

WHOLE PERSON MEDICINE:
A CO-OPERATIVE INQUIRY

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INTRODUCTION

This is an account of a one year innovative research programme into the principles and practice of holistic medicine involving sixteen doctors, two research facilitators, and a research secretary; it took place from the Summer of 1982 to the Summer of 1983. The innovation is co-operative inquiry, which breaks down the distinction between researcher and subject so that all those involved are at different times both researcher and as subject.

In accordance with the principles of co-operative inquiry, this account of our procedures and outcomes is co-authored by several members of the inquiry group, and circulated to all the other members for their editorial comment and modification. Actual authorship is as follows.

John Heron and Peter Reason took the roles of executive editors in co-ordinating different contributions and putting the book into final shape. They wrote An introduction to co-operative inquiry, Wide range of interventions, and An assessment of validity of the inquiry; and also edited and contributed to Overview of the inquiry project, The five part model of holistic medicine, Spirit, The patient as self-healing agent, and The Doctor as self-gardening. Paul Hodgkin wrote Power-sharing and Context and constraints. Roger Green wrote part of The five part model and parts of Spirit. Russell Keeley provided much of the material for The patient as self-healing agent. Paul Foster edited Personal accounts. Frederique Bentley wrote a first version of the Overview.

Peter Reason and John Heron provided the original outline for the book, which was discussed and amended during the latter part of the actual project. Decisions were taken about who would write what, and an editorial group was appointed to monitor the whole process. Over the period of writing there was a series of meetings to which all members were invited, at which progress was reviewed and contributions commented upon. As deadlines were postponed, changes were made both to authorship of chapters, and in the editorial role.

We present this book with the belief that it is a primitive and modest beginning to a journey along a most promising road. For a group of doctors to take on board what for them was an entirely new way of doing research; to apply it at the frontiers of medical practice in the NHS; to relate broad holistic notions to actual and feasible practice; all this was a major challenge. Therefore we make no claim to provide all the answers to the theory and practice of holistic medicine. At most we claim to make one or two pointers about such theory and

practice; pointers which, however, are well grounded in a searching inquiry through action.

While acknowledging the limitations of our inquiry, we hope that it will provide an inspiration and a challenge to both medical practitioners and researchers. Our experience tells us that it is possible to apply holistic principles to medical practice within the NHS; it is possible to share power with patients in a variety of ways; it is possible to affirm the reality of the spiritual life of patients and how this effects their well-being; it is possible for doctors to pay attention to their own personal development, and to share both their vulnerabilities and their secret aspirations with colleagues and patients.

And we hope also to inspire those interested in medical and social research. Again, it is possible to inquire systematically and rigorously into a complex field of human action and do justice to its wholeness without distorting or fragmenting it; it is possible to link inquiry and action in fruitful and illuminating ways; it is possible to co-opt busy practitioners into committed inquiry into their own professional and personal processes; it is possible for co-researchers to descend together into the confusion of chaos and order that is real life without the protective clothing of questionnaires, experimental designs, and other forms of defensive armour, and emerge with worthwhile understandings.

If you want to get at the core of what we were about, we suggest you read first the Overview of the inquiry project, The five part model, and the chapters which discuss aspects of that model: Power-sharing, Spirit, Wide range of interventions, Patient as self-healing agent, and Doctor as self-gardening.

If you want to go deeper into the nature and rationale of co-operative inquiry, the research method used, read the chapters on an introduction to co-operative inquiry and on validity. (Those not used to philosophical and methodological discussion may find these chapters heavy going).

Of course we believe that the book stands together as whole, and our preference is that you read all of it, whatever route round its parts you take.

We would like to thank the British Postgraduate Medical Federation, and its Director, Mr David Innes Williams, first for sponsoring a highly innovative undertaking; and second for subsidising the project with respect to printing, postage and secretarial support.

We owe a particular debt to Elva Macklin, secretary and administrator within the Education Department of the BPMF,

for all her work in keeping record of the group meetings, and circulating to all members minutes, reports, and the endless stream of documents which this inquiry produced.

We would like to thank our visitors - Dr Peter Mansfield, Dr Murray Korngold, Dr Alec Forbes, Dr Fritjof Capra, and Drs Elmer and Alyce Green - those holistic "luminaries" who found, in Murray Korngold's words, that they had to come "stark naked and fast on their feet" to our inquiry. We are grateful for their contributions and for adapting in their own ways to our norms and ways of working.

