CPA) meeting with their care co-ordinator from their community team, nursing staff and consultant. Much of the work preparing for discharge is to ensure women are aware of what services are on offer from statutory and voluntary sectors, so that they feel supported when they leave. Part of WRAP planning work is to help the women create the links needed to engender this support network. This can take the form of, among many others, referral to:

- specialist services for drug, alcohol and gambling addictions
- child and family social services for parenting support and assessment of the impact of the woman's mental health on her children's wellbeing
- talking therapies offered by the mental health trust or organisations such as MIND
- advocacy services
- welfare rights service
- housing and accommodation advice services
- employment support agencies for people with mental health problems
- voluntary pastoral/creative arts service.

Carers support

In keeping with its holistic approach, Foxley Lane sees each woman within her own context, particularly when it can be clear that some of the stressors leading up to crisis have come from within the home environment. The unit also acknowledges that being with someone suffering from mental unwellness can be extremely distressing for carers, particularly if there has been, for example, suicidal feeling expressed. All carers are now entitled to an assessment of their needs.²⁰ Carers are offered support in the form of listening to their experiences and being given contacts for carers organisations in Croydon. This is particularly true of children who are carers as they need more specialised support and help in order to prevent their own mental health being adversely affected by their mother's illness.

Conclusion

Foxley Lane Women's Service has continuously striven to deliver innovative, holistic woman-centred care. While taking pride in its achievements, there is a sense that more needs to be done to respond to the needs of women service users in a changing climate in healthcare provision. There is a passionate belief in the strengths and coping skills of the women who use the service and it is hoped that Foxley Lane will continue to provide them with the time and space they need to regain confidence in these gifts on their journey to wellness.

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Medicine and the healing vocation

Revd Dr Jeremy Swayne

After seven years in general practice I came to recognise the need for a fuller understanding of the nature of illness in individual patients. Building on psychological insights, and beginning to perceive the spiritual dimension of some patients' problems, I was becoming aware of a divergence between the aims and methods of modern medicine and the need for another kind of healing, or wholeness. To explore these issues by spending more time with fewer patients, I set up a new practice providing routine 15-minute appointments. My subsequent encounter with homeopathy introduced another useful therapeutic modality. Since retirement from clinical practice I remain active in the Christian Healing Ministry, and in exploring the relationship between medicine and healing, and between science and religion.

Summary

The paper discusses the need to reconcile the achievements of modern medicine with the limitations its methods impose on our understanding of and response to illness; particularly the dichotomy between medicine as a means of controlling disease processes and manipulating body functions, and healing as a process of enabling self-regulation, re-integration, insight and new growth. I suggest that dependence upon the power of medicine to control is at the expense of equally important, sometimes more important, subtle, whole-making functions of healthcare.

Introduction

It is 40 years since I entered general practice, but in the relative tranquillity of retirement I find myself facing the same challenge that soon confronted me in those early years. This was and is the need to reconcile the huge achievements of modern western medicine with the limitations that its methods impose on our understanding of, and response to, illness. The challenge presented itself as a dichotomy and separation between medicine and healing; between medicine as a means of controlling disease processes and manipulating body functions – the so-called biomedical model – and healing as a process of enabling self-regulation, reintegration, insight and new growth.^{1, 2, 3} The welcome, often life-saving, and increasingly indispensable power of medicine to control, seemed to be at the expense of some equally important, sometimes perhaps more important, more subtle, more creative, more whole-making function of healthcare.

Experience over the years reinforced my appreciation of the validity of both these two modalities of medicine – the controlling and the

enabling – but also my sense of the divergence between the two. Experience included satisfaction and gratitude at what modern medical methods could achieve for my patients (and indeed for my family and myself). It also included an appreciation of what it could not achieve; and of what more could be achieved by other means than the repertoire of interventions that conventional medicine provided and my conventional medical education had neither equipped me to use, nor encouraged me to think about. Initially this experience was gained by providing time, within the context of routine general practice; time for a more thorough clinical appraisal, but often more importantly time to hear more of the story of the patient's illness and of the life experience from which the illness arose. It was evident that the opportunity to tell the story was often 'whole-making' in itself. And the fuller narrative revealed dynamics in the illness and its antecedent and predisposing circumstances that made possible a more complete and relevant therapeutic response. In due course, and in addition to this experience, the introduction of the homeopathic

method of treatment (whose therapeutic effects remain to be fully explained), alongside conventional care, further enhanced my experience of the extent to which it is possible to enable the operation of innate processes of regulation and healing.

I am deeply appreciative of the power of medical science to alleviate disability and manage disease, and often awestruck at its sophistication. I am also deeply appreciative and awestruck at the often astonishing power (an evolutionary necessity, of course) of the human organism and personality to restore and repair itself. Experience has convinced me that we have got the balance of these two powers wrong because in our commitment to the first we have lost sight of or devalued the second. My argument is not about displacing the biomedical model; we have every reason to be profoundly grateful for what it has achieved. Nor is it anti-science. On the contrary, it is about getting the balance right, and the need to revise the medical model and shift the scientific paradigm that underpins it. It is that the narrowness of the biomedical model, and of the paradigm on which it is based, devalues and denatures science and diminishes medicine. 'We do not need to esteem science less. What we need is to esteem it in the right way. Especially we need to stop isolating it from the rest of life.'⁴

“ We do not need to esteem science less... we need to esteem it in the right way. ”

In preparing to write about this, I have discovered how widely my own misgivings are shared, particularly within general practice, and that the momentum for change has been present for a long time. The ascendancy of biomedical science to its pre-eminent position has from the outset been accompanied by the emergence of what might be called a dissident tendency. Dissident voices have certainly been heard throughout my own lifetime in medicine, within the medical profession itself as well as from outsiders concerned at the turn of events. They represent a sort of underground movement, struggling to promote what has been called a 'counter system' in the face of the success and power of the dominant medical model.⁵

Until recently it has been a low-key struggle for hearts and minds, and often only within the hearts and minds of individuals directly concerned with it. Common to their concerns has been the belief that *in general* western medicine is based on too limited an understanding of human nature, of the disease processes and healing processes that affect human wellbeing, and of the ways in which these may be managed. I emphasise *in general* because individual doctors have always been

aware, and often humbly aware, of the limitations of their science to comprehend the complexity of human nature, and of the importance of their art in making good those limitations. It is an irony that the great majority of doctors do have a real care for the whole person of their patient, and know perfectly well that tinkering with the mechanism, whether surgically or pharmacologically, which is often all that their circumstances or their training permit, is only a very partial response to the disorder that is presented to them.

These introductory remarks raise many issues and beg many questions, but in this article I wish to focus on the theme that is central to our understanding of the vocation of medicine.

Medicine and healing

Medicine has always been traditionally associated with healing. I have mentioned in passing the obvious fact that the capacity of organisms to heal spontaneously has been an evolutionary imperative. The goal of medicine has been to assist this biological process as far as possible and to take control when it fails, or to take control until the natural healing process can reassert itself. In Greek mythology, Asclepius was the god of healing, himself representing the more active interventionist approach, bringing external forces to bear to overcome the disorder and bring the individual back to an ordered state of health.⁶ His daughter Hygieia represents the more conservative health maintenance approach. In that tradition, health depends on a state of inner equilibrium and balance, and treatment aims to maintain or restore this equilibrium and encourage balance, not only between the individual's physical, emotional and spiritual aspects, but between the person and their environment. These two traditions are still represented in medicine today, of course. They reflect different paradigms of health and healing, and different models of healthcare. The other daughter of Asclepius, Panacea, remains sought after but unattainable.

This mythical and religious aspect of ancient medicine, and the association of medicine with religion over the centuries, emphasises that it once always was, and in some cultures and philosophies still is, concerned with the whole person, body, mind and soul, or spirit. Indeed, for many healthcare professionals in our present day western culture it remains so. Peter Morrell has pointed out that 'ancient medicine was always integrated – a mind-body medicine rooted in a social and religious matrix of a culturally defined people with a definite belief system. Much of the metaphysical element that was ejected from medicine centuries ago now queues at medicine's backdoor'.⁷ And so the word 'healing', both historically and today, has two senses: the biological

process of recovery, repair and compensation by which organisms overcome or cope with defects, damage and disorder; and a more comprehensive process that honours a wholeness of the person that transcends the bodily form. And a healing profession has traditionally been implicated in assisting and enabling both; until more secular, materialist and scientific times, that is. The fact that the personal and metaphysical dimensions of health and illness have been ejected from mainstream medicine explains quite a lot about the great interest shown by many people in models of healthcare that do acknowledge and seek to respond to this subtle but indestructible stratum of human nature.