We are also grateful to those outside the project who read and commented on early drafts of the manuscript, whose comments have enabled us to improve our presentation to a wider world.

Critique of Orthodox Inquiry

For holistic medicine we are looking for a science capable of studying persons as wholes. One of the difficulties of talking about this kind of science is that in our culture both science and inquiry have been captured - they are almost synonymous with - an orthodox world view. This view is based on a Cartesian split between mind and body, and on mechanical and bio-chemical models of the world and of the body. So when we think about research, we tend immediately to think about dependent and independent variables, about measurements and statistical reliability, about experimental and control groups and so on. We immediately think in ways that are analytic and reductionist rather than holistic; we think about the parts and how they impact on each other, rather than the primacy of the whole.

For example, it is far too readily assumed in medicine that the rigorously controlled clinical double-blind cross-over trial is the only really valid basis for scientific inquiry. Certainly this is seen as an ideal. We argue that this method is a quite invalid approach to the study of persons as wholes, because it fails to take into account that persons are self-directing and can become intentionally self-healing. The random and blind assignment of persons to treatment group and control group, which is the fundamental basis of this inquiry method, is seriously at odds with these human potentials and fails to treat people holistically. More than this, a medical practice (or any other professional practice, medicine is not alone in this) which bases its knowledge on this kind of inquiry will inevitably create a culture of alienation. Such a culture will alienate the patient from what is going on in her or his body and from decisions about treatment. It will encourage and sustain the Cartesian split, so that doctors and patients see bodies as clearly cut off from the exercise of self-determination and the influence of mind. And it keeps the development of medical knowledge firmly in the hands of the practitioner-researchers and out of the hands of the patients to whom it is supposed to refer. So the research model, with its fragmented empiricism which is epistemologically unsound gives rise to a whole host of issues to do with persons rights and needs to participate in decisions about the well being of their bodies, minds and souls. This critique is developed more fully in Chapter Eleven; see also Heron (1985a).

If orthodox research represents a fragmented empiricism which is incapable of taking persons as wholes, what is the alternative? We need an alternative because when

people reject orthodox science and research there is a tendency to replace it with a narrow mystified and mystifying dogma. So we may have practices which are claimed to rest on some ancient secret wisdom, or an "intuition", and are thus declared unavailable to careful and critical investigation.

But this, ultimately, is what research is: it is creative thinking, and then careful thinking, and systematic checking of ideas and predictions against experience. We do not necessarily need the double-blind cross-over trial or the questionnaire survey or any other methodology to do this. These are only ways which may or may not help us think clearly and carefully. We can return directly to the self-directing person as the primary source of knowing, and thus the primary "instrument" of inquiry, in what we have described as experiential and co-operative inquiry. This means, research with people, not on people.

There is an extensive literature stating the critique of orthodox approaches to inquiry in the human sciences. The main points have been conveniently summarised by Reason and Rowan (1981):

Model of the person. People are seen as isolable from their normal social contexts, as units to be moved into research designs, manipulated, and moved out again. People are seen as alienated and self-contained, stripped of all that gives their action meaning, and in this way they are trivialized.

Positivism. The whole language of 'operational definitions', 'dependent and independent variables', and so forth is highly suspect. It assumes that people can be reduced to a set of variables which are somehow equivalent across persons and across situations, which doesn't make much sense to us.

Reductionism. Studying variables rather than persons or groups or communities is a flight from knowing human phenomena as wholes. It means that the person, group, community as such is never known.

Relification. Processes are continually turned into things. Test results are continually turned into things. People are continually turned into things. None of this is philosophically defensible, and a lot of it is morally indefensible too.

Quantophobia. There is too much measurement going on. Some things which are numerically precise are not true; and some things which are not numerical are true. Orthodox research produces results which are statistically significant but humanly insignificant; in human inquiry it is much better to be deeply interesting than accurately boring.

Testing. Intelligence tests and other tests of aptitude and personality are culturally biased and are used in unfair ways. There can be no fair tests within an unfair

society.

Deception. There is too much lying going on. Unnecessary withholding of information comes naturally to many orthodox researchers. There is an arrogance about this which does not commend itself. Research is a game which two or more can play.