If medicine is to serve healing, then, it has four responsibilities:

- 1 To support the natural capacity of the body to regulate and heal itself:
 - (a) by encouraging a healthy lifestyle
 - (b) by enabling those self-healing and self-regulating processes
 - (c) by helping to avoid or remedy situations that are detrimental to those processes.
- 2 To teach people to understand and manage distress and disorder that is within their personal competence for self-care or for the care of one another.
- 3 To intervene, but only as far as and for as long as is necessary, in ways that control suffering and disorder when those natural resources are impaired and until they are sufficiently recovered, or where that personal competence is too limited to cope.
- 4 To respect the unique value of each individual, and to act in such a way as to enhance their quality of life, regardless of the prospect of 'cure'.

Lyng offers this prescription: health is viewed not as a particular state but as a process. Accordingly, health production has three basic activities – to maintain existing human capabilities, to develop new human capabilities, and to maintain balance between the elements of the human system in a constantly changing environment.⁵

...the relationship between
medicine and healing resembles
a broken marriage.

Right relationship

It has been suggested that medicine needs to recover its 'soul'.⁸ By which is meant its expression of concern for the individual, for the personal experience and the narrative of the illness, and for the enrichment of that individual's life that in however modest a way medicine

can bring. In writing about the concerns I felt about medicine in my early GP years, I suggested that the relationship between medicine and healing resembles a broken marriage. As in so many failed relationships, the two partners have stopped talking to each other. Or perhaps that is not quite the case; rather that one partner, the biomedical partner, long ago stopped listening. An essential goal of any remodelling process must be that the intimacy of this relationship should be restored.

The relationship actually exists intact in many encounters between patients and doctors, but it is under strain. The ideals of a healing vocation have not been abandoned; not actually wholly ejected. For example, essential to the healing relationship is trust. A key aphorism in the section *Thinking about medicine* in the *Oxford Handbook of Clinical Medicine* is, 'Where there is no trust there is little healing',⁹ and in *The Human Effect in Medicine*, Dixon and Sweeney list trustworthiness, together with self-discipline, humility, tolerance and patience as tools necessary to any clinical activity. But they make the point that these attributes are not to be separated from the use of scientific knowledge but are the context for its use (my paraphrase).⁶

Medicine will fulfil its vocation, and be more effective, when it learns to use its science in the service of healing. This requires more than the ability to analyse, control and manipulate body functions and disease processes that is its supreme achievement hitherto. It does not require a major revolution, simply that it directs considerably more of its attention to those things that it knows perfectly well are fundamental to its purpose, the integrity of the person who is its patient, and the natural healing resources that that person, to some degree even in conditions of most severe damage and disability, possesses.¹⁰

This is as much a matter of attitude as of practice. It is our attitude to one another, in any relationship let alone a therapeutic relationship, that confers meaning and value on the other person. James Marcum quotes from a contributor to the book *Changing Values in Medicine* who argues that 'by reducing the body to a collection of parts, the patient as a person vanishes before the physician's gaze. That is literally de-meaning, and it does happen'. Marcum himself asserts that 'the meaning that a patient attaches to illness and suffering, especially in chronic or fatal illness, is critical for the healing process – and that meaning is accessible through the patient's illness story' if the opportunity is provided for it to be told.¹¹ Note that this quotation includes the intriguing and important reference to a healing process as part even of a fatal illness.

What are the ways in which medicine may deviate from its broader healing goal because of its narrow biomedical focus? George Engel put it bluntly in his 1977 critique of the biomedical model, saying 'rational treatment directed only at the biochemical abnormality

does not necessarily restore the patient to health, even in the face of documented correction or major alleviation of the abnormality'.¹² Alan Barbour, a hospital clinician in America, made a similar point, elaborating it as an account of the various misconceptions and false starts that the clinical process can pursue.

- 1 The disease is not the cause of the illness.
- 2 The disease itself results entirely or partly from the life situation, but the treatment is purely biomedical.
- 3 Personal distress unrelated to the disease is superimposed (upon it). Compounding the problem of diagnosis and treatment.
- 4 The disease is caused by multiple factors, but the medical model focuses on one particular cause or treatment.
- 5 (The disease is a substantial primary problem, but) it is a *person* ... who needs to surmount the illness with new value and meaning.¹³

Howard Brody reflects the last point in particular in the description of the several possible levels of resolution of an illness.

- 1 I simply recover completely and return to the *status quo*.
- 2 I make an accommodation with my rebellious body and resign myself to a different way of functioning.
- 3 I come to listen more sympathetically to my body, to see it as a source of values that legitimately should play a role in how I live my life, and not simply as having value only when it carries out the wishes of other aspects of the self.¹⁴

I suppose we could describe that last level as a new experience of self-affirmation and self-respect; a new and better way of loving ourselves that is quite different from egotism. And this is essential to the healing goal of medicine. As an editorial in the *Journal of the Royal College of Physicians* in 2003 advised, 'the good consultation should always leave a patient with an increase in self-esteem...'¹⁵

Medicine needs to distinguish between cure and healing (and treatment and healing) while it seeks to serve both. Alan Barbour explained it this way: whereas curing and treatment refer primarily to what is done *to* the patient, healing includes, in addition to the treatment, all forces that combine to restore and foster health: the biologic mechanisms of defence and repair; the personal qualities of the doctor, the patient and their relationship; the overall understanding engendered; the social unit in which the patient lives; and the patient's ultimate propensity, latent in everyone, to restore, strengthen, and enhance physical, emotional, social, and spiritual health.¹³

This wider perspective of healing is not an optional extra for medicine, not a luxury to be afforded when time permits. It is medicine's *raison d'être*. Nor is it merely a somewhat academic philosophical and ethical context for the practice of medicine. Nor is there any discontinuity between the principles that govern the physical mechanisms of bodily healing, and the principles that govern healing on other levels of the person and of the disordered circumstances of that person's life that are implicated in the illness. The condition of our bodies, the quality, meaning and value of our personal lives, our contribution to the lives of others and our relationships with one another, and our role in society, even when that is a dependent role, and even our interaction with our physical environment, are inextricably interconnected. No one healthcare professional can offer help on all these levels, and of course they are not necessarily implicated in meeting needs on all these levels. But no medical intervention is unaffected by, nor fails to affect, what is happening on those other levels that are not the direct and immediate focus of its attention.

The realisation of this may be peripheral to a doctor's consciousness of the task in hand, but it is not irrelevant, and should be part of the 'tacit' knowledge of his or her role. That is the kind of knowledge (described by Polanyi) that is not part of the formal and conscious protocol by which we perform a task, but that subtly informs and influences its performance.¹⁶ This more diffuse knowledge or insight not only enhances the performance of a task but also the personal satisfaction we gain from it. In a medical context it enhances patient and doctor satisfaction.

Awareness of this broader healing perspective for medical activity has two advantages. First it is helpful to recognise that there are certain basic principles that are common to healing processes on different levels, and second, it changes the expectations we may have of what medicine can or should achieve.³

Healing is not a matter of remedying defects, relieving symptoms, or modifying pathological changes. These things may be a part of the process or a result of the process, but they are not in themselves the process or the purpose of healing. Healing is not the same as cure. Chronic and progressive disease may co-exist with a state of wellbeing which defies the symptoms. Too narrow-minded a pursuit of cure may even prevent healing in this sort of situation. Such narrowness will also blind us to the possibility that disease or illness may not only be the antagonist of healing, but also the agent, drawing attention, if well handled, to the adverse circumstances that caused or predisposed us to the illness, and creating the opportunity for change.

Healing is not always compatible with comfort (even inflammation, probably the first healing process we encounter in our medical studies as well as in our experience of illness, is never comfortable). Certainly it

cannot be when the illness is the agent of healing. Whether or not we accept that particular concept, we may agree that understanding and change are often important ingredients of healing. We may also agree that understanding and change are often difficult and painful to achieve, for both doctor and patient. That is why they will both settle for second best, as often as not, and choose a palliative prescription instead. As Kafka pointed out, 'To write a prescription is easy, but to come to an understanding with people is hard'.¹⁷ To help them to come to an understanding with themselves is harder still.

Healing is a universal quality and a universal process. We all possess natural powers of healing in our own body, mind, and spirit. We all have access to personal qualities which can assist healing in other people. There are many techniques of treatment, from wart charming to neurosurgery. These are contributions towards healing which only specialists can make. But any person can contribute compassion, empathy, and insight. Healing is not bestowed upon people by doctors. Doctors do not make people better; they help them to get better. And so do friends, neighbours, comedians, poets, and the makers of Guinness.³

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Homeopathy – all in the talking?

A GP's experience

Alice Fraser

GP

I work as a GP in a busy central London NHS practice of 6,000 patients and have a long-standing interest in the integration of complementary and alternative therapies with standard medical practice. This has developed since becoming a GP, mainly due to the realisation that conventional medicine alone cannot always help my patients. I founded the Brighton and Hove Integrated Health Forum in 2005, a group which is still thriving with more than 100 members from a variety of healthcare backgrounds who meet regularly for lectures, discussion and networking opportunities.

I met Matt at the NHS health centre at which I am a principal GP. It was through an initiative we were trying to start at the centre to introduce a programme for patients to help them identify their physical, emotional, spiritual and environmental health needs with the help of a number of health education mentors. Matt was to be one of the mentors.

We are a practice with a 15-year history of offering patients integrated conventional and complementary healthcare on the NHS, mainly due to our close involvement with the Westminster Complementary Therapy Project which is funded by Westminster Primary Care Trust.



During our initial meetings for the new initiative Matt became aware of my obvious interest in complementary therapy, but I think felt some scepticism from my colleagues, and perhaps myself, about homeopathy in particular. I had, in fact, been treated by a homeopath as a child, and had always been given arnica for bruises and calendula for eczema by my father, who as a documentary film maker had made one of the first series in the 1980s about complementary medicine, *The Medicine Men*.

To my surprise, after our initial meeting Matt called me and asked if I would be interested in some complementary sessions with him so that I could find out a bit more about what he did. I jumped at the chance, mainly because I had been suffering terribly from allergies in the recent weeks, for which I had resorted to oral steroid treatment. I knew these allergies had been partly fuelled by stress and burning the candle at both ends, but also that my atopic state was usually only just beneath the surface. I also wondered if he could help with some symptoms of irritable bowel syndrome (IBS), for which I have never taken any treatment, but was willing to try homeopathy.

So I felt more than a little intrigued as I walked to Matt's clinic in Harley Street. He had told me that the first session would last two hours and I did wonder what we would be doing for that length of time.

He explained when I arrived that he does things slightly differently to other homeopaths. He takes a full medical and family history as well as a drug and lifestyle history but his constitutional history-taking is different. He explained that he prefers to go much deeper with this than other practitioners as he feels he gets closer to

the core of the person, their problems and the best remedies for them.

With slight trepidation, partly because he was a colleague, and partly because I am unused to ‘talking therapy’ I attempted to answer his questions which went ever deeper. When he asked ‘Who is Alice?’, and I responded ‘...well, Alice *used* to be successful, over-confident, always right, popular, high achieving etc...but she now feels a bit more vulnerable’ he seemed really pleased, saying ‘Brilliant, that’s so exciting!’ I let myself go, and decided that maybe this was going to be good for me in more ways than allergy and IBS treatment.

After that first session I walked down Harley Street feeling elated. This was partly because I felt I’d made inroads into getting some help for my allergies, but more fundamental than that, I’d talked about some things with Matt, in a safe environment, which I knew affected my outlook on life and the way I work and make relationships. He had also seemed, unlike many other ‘therapists’ I have heard about, to give me answers, and also some personal anecdotes, which I felt helped me feel less self-conscious in this situation.

Later that day, I had a slump in energy – similar to the slump after an adrenaline rush, which I have mainly felt after an exam or a performance of some kind. It was short-lived, and I went home to my partner that night and told him about what Matt had said. He was stunned

at how ‘spot on’ Matt’s comments had been, and this somehow reassured me to go back and finish the process. That night I took the first ‘dose’ of the remedy Matt had given me to take in divided doses over the next 24 hours. He explained it was a strong one, for a strong personality!

The subsequent sessions were an hour long, and went along in much the same vein, although touching on other areas in my life. Each time I got a different remedy to take at home; each one, I understand, helping with a different ‘part of Alice’.

It is now about four months since I last saw Matt. My thoughts are this:

I am in no doubt that my allergies and IBS symptoms are less, and more manageable.

I am unsure in my mind whether this is due to remedies, talking, or both.

I had not been aware previously how good it is to talk.

I feel more able to tell patients about having talking therapy, knowing what it involves.

I am happy I took an opportunity like this when it was presented to me.

I knew who I was, and I am still her, but it was nice to have ‘delved’ into her.

I feel less vulnerable again.

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Coronary heart disease

In coronary artery disease (CAD), sometimes called coronary heart disease, one or more of the coronary arteries becomes narrowed and blood flow to the heart is restricted. Exertion or stress, which increase the oxygen demands of the heart muscle, may bring on symptoms, such as chest pain, and even a heart attack. Primary treatments include lifestyle changes, aspirin and lipid-lowering drugs. In some cases, angioplasty or bypass surgery may be recommended. Various nutritional therapies will help, as will managing stress.

Summary

In the fourth of a series of extracts from 'Family Health Guide – New Medicine', we look at an integrated approach to the symptoms and treatment of coronary heart disease.

Extracted from Family Health Guide – New Medicine, Editor-in-Chief: Dr David Peters, published by Dorling Kindersley. Contributors: Dr John Briffa, Leon K. Chaitow, Dr Andrew Chevallier, Dr Peter Fisher, Dr Adrian Hemmings, Dr Randy Horwitz & Dr David Kiefer, Professor George Lewith, Michael McIntyre, Kenneth R. Pelletier, Dr Penny Preston.

What are the symptoms?

- In the early stages of CAD there may be no symptoms
- Later, angina may develop

If a heart attack occurs, the individual may experience:

- Persistent, severe pain in the chest that may spread up into the neck and down the arm – the pain may come on while at rest
- Sweating
- Shortness of breath
- Nausea and vomiting

Why might I have this?

Predisposing factors

- Smoking
- Genetic factors
- A diet high in certain fats
- Lack of exercise
- Excess weight
- High blood pressure
- Diabetes mellitus
- High intake of trans-fatty acids
- Oxidised cholesterol
- Raised triglyceride levels
- Raised homocysteine levels
- Anger, hostility, anxiety, depression

Triggers (in existing disease)

- Physical exertion, cold, windy weather, extreme emotions, excitement
- Blood-sugar imbalance

Why does it occur?

The coronary arteries branch from the aorta and supply the heart muscles with oxygenated blood. Coronary artery disease (CAD) is usually due to atherosclerosis, in which fatty deposits build up on the internal lining of the coronary arteries. These deposits narrow the arteries and restrict the flow of blood through them, reducing the supply of oxygen to the muscles. If one of the arteries becomes blocked, a heart attack (myocardial infarction) occurs and the heart muscle is damaged. CAD due to atherosclerosis is more likely if you have a high level of cholesterol in your blood and if you eat a diet that is high in fats. Smoking, a lack of exercise, excess weight, high blood pressure and diabetes mellitus are all risk factors.

CAD is more common with increasing age and may sometimes run in families. The risk of developing CAD is generally lower in women than in men – until women reach the age of 60, when the risk for both sexes becomes approximately the same. The lower risk of CAD for a woman is thought to be due to the protective effect of the female hormone oestrogen during the fertile part of her life. This protection against CAD wears off gradually after the menopause.

CAD may be an underlying factor in arrhythmias and heart failure, in which the heart becomes too weak to pump blood around the body effectively. Chronic heart failure may occur in the elderly, causing excess fluid in the lungs and tissues, as well as shortness of breath and swollen ankles.

Treatment plan

Primary treatments

- Lifestyle changes (see Self-help)
- Thrombolytic, anti-angina and other drugs, surgery
- Cardiac rehabilitation programme

Back-up treatments

- Nutritional therapy
- Cardio-protective diets
- Western herbal medicine
- Moderate aerobic exercise
- Breathing retraining
- Mind-body therapies
- Ornish approach

Worth considering

- Acupuncture

Self help

PRIMARY TREATMENT

If you have CAD, or wish to reduce the risk of CAD, take the following measures:

- Stop smoking.
- Eat a diet low in saturated fats.
- Maintain your cholesterol levels at a desirable level.
- Lose weight if necessary.
- Exercise regularly according to your doctor’s advice.
- Take a blood-pressure lowering drug if your blood pressure is high.
- Consider taking a low dose of aspirin (75mg) every day to reduce the risk of a heart attack. (Check with your doctor as taking aspirin is not appropriate for everyone – for example, for some people with asthma.)