Debriefing. There is an assumption that a bad experience can somehow be wiped out by a brief and superficial explanation. But experience cannot be removed in that way. We should not inflict harm on people in the first place; good research means never having to say you are sorry.

Contamination. Orthodox research tries to eliminate real life, but it cannot do so. Researchers give off all sorts of messages in all kinds of ways. They try to direct scenes on the research stage, but they are actually part of the play. The eye-blink reflex is natural, but measuring it is a social situation.

Sampling. Large messages are extracted from small samples. Broad generalizations are made from unrepresentative bases. Old paradigm research often breaks its own rules in this area, quite regularly and shamelessly.

Detachment. Researchers actually try to know as little as possible about the phenomenon under study - it might affect the results if they knew too much. This is exactly the opposite of an approach which could do justice to human action.

Conservatism. Because of its lack of interest in the real social context, old paradigm research continually gets co-opted by those who want to prop up those who run the existing system. It studies those at the bottom while holding up its hands for money to those at the top. Thus in fact it serves to keep those at the bottom right there, and those at the top there.

Bigness. Researchers in the old mode are continually asking for bigger and better instruments, bigger and better samples, bigger and better premises, bigger and better travelling expenses. This turns research into big business, and makes it more likely to be the servant of those who can afford to pay big money; it answers their questions.

Low utilization. It is often remarked that large organisations pay for more research than they need, and then use only a tiny proportion of it. Sometimes questions are put to confirm decisions which have already been made. Because the whole process is alienated, there are few connections and very little commitment, and the people who receive the report may indeed be very different from those who commissioned it.

Language. Research reports are written for the expert, and have heavy constraints on the way they have to be written up for journal publication. The effect is to mystify the public, hiding common sense notions actually being employed. Another effect is that conformity is rewarded more highly than creativity.

Pressures. Journal publication policies and funding

policies of grant-awarding bodies put severe pressure on for safe, respectable research. Fads come in from time to time and offer a band-waggon to climb upon. Researchers are continually short of time and funds, continually looking for projects which mean a minimum of disturbance to the even tenor of their ways. Research gets more and more specialized, less and less to do with anything real. Determinism. Old paradigm research holds to a determinist model, where the independent variable coerces the dependent variable into performing correctly. Belief in determinism leads to the setting up of coercive (master-slave) relations in the laboratory, where there is an alienated relationship between the experimenter and the subject.

Scientific fairy-tale. Textbooks which have a chapter on the scientific method have various ideas about what this includes, but all of them are equally dogmatic about the three or four points they mention. What they put forward, however, is a storybook image, which does not correspond with the way in which science is actually carried on. In real science there are norms and counternorms: for example, in real science it is often considered highly praiseworthy to be unwilling to change one's opinions in the light of the latest piece of evidence; lack of humility is highly valued; bias is freely acknowledged; there is a lot of interest in how discoveries might be applied; there is a great deal of emphasis on the importance of intuitive judgement. So the textbook versions falsify science, and dominate education.

Philosophical Bases for Inquiry

Given this critique of orthodox inquiry, we need to think clearly about a way of thinking about knowledge and knowing that are more adequate for a science of persons. We give here a brief outline of some of the main philosophical arguments to support this new mode of inquiry. For a fuller account see Heron (1981a).

1) Persons as self-determining. We regard persons as self-determining, that is, as the authors of their own actions - to some degree actually and to a greater degree potentially, and therefore argue that their self-determination must be included in any inquiry claiming to be about persons. I can only properly study who you are if your intentionality contributes to what you do in the inquiry, and this means you need to help plan the inquiry as co-researchers as well as being a subject within it. In co-operative inquiry all those involved both contribute to the thinking that generates, manages and draws conclusions from the research, and also engage in the experience and action that is to be researched. The self-determining nature of persons is also particularly significant in holistic medicine, where persons are seen as potentially self-healing agents - where this means not just that their bodies are self-healing, but that their minds can also influence that

physical self-healing (Pelletier, 1978).

2) Research presupposes self-determination. Research on the physical world has presupposed an explanatory model of absolute causal determinism: every event can in principle be explained in terms of a causal law which states that given the antecedent conditions that event is the only possible outcome. Research behaviour, (which is always of course human behaviour) itself necessarily requires a different model of explanation, because such behaviour involves the generation of new ideas which in principle cannot be explained in terms of causal laws and antecedent conditions. It is incoherent to suppose that brand new research ideas could be predicted by causal laws based on old research ideas. Innovative research behaviour can only be fully explained in terms of the notion of a self-determining person, an agent whose intelligence transcends the operation of causal laws in generating new and fruitful ideas.