Treatments in detail

Conventional medicine

Tests

If you are experiencing chest pain, your doctor may suspect CAD and will probably organise tests. These may include an electrocardiogram (ECG) to record the

electrical rhythm of the heart and an exercise test to discover how your heart performs under stress. If the tests indicate your heart is not receiving enough blood, you may need a coronary angiography. A dye injected intravenously highlights the coronary arteries under x-ray and reveals where they are blocked or narrowed. If tests confirm CAD and that you are having angina episodes, various treatments may be prescribed. If your doctor suspects that you had a myocardial infarction, your heart rhythm will be recorded on an ECG at regular intervals. The ECG recordings will enable the doctor to look for changes characteristic of a heart attack and to monitor progress. A series of blood tests will measure the levels of certain enzymes that are produced by damaged heart muscle.

PRIMARY TREATMENT

Thrombolytic drugs

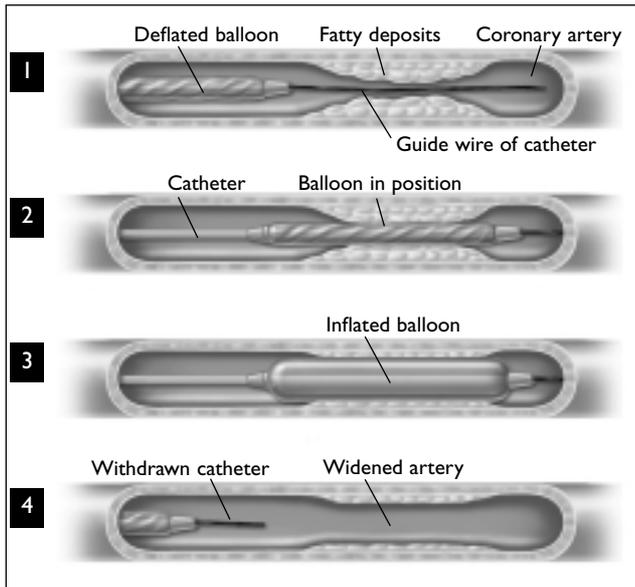
Drugs such as streptokinase, may be given if a heart attack is confirmed. These aim to break down the clot (thrombus) that is blocking the coronary artery in order to minimise the damage to the heart muscle. Taking aspirin can also help the process.

Angioplasty

In an angioplasty which is a less invasive alternative to open-heart surgery, a tiny balloon is inflated to open up a coronary artery that has become clogged with fatty deposits. The patient, who is usually awake throughout, has a mild sedative and a local anaesthetic. Then a catheter (a hollow tube) carrying the balloon is inserted into a blood vessel in the groin and guided, with the help of x-rays, through the arteries to the blockage. The surgical procedure follows four stages:

The four stages of an angioplasty

- 1 Using x-ray images to guide them, doctors thread the catheter through a leg artery to the blocked coronary artery.
- 2 The balloon is now positioned correctly. Patients sometimes report feeling a slight tugging sensation when it is in place.
- 3 The balloon is inflated for up to two minutes, stretching the artery wall and increasing its diameter.
- 4 The balloon is deflated and withdrawn. Substantially more blood can now flow through the coronary artery.



PRIMARY TREATMENT Surgery
Such as an angioplasty or a coronary bypass may be needed to widen or bypass narrowed coronary arteries.

Coronary care

After a heart attack, you may need to be monitored on the coronary care unit for about two days, where you may be given oxygen and a pain-relieving drug, such as diamorphine. In the short term, you may need intravenous drugs, such as beta-blockers, which aim to slow the heart rate and may help relieve the pain.

PRIMARY TREATMENT Long-term treatment
Long-term treatment for CAD may include aspirin and beta-blockers, which can help to reduce the risk of a myocardial infarction. Drugs called angiotensin-converting enzyme (ACE) inhibitors may also improve the prognosis in some cases. They dilate (widen) blood vessels around the body, making it easier for the heart to pump blood round the body. Lowering cholesterol with drugs and diet (*see Cardio-protective diets, below*) can also reduce the risk of further myocardial infarctions and strokes. Following a myocardial infarction, you can gradually increase your activity levels. Take appropriate exercise and follow a cardiac rehabilitation programme, which will focus on various aspects of life after a heart attack, such as diet and stopping smoking. Emotional support is also very important.

Caution

Heart drugs can cause side effects: ask your doctor to explain these to you.

Nutritional therapy

PRIMARY TREATMENT

What you eat partly determines whether or not your coronary arteries will gradually accumulate cholesterol and other fats on their internal walls.

Healthy and unhealthy fats

The type of fat we eat has an important bearing on the development of CAD. While much emphasis has been placed on the need to avoid saturated fat in the diet – for example, in red meat, dairy products and eggs – some evidence suggests that the role it plays in heart disease may not be so important after all.

There is mounting evidence to suggest that fats known as ‘partially hydrogenated’ and trans-fatty acids are a more important risk factor for CAD. These hard fats, which are found in many fast foods, baked goods, processed foods and margarine are associated with an increased risk of heart disease. You should avoid these fats if possible.

The omega-3 fatty acids in oily fish, such as salmon, trout, mackerel, sardine and herring, have several effects in the body that would be expected to reduce the risk of CAD. For example, they can raise the levels of ‘healthy’ high-density lipoprotein (HDL) cholesterol, reduce blood pressure and thin the blood. According to experts, eating one or two portions of fish each week, or supplementing your diet with 1g of concentrated fish oils per day, is likely to reduce the risk of heart disease.

Triglycerides

Raised levels of blood fats known as triglycerides appear to be another risk factor for CAD. Raised triglycerides often occurs in conjunction with accumulation of body fat around the middle of the body and a condition called insulin resistance (which may lead to diabetes in time). Together, these risk factors are a metabolic syndrome (known sometimes as Syndrome X), which is present in about 25 per cent of the UK’s middle-aged population. Its importance as a risk for CAD development is well established. Fish oil supplements can help here, too.

Homocysteine levels

Raised levels of a substance called homocysteine appear to be a major risk factor for CAD and heart disease. Homocysteine is a breakdown product of the amino acid methionine, and is normally converted in the body to a harmless substance called cystathionine. However, this conversion is dependent on the presence of vitamins B6, B12 and folic acid. A deficiency of one or more of these nutrients might cause homocysteine levels to rise. Higher intakes of folic acid and vitamin B6 in the diet are associated with a decreased risk of CAD. Anyone

with a raised homocysteine level (as determined by a blood test) should take 10mg of vitamin B6, 50mcg of vitamin B12 and 400mcg of folic acid per day.

Vitamin E

When trying to prevent CAD, medical attention focuses on the need to control the level of cholesterol in the blood. However, it is when cholesterol becomes damaged through a process known as oxidation that it has the propensity to settle on the inside of the body's arteries. Vitamin E is an anti-oxidant nutrient that can protect cholesterol from oxidation. Vitamin E may also help to prevent heart disease through its ability to thin the blood. Two studies (one on men and one on women) found that taking vitamin E supplements (100 IU or more per day) for two or more years was associated with a 20–40 per cent reduction in the risk of CAD. However, other studies do not back up these findings.

Vitamin C

Evidence is starting to emerge that vitamin C may protect against CAD, especially if taken with vitamin E. But the protection probably applies only to people with poor dietary intake of the vitamins. A 16-year follow-up study of over 80,000 nurses in the US suggested that increased vitamin C intake reduced the risk of CAD. After factoring out other risks for CAD, such as age, smoking and exercise, the women who took vitamin C still had a significantly lower risk of CAD. As a result, taking 1g vitamin C each day in conjunction with vitamin E supplements may help to reduce the risk of CAD.

Multi-vitamin/mineral supplement

Taken daily this may be a good way to protect against CAD. Studies have found that a daily intake of a multi-vitamin is associated with a lower risk of CAD. Many nutrients within the mineral supplement, such as vitamin E, vitamin C, copper and selenium, may be beneficial in reducing the risk of CAD.

Bioflavonoids

These are phenolic compounds that are present in a wide range of foods and medicinal plants. Many studies indicate that flavonoids are anti-inflammatory, antiviral and able to dilate blood vessels. Most importantly, they are antioxidants, able to neutralise free radicals and reduce their formation. Bioflavonoids are found in nuts, cereals, olive oil, vegetables, fruits, berries, tea, red wine, dark chocolate and many herbs (*see Western herbal medicine, below*). Many of these foods are part of the so-called Mediterranean diet.

Polyphenols extracted from the purple grape skins in red wine have been shown to inhibit the formation of endothelin-1, a chemical that makes blood vessels constrict. It seems that the polyphenols reduce the stickiness of blood and protect the lining of the blood vessels of the heart by producing nitric oxide. In this way, both wine and dark grape juice can reduce atherosclerosis and heart disease.

Chinese red-yeast rice

This is a supplement that contains lovastatin, a naturally occurring statin. Other compounds that lower cholesterol include cholestin, which has been shown to lower raised levels of cholesterol and triglycerides in blood serum.

Caution

Consult your doctor before taking omega-3 fatty acids or fish oils with warfarin, or zinc with antibiotics, or vitamin E with warfarin or aspirin, or vitamin C with antibiotics or warfarin.

Cardioprotective diets

In parts of France and other Mediterranean countries, death from heart disease is significantly lower than in other developed countries, despite a high consumption of fat and saturated fats. The reason advanced for this cardio-protective effect is the diet accompanied by regular consumption of red wine. A long-term study of 89,299 male physicians in the US found that drinking moderate amounts of red wine (one or two glasses a day) reduced overall mortality. However, there was no benefit from drinking more! The people of Okinawa, a collection of islands between Japan and Taiwan, commonly live active, independent lives well into their 90s and 100s. Their rates of obesity, heart disease, osteoporosis, memory loss, menopause and breast, colon and prostate cancer rank far below those in other industrialised countries. Researchers point to their mainly vegetable diet, which includes plenty of onions and soya, giving high levels of antioxidant bioflavonoids and carotenoids. In addition, a slower decline in sex hormones, which appears to be linked to diet and lifestyle, is believed to contribute to the impressive cardiovascular health of the Okinawans.

What diet?

In 2002, a review looked at 147 studies of dietary factors and their relationship to CAD. The factors included fat, cholesterol, omega-3 and omega-6 (polyunsaturated) fatty acids, carbohydrates, glycaemic index, fibre, folate and dietary patterns.

The review concluded that there are apparently three effective strategies for preventing CAD. First, replace saturated fats with unsaturated fats in the diet. Second, increase the amount of omega-3 fatty acids derived from fish, fish oil supplements or plant sources in the diet. Third, eat a diet that is high in fruits, vegetables, nuts and whole grains, but one that is also low in refined grain products.

As yet, it is unclear just how much or in what proportion each of these is important. Nor is there certainty about the precise role played by essential plant substances, such as antioxidant vitamins, minerals, flavonoids and lycopenes. However, the authors suggest that a diet containing these components, combined with regular exercise, no tobacco and remaining at your ideal body weight, could prevent most cases of CAD.

Garlic and onions contain organosulphur compounds that reduce the stickiness of human blood platelets and appear to confer cardiovascular benefits on those who eat them regularly. In addition, they reduce levels of unhealthy fats in the blood and can help to lower blood pressure. The protective effect of garlic (*Allium sativum*) is attributed to its ability to reduce arterial plaque and atherosclerosis, and to protect the lining of the blood vessels in the heart. Garlic also appears to inhibit cholesterol manufacture in the liver and to increase the excretion of cholesterol. It may also relax the heart muscle and maintain the elasticity of the aorta.

Tea (*Camellia sinensis*) has cardioprotective properties because it is rich in catechins and polyphenols which are antioxidants. A study carried out on black tea consumption found that tea drinking appeared to improve the function of the coronary blood vessels in patients with CAD. In a Japanese study, people drinking over ten cups of green tea a day had a decreased risk of death from cardiovascular disease.

Tomatoes contain lycopene, an antioxidant carotenoid which has the ability to inhibit cholesterol synthesis and prevent heart disease. Tomatoes are also a good source of beta-carotene, flavonoids, potassium, folic acid, vitamins C and E – all of which may work together to maintain a healthy heart.

Other cardioprotective foods Several studies suggest that eating plenty of fruit and vegetables is associated with a reduced risk of CAD. Substantial epidemiological evidence indicates that diets rich in fibre and whole grains are associated with decreased risk of CAD. Studies show that eating whole-grain foods can also help to reduce the risk of CAD, by up to 30 per cent if you eat more than three servings per day. Legumes also seem to have a beneficial effect on the heart. Soya has been shown to reduce 'bad', low-density cholesterol (LDL), while increasing the ratio of 'good', high-density cholesterol (HDL).

Caution

Consult your doctor before taking medicinal doses of garlic at the same time as anticoagulant drugs.

Western herbal medicine

From across the world, epidemiological evidence makes the case that common chemical compounds found in traditional plant remedies help to maintain a healthy heart. If you have coronary artery disease, a herbalist may prescribe one or more of the following plant remedies.

Hawthorn (*Crataegus monogyna* or *Crataegus laevigata*) flowers are rich in bioflavonoids while the spring leaves are particularly high in oligomeric proanthocyanidins (OPCs). These OPCs are bioflavonoid antioxidants that are about 20 times as potent as vitamin C and 50 times as potent as vitamin E. OPCs protect the heart by binding to the surface of blood vessel (endothelial) cells where they neutralise harmful free radicals. OPCs can also be found in grapeseed (*Vitis vinifera*) extract.

Hawthorn extract strengthens the power of the heart muscle, increases blood flow through the coronary arteries and appears to keep the rhythm of the heartbeat regular. This research demonstrated that those patients with heart disease who were taking hawthorn found their breathlessness and fatigue improved significantly compared to patients taking a placebo.

Ginkgo (*Ginkgo biloba*) can improve circulation and is used to treat CAD.

Standardised ginkgo biloba extract (GBE) helps to normalise the circulation of the blood and exerts a beneficial effect on the lining and tone of the blood vessels. GBE reduces the stickiness of blood platelets that can lead to coronary artery blockage and heart disease.

Motherwort (*Leonurus cardiaca*) is another herb with a long folk use for treating cardiac debility, rapid heartbeat and anxiety affecting heart function.

Other herbs and spices Several kitchen herbs and spices also have a beneficial effect on the heart. They include rosemary (*Rosmarinus officinalis*), which contains phenolic diterpenes that reduce 'bad' low density lipoprotein (LDL) cholesterol in the blood. The antioxidants in cinnamon (*Cinnamomum verum*) bark can lower blood fat levels. Turmeric (*Curcuma longa*) has antioxidant activity that can help to lower cholesterol levels and has demonstrated reduction of the symptoms of angina pectoris. Ginger (*Zingiber officinale*), a close relative of turmeric, prevents the aggregation of blood platelets in patients with coronary artery disease.

Terminalia arjuna The bark of this Ayurvedic remedy is a source of OPCs and bioflavonoids that strengthen the power of heart muscle as well as relieving angina and the frequency of angina attacks.

Caution

If you are already taking prescribed medication, consult a medical herbalist first.

Aerobic exercise

Performing aerobic exercise on a regular basis is commonly associated with protection against heart disease. However, exercise is usually beneficial for people with existing heart disease, too. Among the benefits of aerobic and general exercise are decreased risk of thrombosis, myocardial ischaemia (involving symptoms such as angina) and stroke. If you have CAD, you should follow a graduated exercise programme that is based on research evidence in cardiovascular rehabilitation and prescribed by a physiotherapist.

One remarkable study that lasted 33 years revealed that aerobic exercise, when performed 3–4 times each week, slows down the ageing process of the heart. Another long-term (13-year) research study involving 10,000 men showed that regular exercise helps to prevent strokes as well as helping people recover from strokes. In the study, walking, stair climbing, dancing, cycling and gardening all reduced the risk of stroke. However, the lowest risk was associated with walking 20km or more a week. The research also strongly suggests that regular participation in moderate intensity (non-aerobic) lifestyle activities, such as walking, stair-climbing, vigorous housework and gardening, for not less than 60 minutes per week, give almost the same heart health benefits as regular and more intense aerobic activity.

It is current exercise levels that protect the heart, rather than an earlier history of physical exercise. Researchers send a clear message when they say it may never be too late to start exercising.

Breathing retraining

Hyperventilation and altered breathing patterns can aggravate existing cardiovascular disease by reducing oxygen delivery to the tissues, including the heart itself, and by causing contractions of the smooth muscles surrounding the blood vessels. Breathing retraining may therefore be a useful way of easing these stresses to the heart, as well as lowering general levels of anxiety. Physiotherapists and yoga instructors can help you learn better breathing habits.

Acupuncture

Acupuncture cannot treat the primary causes of CAD, but it can treat the pain and may act to dilate the coronary arteries, sometimes providing effective long-term treatment. A study using coronary arteriograms has shown that acupuncture can dilate coronary arteries.

The authors suggested that this might be the basis of a useful treatment for angina and CAD.

Mind–body therapies**Stress**

Stress can have a ‘double whammy’ effect in cardiovascular health. First, it can impact the body directly – for example, the chronic overproduction of stress hormones, such as adrenaline and cortisol, negatively affect the cardiovascular system. Second, stress can indirectly contribute to poor cardiovascular health when people respond to it with unhealthy behaviour, such as poor diet, lack of exercise, smoking and excessive alcohol.