In research on persons, in contrast to research on the material world, we need to acknowledge fully the self-determining agency of all those involved in the inquiry, both those who in orthodox terms would be called the "researcher" and also those who would be called the "subject". The researcher cannot coherently apply to his human subjects an explanatory model of absolute determinism from which his own behaviour is necessarily exempt.

3) The nature of knowledge. Knowledge is of at least three kinds. Experiential knowledge is through direct encounter face-to-face with persons, places or things; practical knowledge concerns "how to" do something, the knowledge demonstrated in a skill or competence; and theoretical or propositional knowledge, knowing that, is expressed in statements about people, places or things. In research on persons the propositional knowledge stated in the research conclusions needs to be the outcome of the experiential and practical knowledge of the subjects of the inquiry. If the propositions are exclusively generated by a researcher who is not involved in the experience being researched, and are imposed without consultation on the practical and experiential knowledge of the subjects, we have alienated findings which directly reflect neither the experience of the researcher nor of the subjects. So the findings hang in void. It also follows from this tri-partite nature of knowledge that the outcomes of inquiry are not only sets of propositions or theories about its subject matter, but are also the validated competences and experiences of those participating in it. This point is echoed by Torbert, who argues that the important thing is "not how to develop a reflective science about action, but how to develop genuinely well informed action - how to conduct an action science" (Torbert, 1981).

4) Intentionality and meaning. Persons give meaning to their world by construing it and acting within it in various ways.. This symbolising process necessarily transcends any attempt to explain it away in terms of other factors: the notion of giving meaning is prior to the notion of explanation. If you are going to research persons you must discover how they are symbolising their experience and what their purposes are in acting the way they do. Researchers cannot with accuracy or impunity give their own view of what the subjects are about. We can only inquire into persons' experiences and actions in the world if we involve them fully in the inquiry, and we can certainly only inquire into their meanings and intentions if we ask them directly what their meanings and intentions are.

Given these bases of knowledge in research, we must realise that we are reaching for a different kind of knowing than in orthodox science and inquiry, which are based on at least six presuppositions with which we take issue. (1) That there is one "reality". (2) That this one reality can be known objectively. So (3) that this knowledge is identical for all knowers. (4) Knowledge is expressed in propositions which are validated empirically, in the ideal form by carefully controlled experiment. (5) The whole may be explained in terms of the sum of the parts, and the aim of the inquiry is to discover more and more fundamental elements. (6) Explanation is sought in terms of linear, energetic cause and effect.

In contrast to this orthodox view, a new paradigm holds (1) that reality is both one and many, in the sense that we can only have knowledge of objective reality from many different subjective perspectives. Thus (2) knowledge is subjective-objective, always knowing from a perspective (Schwartz and Oglivy, 1979), and thus (3) we must speak in terms of many knowings, of epistemological heterogeneity. Reality is revealed in the way in which different perspectives in the inquiry area overlap. Such multiple knowings may (4) be in the form propositions (statements about the world); practical skills (ability to act intentionally within the world); experiences (knowledge through encounter); or expressions of knowing such as art, theatre and story telling (Reason and Hawkins, 1983). Knowing within this new paradigm is validated not simply through controlled experiment, but rather through critical, informed, and discriminating awareness and judgement of the inquirers. This approach to validity, which we have pioneered in our earlier inquiries, is explored in more detail in Chapter Eleven. Finally, (5) a new paradigm of inquiry will seek to understand and act in whole systems and whole situations as such, not fragmenting wholes into the simple sum of the parts, but understanding the parts in terms of their interaction within a whole (Bateson 1972, Diesing 1972). Arising from this systemic view, (6) explanation is sought in terms of mutual action and interaction within the total system, not

solely in terms of sequential cause and effect.

Methodology

We have argued above that you are only doing research on persons in the full and proper sense of the term if you research them as self-determining, which means that what they do and experience as part of the research needs to be to some significant degree determined by them. So research on persons necessarily becomes research with persons. The researcher needs to invite the experimental subjects to become co-inquirers whose thinking and decision-making will contribute to generating, designing, managing and drawing conclusions from the research.