Physiological effects

Stress affects the cardiovascular system in a number of ways. It speeds up the heart rate, raises blood pressure and increases the tendency for blood clots to form. Blood vessels throughout the body become narrow and the arteries that supply blood to the heart muscle constrict. As blood flow becomes more turbulent it can injure the lining of the arteries and, over time, lead to blockage of the arteries as the body attempts to heal these injuries.

Hostility and anger

Numerous studies have demonstrated a strong link between higher levels of hostility and anger and heart disease. In one of the most famous studies, physicians who scored high in a measure of hostility at the age of 25 were seven times more likely to have died from heart disease (as well as from other causes) 25 years later than physicians who had a calmer disposition.

People who express higher levels of hostility are also more likely to engage in unhealthy lifestyle behaviours, such as smoking, drinking alcohol and eating a diet that is high in fatty acids. In a 1983 study, Finnish men with the highest levels of expressed anger were found to be at twice the risk of having a stroke during eight years of follow-up.

Research published in 1996 examined a sample of 1,305 men who did not have coronary artery disease at the beginning of the study. Among these men, those reporting the highest levels of anger were three times as likely to experience either a non-fatal heart attack or fatal heart disease at follow-up seven years later.

Anxiety and depression

Studies have also demonstrated a link between both anxiety and depression (including hopelessness) and cardiovascular disease. For example, several large-scale,

community based studies have shown significant relationships between anxiety disorders and deaths from heart disease. Other studies have shown the relationship between both anxiety disorders and worry and coronary artery disease.

Overall, the clinical and research literature suggests that symptoms of depression represent a significant risk factor for developing cardiovascular disease. For example, a study of 1,190 medical students found that the incidence of clinical depression was a risk factor for coronary artery disease later in life.

The management of stress

In many respects anxiety, hostility–anger, depression–hopelessness can be viewed as the emotional and behavioural consequences of stress, or what happens when people perceive that they do not have the internal or external resources to meet the demands or challenges of life.

Experiencing occasional feelings of anger, worry and sadness is normal. However, when these mood states become more frequent or even chronic, it is a clue that normal life stresses and challenges are no longer being managed effectively. Not everyone who is clinically ‘stressed’ reacts this way: the tendency to do so may be genetically determined.

The chronic activation of the stress response can not only wear away at the quality of mental and emotional health and wellbeing, it can also have a significantly negative effect on the quality of physical health and wellbeing, especially cardiovascular health. Given the clear link between stress and cardiovascular health, it is not surprising that clinical research shows that stress management techniques, such as relaxation can be effective in treating and preventing coronary artery disease.

One of the best examples of this comes from a study, published in 2002, by Professor James Blumenthal and his team of researchers at Duke University in north Carolina. They conducted a trial in which individuals with documented coronary artery disease followed an exercise programme, a stress-management programme or the usual medical treatment for five years. Those who

were trained in stress management, which included instruction in a variety of relaxation techniques and stress-coping strategies, were significantly less likely to have a recurrent coronary event, such as a heart attack, at the five-year follow-up.

If you have coronary artery disease, ask your doctor about a stress-management programme or take up meditation or guided imagery.

The Ornish approach

The Lifestyle Heart Trial was initially published in 1990 and updated in 1998. It follows the approach devised by American doctor Dean Ornish in the 1980s and entails a low fat diet, combined with a programme of stopping smoking, aerobic exercise, stress management training and psychological support.

The Ornish approach is a good example of the benefits of integrating mind–body therapies with nutritional changes. Patients exercise for an hour three times a week, participate in group therapy sessions and learn to manage their stress with techniques adapted from yoga and meditation. They also follow a rigorous high-fibre diet that provides the following calorie breakdown: 10 per cent comes from fat, 15–20 per cent from protein and 70–75 per cent from complex carbohydrates.

Research suggests that the Ornish approach can reverse and prevent coronary artery disease without the need for either drugs or surgery. These findings have been replicated at many different places throughout the US since 1983. The longer the regime is maintained, the more heart scans show that the atherosclerosis continues to reverse.

Prevention plan

The following measures should reduce your risk of developing coronary artery disease.

- Eat a diet that is high in vegetables, fruit and oily fish, and low in salt and saturated fat.
- Take regular exercise, such as brisk walking or cycling, for 30 minutes on five or more days of the week.
- If you smoke, give it up.

Back issues of JHH

Back issues of the *Journal of Holistic Healthcare* include themed issues on nursing, education, spirituality, mental health and resilience. Other issues contain a range of interesting papers.

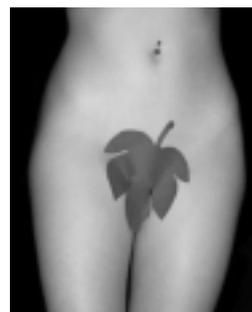
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William House

GP



Toxic assets

Some poisons look good, taste good and seem to do you good. There's even something about the human that likes to play with poisons. Tasting the forbidden can be exciting and beguiling as any reader of the Old Testament or John Milton knows. The forbidden fruit is so good! We pick another fruit, and another. Some of us gorge ourselves and come to rely on them. We are faced either with painful withdrawal or carrying on and hoping for the best, in which case the problems come later, often much later.

The shape of those problems depends on the poison. In the case of sub-prime mortgages the first trouble most of us in the UK saw were queues outside Northern Rock branches. But long before that the toxicity of sub-prime mortgages was known: they are loans to poor people with no prospect of paying them off and little chance of meeting interest payments – 'non-performing loans' in the jargon. The bankers' response was to create financial rescue packages containing 'assets' with varying degrees of toxicity that looked good and seemed to do the business – keep people lending and borrowing. They were too complicated for even some of the bankers to understand but that didn't seem to matter so long as the bankers stayed rich and the poor went on

consuming the poisonous fruit – that is, getting into debt.

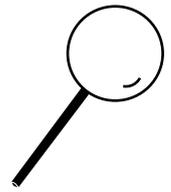
What about health? There are close parallels. The chief poisonous fruits here are cigarettes, alcohol, fast food and sedentary living. They are all killers and we know it. They are consumed much more by poor people who, partly because of this, die young. The medical response has been to create medical rescue packages containing mixtures of toxic substances – cocktails of pills – that look good and seem to do the business – keep people consuming the poisonous fruits of our society. They are too complicated for even some doctors to understand, but that doesn't seem to matter so long as the tobacco, food, alcohol, pharmaceutical and medical industries remain rich, and the poor go on consuming their products.

So we follow our human desire to taste the forbidden and apply ingenious fig leaves to camouflage our destructive behaviour. The banking version of this has already collapsed: the fig leaf fell off. The medical fig leaf of pills is slipping. It is not real health any more than the banking version was real wealth: the NHS is bursting at the seams and cannot be afforded and more people are being damaged directly by complex packages of pills. Furthermore, the suffering that pills don't help, like most mental illness,

is starting to dominate medical practice. Worse still are the grotesque inequalities. Those at the bottom of the pile not only consume more poisonous fruit but don't even bother with the fig leaf of pills. Then we see the true horror of what lies beneath: the shameful WHO world record for disparity of life expectancy is held by Glasgow where the lives of people on the poor side are on average 28 years shorter than those on the rich side. This is the health equivalent of queues outside Northern Rock.

The underlying problems are hedonism and greed leading to gross income and health inequalities. In the words of Francis Bacon 400 years ago: 'Money is like muck. It is not good, lest it be spread'. If this seems moralist and preachy then maybe that's a measure of how utilitarian our society has become. But like our attraction to risk, vices such as greed, lust and gluttony are part of the human condition: they have survival value. We have been powering our society with these basic drives. Now we must start to temper them with their virtuous counterparts or it won't be our survival they ensure, it will be our demise: if not through economic collapse or the poverty-stricken underclass, then through the shadow that is cast over all of this: the destruction of our ecosystem.

Research Summaries



The research page is compiled with the help of Greenfiles (www.greenfilesjournal.com) and James Hawkins.

Beware breast enlargement

Women interested in breast augmentation who have a history of psychopathology or are suspected by the plastic surgeon of having some form of psychopathology should undergo a mental health consultation before surgery, suggests this research.

It evaluated the unexpected relationship between cosmetic breast implants and suicide that has been found in six epidemiological investigations completed in the last several years. Across the six studies, the suicide rate of women who received cosmetic breast implants is approximately twice the expected rate based on estimates of the general population.