The respective roles of the researcher and subject in the traditional research paradigm are brought out in the following table (Heron, 1981b).

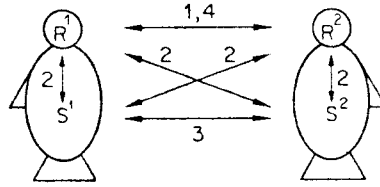
	Researcher	Subject
Contribution to research thinking and decision-making	Strong	Zero
Contribution to research action and experience	Zero	Strong

This model of authoritarian, unilateral control has its equivalents, of course, in traditional education, therapy, medicine and management. The new paradigm model of participatory, bilateral initiative and control, where self-determining persons are in co-operative relationship is shown in the following table.

	Researcher	Subject
Contribution to research thinking and decision-making	Strong	Strong
Contribution to research action and experience	Zero, Weak or Strong	Strong

New paradigm research has been called co-operative inquiry because of this full participation by subjects in the research thinking and decision-making, as well as in the research action and experience. For the same reason it has also been called participatory research.

Another way of representing co-operative inquiry is as follows:-



In this model, each person is involved as both researcher and as subject. Each is involved as co-researcher, contributing to the research propositions at all stages from working hypotheses to the research conclusions. And each is involved as co-subject, being fully involved in all stages of the research action. So there is full reciprocity, and each person's agency is fundamentally honoured in both the exchange of ideas and in the action.

Put very simply, because obviously the model is much more complex to apply than to describe, the four stages of the research are as follows:-

1) A group of co-researchers discuss some initial research propositions, and agree to some hypotheses about the topic under scrutiny: they may agree to look at and describe some aspect of their lives in detail; they may agree to try out certain actions in practice. And they also agree to some set of procedures by which they will observe and record their experience and each other's experience. Thus in this book we describe our inquiry as a group meeting to investigate the theory and practice of holistic medicine. Early on we developed a conceptual model of holistic medicine, a variety of strategies for applying this model in the surgery, together with ways of observing and recording the experienced results of this endeavour.

2) The group then applies these ideas and procedures as agreed: they get into action and observe and record the outcomes of their own and each other's behaviour. At this stage they need to be particularly alert for the subtleties and nuances of experience, and to ways in which the original hypothesis does and does not accord with experience. So our group applied diverse holistic strategies within the NHS, recorded this activity in various ways, each member writing a report on each full cycle of application for the next meeting of the group.

3) The co-researchers will in all probability become fully immersed in this activity and experience. At times they will be excited and carried away with it, and at times they will forget they are involved in an inquiry project. They may forget or otherwise omit to carry out or record the agreed procedures; or they may stumble on unexpected and unpredicted experiences, and develop new creative insights into the whole process. This stage of

full immersion is fundamental to the whole process: it is here that the co-researchers, fully engaged with their experience, may be open to what is going on for them and their environment, they may develop an openness which allows them to bracket off their prior beliefs and preconceptions and so see their experience in a new way. For example, some of our inquirers found that significant self-development and personal growth is fundamental to effective holistic practice (it is interesting to note that Torbert makes a similar point in his own collaborative inquiries (Torbert, 1981)); and this was not a hypothesis which all members took into the inquiry.

4) After an appropriate period engaged in stages 2 and 3, the co-researchers return to consider and discuss their original research propositions and hypotheses in the light of their experience, modifying, reformulating, and rejecting them, adopting new hypotheses, and so on. And they may also amend and develop their research procedures more fully to record their experience. This research is experiential because its empirical base is the experiential knowledge of persons in relation to their situation in their world, not an abstracted and separated set of propositions nor a set of formal observations. There can be no other base for researching the human condition from the standpoint of person as agent, which is essential for a holistic view.

This whole cycle of movement from reflection to action and back to reflection needs to be repeated several times so that ideas and discoveries tentatively reached in early cycles may be clarified, refined, deepened, and corrected. This "research cycling" clearly has an important bearing on validity and is discussed in more detail in Chapter Eleven.

Co-operative inquiry as we have briefly described it here overlaps with, but can be significantly distinguished from other methodologies such as action research, anthropological field study, participant observation, phenomenological inquiry, qualitative sociological research and inquiry based on clinical case studies. We see these methods as half-way houses, as often compromising with positivism, while our approach to co-operative inquiry more fully embraces the discriminating subjectivity and epistemological heterogeneity outlined above. John Rowan (1981) has demonstrated one way in which these different methods can be differentiated and compared.

Applications

In the medical field, we can see this paradigm of inquiry applied in three general ways. First of all, groups of practitioners can work together to inquire into the procedures of their practice and the principles and standards which inform them. Thus in the inquiry reported in

this book GPs were inquiring into holistic medical procedures and the assumptions and standards which inform them. This is similar to peer review audit of practitioners' process but with a formal element of inquiry interwoven with it. This inquiry into process can be developed into an inquiry into patient outcomes. In the medical field this necessarily involves co-opting patients as co-inquirers so that their view of outcomes can be integrated with the practitioners view. For example, patients being treated for lower back pain might be invited to join with doctors in assessing criteria for effective outcomes and the degree to which these outcomes are attained.

Second, a more complete version of a co-operative inquiry involving doctor and patients would be one in which practitioner and patient, each from their respective standpoint, contribute to the diagnosis, the design and implementation of treatment, as well as to the criteria for assessment of outcomes. The relationship between Cousins and his practitioner (Cousins, 1977) certainly pointed in this direction. A group of cancer patients adopting new approaches to cancer therapy could simply be directed by a enlightened specialist, or more radically could join with the specialist in contributing to all phases and aspects of the therapy, as conscious and intentional inquirers and self-healers. In this example it is implied that patient process and outcome, is the primary focus of the inquiry. However, it could also be the case that practitioner process and outcome in terms of knowledge, experience and skill, personal development, or even personal pathology could also be included.

A third application within medicine is, of course, co-operative inquiry involving patients only to the exclusion of any professional practitioners who are not themselves patients. This form of inquiry equivalent to a medical self-help group with the important addition of an explicit inquiry dimension. Some feminist self-help groups in the medical field come close to this model, although the inquiry dimension is still relatively tacit and informal. This approach has enormous potential for the liberation of people and their knowledge from the oppression of professionalism.

Beyond medicine, the range of application of co-operative inquiry is unlimited. To date, such inquiries have been conducted into violence in prisons (Maruyama, 1981); into urban educational desegregation (Torbert, 1981); into the development of rural life in Tanzania and India (Swantz, 1981; Tandon, 1981); into the application of new technology in business (Eldon, 1981); into the theory and practice of co-counselling (Heron and Reason, 1981, 1982). Forays have also been made into altered states of consciousness groups (Heron, 1984); religious experience; educational practice, assessment and accreditation; group process (Randall and Southgate, 1980); learning in staff team (Hawkins, 1985).

CHAPTER TWO: OVERVIEW OF THE INQUIRY PROJECT

Origins. John Heron, Assistant Director of the BPFM, in charge of its Education Department, had since 1977 run an annual programme of workshops focussing on communication, interpersonal skills and educational, philosophical and personal development for doctors. He considered that this innovative programme had by early 1982 reached a point at which it was appropriate to explore the direct overlap between education and medicine - where the practitioner in the surgery has an educative role. In November 1981, there had been the first official encounter of a co-operative kind involving dialogue between conventional medicine and various practitioners of complementary medicine at a large Conference sponsored by the BPFM, and at the same time significant numbers of medical practitioners were concerned to relate conventional medicine to the principles of holism.

His first thought was of a one year course in medical education, where holism would be introduced among other things in terms of the doctor as educator of the patient as a whole person. It was at this point that he invited Peter Reason as co-facilitator. Peter's background was in organisational behaviour and organisation and human development. He has been closely involved in the development of the "new paradigm" of co-operative and experiential inquiry, having recently edited Human Inquiry (1981) with John Rowan. He has also initiated with John Heron two co-operative inquiry projects into co-counselling (Heron and Reason 1981 & 1982). After initial discussions John proposed that rather than set up an educational course with a subsidiary element of co-operative inquiry, the whole project should be re-construed as one major co-operative inquiry into the theory and practice of holistic medicine with John and Peter as the initiating researchers and facilitators.

It was a basic assumption of the inquiry that there was no really adequate form of holistic medicine in existence. Complementary practitioners often laid claim to a holism that was unjustified, partly because of their lack of competence in psychological and personal growth techniques, more obviously because of their lack of a certain range of conventional medical skills. Similarly conventional practitioners also have a limited if different range of interventions which equally made their claim to holism an aspiration rather than a reality.