Sarwer DB et al. *Am J Psychiatry* 2007; 164(7): 1006-13

Winter of discontent

The lack of sunlight last summer could have a knock-on effect throughout the winter months and beyond. Scientists are warning of various forms of ill-health due to vitamin D deficiency and a high incidence of flu and colds. This is coupled with a warning of an epidemic of seasonal affective disorder (SAD) due to our poor summer weather. Those already prone to SAD are said to be more vulnerable. Vitamin D has been found to reduce the risk of dying from all causes including cancer, heart disease and diabetes. It also protects against viral infections. 90% of the body's vitamin D is generated by the action of sunlight on the skin and while sunscreens are necessary to prevent skin damage, the irony is that this is blamed for causing a deficiency in 60% of the British adult population. Obese people are more likely to be deficient also.

Meanwhile researchers have found vitamin D3 levels affect the healing of a skin wound. Wounds need D3 to protect against infections and begin the repair process. Lower levels correlate to increased susceptibility to infection.

Philippe Autier, Sara Gandini, *Arch Intern Med.* 2007;167
Amer. J. Clin. Nutrition March 2007
CAM March 2007

Epileptics deficient in vitamin D...

Almost every week a new piece of research finds out something else about the importance of vitamin D to our health. Now researchers have discovered that nearly half of all epileptics are deficient in vitamin D, which also increases their risk of osteoporosis, auto-immune disease, cancer, and heart disease.

Around one-third of the general population is vitamin D deficient, but researchers fear the problem is worsened in epileptics by the anti-epileptic drugs they are given. The lifestyle of epileptics could also make their deficiency worse as they may go outdoors less frequently and thus get less sunshine.

American Epilepsy Society 61st annual meeting: November 30–December 4, 2007

...need the world's most effective sun cream

Researchers believe they may have discovered the ultimate sunblock – an extract of broccoli sprouts.

The key is a chemical in the broccoli called sulforaphane, which helps boost protective enzymes in the skin that defend against UV (ultraviolet) radiation. As such, it doesn't act as a sunblock as the rays still enter the skin's cells, but it does protect against the sun's damaging effects.

Six volunteers reported a nearly 40% reduction in erythema, the reddening of the skin that is one of the early tell-tale sign of damage after we've been out in the sun. It also reduced inflammation even several days after the participants stopped applying the lotion.

Journal of the American Medical Association 2007; 298

Good news for kids

There are those among us who think tomato ketchup has only a tenuous link to its constituent parts, as it tastes nothing like tomatoes, and is best left to the kids. Good news, however, for those who love it. It is good source of the powerful antioxidant lycopene, which is more easily absorbed from cooked than from raw tomatoes. Tomatoes (and their processed products) are recommended for contributing to a lower risk of prostate cancer and cancers of the digestive tract.

Positive Health, July 2008; 11–27

There is no alternative

If you want to use garlic to help lower your cholesterol, you need to eat the real thing. A trial of raw garlic, a brand of garlic powder supplement known to have 'similar allicin bioavailability' as raw garlic, and the aged garlic extract kyolic found that none of the garlic products has a statistically detectable or clinically relevant effect.

Gardner CD et al. *Arch. Int. Med* 2007; 167

Stick to sugar

Latest evidence on artificial sweeteners shows that as well as being associated with various health problems, they actually make you fat. Researchers have discovered that low calorie sweeteners can increase the desire for sweet foods and disrupt the brain's ability to assess the calories we are consuming, thus leading to over-consumption.

Neuroimage 2008; 39

Reviews

I welcome readers' contributions. If you're reading something you want to share, please let me know. You can also contact me if you think there is something – book, DVD, CD, video – that we should be reviewing.

Richard James, Reviews Editor (richard@integrativehealthcare.co.uk)



Shadows in Wonderland – a hospital odyssey

Colin Ludlow

Hammersmith Press, 2008

ISBN: 978 1 90514 020 6

£9.99



Shadows in Wonderland is a rare gem: an honest and eloquent account of one patient's difficult journey through serious illness in a large London teaching hospital. To any reader who has worked in one of these, or indeed any large hospital, his experiences will be depressingly familiar. But this is not a depressing story, for shining through his account is his resilience of spirit in the face of near death, and his determination to find meaning in the complex, contradictory and often alien world of the hospital.

Not long after his wife was diagnosed and treated for cancer of the bowel, he was found to have the same condition. His expected 12-day admission for surgery turned into a five month 'odyssey' in which he faced a series of life-threatening complications. For those of us trying to help the NHS to improve there are two reasons why this book is particularly compelling. Firstly, the sheer length and complexity of his illness gave him an unusually broad exposure to the workings of a large hospital. Secondly, it is valuable for the insights he brings from his own experience and expertise as a TV producer – a creative artist. Of course, hospital dramas seem to be compulsive viewing on TV and hence moneyspinners for broadcasters but his personal experience reveals that:

The hospital we don't see – and therefore don't carry with us as part of our expectations – is the chaotic Babel, the stifling prison where hope is bled dry, the shadow world of nightmare, the terrifying Wonderland where miraculous cures can all too readily turn into the ashes of long-term suffering and despair. It is a significant – and in many ways a dangerous – omission.

He transcends the limited view of TV drama and shows how a wide knowledge of the literary and dramatic arts can be valuable for the understanding of illness and healing. He draws parallels between Prague Castle (inspiration for Franz Kafka's novel, *The Castle*) and The Royal Free Hospital in which his personal drama took place.

Both are monumental, oppressive, intrusive and hard to escape.

He goes on to develop the idea of shadow through Shakespeare and Carl Jung and to compare the prison and the hospital through many references to literature and drama.

In a chapter on fear, he attests to the power of touch and the confused approach to this in the NHS. He explores the

importance of place through insights from French anthropologist, Marc Augé, and others. He thus parallels the presentations at the BHMA conferences in November 2007 and spring 2008. He provides eloquent confirmation of BHMA core principles. He wants the hospital to be a place of healing, and that '...if there is one attribute the NHS seems to lack, it is wholeness'.

This book is in effect a single case study, an auto-ethnography, an eloquent, closely observed and devastating critique of modern hospitals. It is most powerful when he is reporting and reflecting on his own experience. Here and there he crosses into speculation with some loss of authenticity. However, within its particularity lay the seeds of the universal, recognisable by anyone who has spent time in a large hospital. It should be required reading for all hospital staff, managers and healthcare commissioners.

William House, GP

See page 5 for an extract from *Shadows in Wonderland – a hospital odyssey*.

Lifting your spirits: seven tools for coping with illness

Jan Alcoe

Janki Foundation, 2008

ISBN: 978 0 95483 861 4

£15.50



This lovely little resource pack of booklet and 2 CDs will be very useful to anyone new to the ways of holistic healing and needing a bit of uplift – whether or not they have a serious illness. As the title suggests, it is intended for those who are coping with illness and it is grounded in the author's own experience of doing so.

The booklet is beautifully illustrated (with paintings by Lou Beckerman) and has seven short sections, introducing the 'tools' of meditation, visualisation, appreciation, creativity, listening, play and reflection. Each one has introductory notes, likely benefits, suggestions for positive thoughts, reflections from previous users, and suggestions for practising. The latter include links to tracks on the CDs, as appropriate. There are a couple of poems and songs, but most of the tracks are guided meditative exercises, presented by a team of experienced voices mellifluous and well-paced. They are generally very short and so should be accessible even for those whose ability to concentrate is limited. There is also a longer exercise to allow a deeper experience.

I found a few cavils. On quite a few of the pages the text is printed over swirly designs, so my eyes find it really difficult to

read. On the CD, some of the tracks run into each other; this confused my CD player, which sometimes started a track half way through a sentence. It also meant that I was brought back with a start, as the next track started before I was ready to get up and switch off. A longer gap, and perhaps announcements of the end of each exercise, would be useful. But these are minor technical points and I guess neither of these would be a problem if I copied the tracks onto a programmable MP3 player.

Overall, I would recommend this toolbox to anyone struggling with ill health, and their carers. Practitioners will also want to make it available for their patients.

Richard James, acupuncturist, psychotherapist, doctor and educator

7 Minutes to natural pain release: tapping your pain away with WHEE, the revolutionary new self-healing method

Daniel J. Benor

Energy Psychology Press, 2008

ISBN: 978 1 60415 034 6



£17.00

This book presents an interesting view on pain and its manifestation in our lives. Dr Benor gives many conventional causes of pain, how we perceive and rationalise them, then details ways in which we can control and remove such pain, physical and emotional. He covers the holistic spectrum of mind, body and spirit; how we cope with pain, in later chapters why we may even need pain, and throughout the book he gives many interesting case studies.

Dr Benor is a psychiatrist and psychotherapist but after becoming disenchanted with the medical approach ('give the patient medication') he searched to find a better way. He has obviously studied widely, the results of which he has attempted to get into this book. If the reader lacks information on the topics he covers, the suggested reading and glossary may be necessary, as much basic knowledge of energy psychology therapies is assumed.

Using meridian energy therapies as a base to provide an all-encompassing 'new therapy' he uses EFT (Emotional Freedom Techniques) and EMDR (Eye Movement Desensitisation and Reprocessing) with a good handful of other therapies including kinesiology (muscle testing) and TA (Transactional Analysis) amongst others. He tells us: 'In EFT and related therapies one taps or presses a finger at a series of acupressure points on the face, chest, and hand, while reciting an affirmation. Similar to EMDR in its effects, the negative feelings are released as one repeats this process'. The basis of WHEE, then, is a compilation of tapping and/or movements on the left and right of the body while uncovering the emotional attachments to the pain or anxieties being worked on, all the time being aware of changes in the client.

By chapter 3, Dr Benor gets to the meat of the WHEE therapy. I found this lacking in real detail and without my knowledge of EFT and other therapies I would have had difficulties in understanding it. Diagrams and details of the procedures may have helped at this point.

He notes that a client's core beliefs and values are an integral part of all 'psychology type' therapies and he talks about the use of imagery and dreams and how visualisation, used extensively in EFT, can be of benefit in the execution of WHEE. His use of muscle testing for dealing with resistances is a great idea and one that anyone can quickly learn. His comment (page 111) about therapists' inner blocks 'that can inadvertently reduce their ability to let clients tackle their blocks' was well put. It is all too easy to think that we are not connected to the client and that our issues do not spill over into the client's issues. This led on to the need for therapists to have some form of mentoring or supervision, which thankfully is common in the EFT practitioner's world.

The reasons why one may wish to keep pain were well observed; we do need to be aware of a client's emotional attachment to pain and the secondary gains that may make it impossible for us, as therapists, to treat them successfully.

Diane Holliday, EFT and natural health practitioner

Healing the Gerson way: defeating cancer and other chronic diseases

Charlotte Gerson and Beata Bishop

Totality Books, 2007

ISBN: 978 0 9760 860 5

£18



This is an excellent and timely reminder of how excess and/or depletion adversely affects the body, and the amazing healing resources the human being has if given the correct environment. Beata Bishop is able to use her first-hand experience of living with the Gerson protocol to help the reader fully understand the principles behind the treatment, and then she details the steps involved in implementing it. She makes no apology for the intensity and breadth of the Gerson plan as she knows the impact of having a diagnosis of cancer, and the devastation that can ensue. This account of a treatment that brings a patient literally from the brink of death to recovery from terminal conditions simply through rigorous attention to diet, routine, and detoxification is an inspiration. Many case histories included in the text testify to the efficacy of this approach not just in treating cancer, but also in a wide range of conditions.

The treatment is onerous as 20 pounds of fresh fruit and vegetable have to be prepared each day for juicing and cooking. Regular coffee enemas also need to be administered, and by the time this protocol is employed the patient is often very sick so a full-time carer is usually employed.

Radical it is, yet it is the perfect antidote to the modern 'quick fix and party on' attitude that many people have towards the treatment of ill health. This is timely because there is a growing acceptance that our diet and environment are now so far removed from that which is sustainable in the longer term, both for our internal and the external environment in which we live.

I was reminded of the power of tackling toxicity and malnourishment. This takes a lot of time and consideration, and if anyone needs reminding of why it is worth investing in that journey through healing, then give them this book to read.

Sarah Frazer, nutritional therapist

Guidelines for Contributors

About the journal

The *Journal of Holistic Healthcare* is a UK-based journal focusing on evidence-based holistic practice and the practical implications of holistic health and social care. Our target audience is everyone concerned with developing integrated, humane healthcare services. Our aim is to be useful to anyone who is interested in creative change in the way we think about health, and the way healthcare is practised and organised.

Our basic assumption is that holism can improve healthcare outcomes and will often point to cost-effective ways of improving health. Holistic healthcare can be understood as a response to our turbulent times, and medicine's crisis of vision and values; an evolutionary impulse driving individuals and organisation to innovate. But when complex and creative adaptations do occur, these ideas, experiences and social inventions don't always take root. Though they might be the butterfly wingbeats that could fan the winds of change, even crucial seeds of change may fail to germinate when isolated, unnoticed and lacking the oxygen of publicity or vital political support. Some of these ideas and social inventions have to be rediscovered or reinvented, and thrive once the culture becomes more receptive – or more desperate for solutions.

The *JHH* sees holism as one such idea, a nest of notions whose time has come. So we want the journal to be a channel for publishing ideas and experiences that don't fit easily into more conventional mainstream journals, because by making them visible, their energy for change becomes available to the system.

The journal's themes include the theory and practice of mind-body medicine; every aspect of whole person care – but especially examples of it in the NHS; patients' participation in their own healing; inter-professional care and education; integration of CAM and other promising new approaches into mainstream medicine; health worker wellbeing; creating and sustaining good health – at every level from the genome to the ozone layer; environment health and the health politics of the environment; diversity and creativity in healthcare delivery, as well as holistic development in organisations and their management: a necessarily broad remit!

Writing for the journal

We intend the journal to be intensely practical; displaying not only research, but also stories about holism in action. Personal viewpoint and theoretical articles are welcome too, providing they can be illuminated by examples of their application. The *Journal of Holistic Healthcare* is a vehicle for injecting

inspiration into the system: ideas and research that might enable positive change. We realise that there is nothing as practical as a good theory, and we encourage authors to foreground what they have done and their experiences, as well as what they know. Though we don't always need or want extensive references, we ask authors to refer to research and writing that supports, debates or contextualises the work they are describing, wherever appropriate. We like further reading and website URLs wherever possible. And we like authors to suggest images, photos, quotes, poems, illustrations or cartoons that enrich what they have written about.

Because the *JHH* aims to include both authors' ideas and their experience we invite authors to submit case studies and examples of successful holistic practice and services, research findings providing evidence for effective holistic practice, debate about new methodologies and commentaries on holistic policy and service developments. Our aim is to be a source of high-quality information about all aspects of holistic practice for anyone interested in holistic health, including policy-makers, practitioners and 'the public'. We aim to link theory to practice and to be a forum for sharing experiences and the insights of reflective practice.

Articles should be accessible and readable, but also challenging. Key articles will link theory and research to practice and policy development. Contributions from the whole spectrum of healthcare disciplines are welcome.

The journal is particularly concerned to highlight ways of embedding holistic thinking and practice into health care structures, including primary care organisations, networks and collaborative initiatives.

Original research

JHH is a platform for holistic ideas, authentic experiences, and original research. We estimate our regular (and growing) circulation of 700 copies is read by as many as 2000. And, though we don't yet attract researchers seeking RAE points, we are free to be a voice for the kind of ideas, reports, experiences and social inventions that wouldn't fit easily into more conventional mainstream journals: small studies, pilots, local reports, surveys and audits, accounts of action research, narratives, dissertation findings (otherwise hidden in the grey literature), pragmatic and qualitative studies and practice evaluations. By publishing them in the *JHH*, important seeds for change become available to people who need to grow them on. Another advantage of submitting to *JHH* is the peer feedback to authors, some of which we may include as commentaries on a published paper.

Advisory Board

Jan Alcoe
Consultant and Trainer

David Aldridge
Chair of Qualitative Research in Medicine, University of Witten Herdecke, Germany; Fellow of the Royal Society of Medicine

Michael Dixon
GP

Sarah Egger
Consultant Old Age Psychiatrist, Honorary Senior Lecturer, Imperial College School of Medicine, London

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Acupuncturist, psychotherapist, doctor and educator

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Clinical lead in complementary therapies, Christie Hospital; University Reader in Integrated Health, Derby University

Sue Morrison
Associate Director (CPD), London Deanery GP Department

David Peters (Editor-in-chief)
Doctor and Osteopath; Professor of Integrated Healthcare, University of Westminster; Chair of BHMA

David Reilly
Consultant Physician, Centre for Integrative Care, Glasgow Homoeopathic Hospital

Paul Thomas
GP; Professor of Research, Training and Education for Primary Care, Thames Valley University

Mike Waldron
Managing Director, inter-pares associates ltd

British Holistic Medical Association

PO Box 371
Bridgwater
Somerset TA6 9BG
Tel: 01278 722000
Email: admin@bhma.org
www.bhma.org