Both John and Peter had for some years been pioneers in developing the theory and practice of co-operative inquiry, and considered that it was in itself a form of holism in action, particularly suited to research the nature of holistic medicine.

Recruitment and briefing. A recruitment brochure briefly stating the focus of the inquiry, and outlining its method and design, and possible issues to be explored, was sent to 7,500 General Practitioners in the four Thames Health Regions including Greater London. Copies were also sent to a number of doctors all over the UK who were on the mailing list of the BPF Education Department. An initial meeting for those interested was held at the BPF in the Spring of 1982. At this meeting there were some 34 GPs, who were briefed more thoroughly about the method of inquiry, and the possible structure of its programme. An important part of this meeting was evolving criteria of selection for entry to the project which were:

1. Medical degree. This requirement came from within the BPF, whose Director considered that in the first instance such a radical programme should be exclusively for doctors.
2. Some degree of acquaintance with some complementary medicines, including both physical and/or psychological approaches.
3. Some degree of personal growth and emotional competence: ability and willingness to look at emotional and interpersonal issues that might be stirred up within the group by the inquiry process.
4. Access to patients.
5. Commitment to the enterprise in terms of time and energy.
6. Balance of the sexes.

It was agreed that applicants would assess their own suitability to enter the project in the light of these criteria. At this first meeting the time structure and dates of the programme were also agreed, and the date for the first formal meeting of the inquiry group was set for the Summer of 1982.

This meeting was attended by those who in the interval since the first briefing meeting had sent in a written commitment to join the project. The meeting was to prepare for the main project: its primary task was to select a range of visiting speakers to contribute to the project as "holistic luminaries" from time to time. Secondary tasks were to prepare a reading list and to propose agenda items for the first full weekend.

Participants. There were nineteen participants with an age range from 28-60. Sixteen were medical doctors, the other three being John and Peter and Elva Macklin, administrator of the Education Department who attended both as participant and as secretary to the project. Of the sixteen doctors, fourteen were in general practice in

the NHS; and of these fourteen, four were trainers in the GP vocational training scheme, two were trainees, two had University appointments. with Departments of General Practice, and one was a member of the radical Limes Grove Practice. Of the remainder, one was exclusively in private practice, and the other was an SHO in psychiatry. Four of the doctors were female, and of the total group of nineteen two were Asian, the rest Caucasian.

In terms of the entry criteria it was clear that recruitment failed to achieve a balance of the sexes, and we reluctantly accepted this. The participants varied greatly in experience of personal development work, from those who had been involved in it for many years to those who had only just opened the door. There were five trained co-counsellors in the group, several who had participated in Balint Groups, and several who had experience of a range of meditation and transpersonal methods. All were interested in complementary therapies and a small number included acupuncture as part of their practice. The one doctor in private practice consistently used the widest range of complementary practices.

The motivation for joining varied with each participant, but most members wanted to develop new perspectives and skills. Some considered themselves well versed in holistic medicine, others thought of themselves as novices or enthusiasts in this respect. Some were dissatisfied with the status quo as they perceived it, others were content but keen to try new ways. There was a common underlying desire to provide a better service for patients and to increase personal satisfaction in work. Most knew that they would have to make some efforts in time and money, and many experienced some resistance from colleagues back at work who did not accept the value of the project. There were the expected variations in personality, and often clashes of temperament and ideology, but there was an overall commitment to the central focus of the inquiry which implied co-operation and creative conflict resolution.

Finance. The original brochure proposed that the project would be self-financing with each participant contributing £200.00 to cover the cost of visiting luminaries' expenses and other immediate overheads. Before the first briefing meeting John Heron raised £3,000 toward the costs of the project from the Blue Band Positive Health Programme. After a great deal of discussion this support was turned down, partly on the grounds that Unilever was involved in the expropriation of profits from the Third World, partly on the grounds that the contribution of Blue Band Margarine to health could be questioned, but primarily on the grounds that members preferred to be completely autonomous, without anyone flying on their coat tails. As it turned out the £200.00 contributed by each participant enabled the project to break even with respect to the costs of visitors and room hire. The project was of

course substantially subsidised by BPMF for printing, postage, and secretarial support.

Luminaries. The idea of inviting visiting speakers was mooted in the brochure, and explored at the briefing meeting. Part of the agenda of the first formal meeting of the project in the Summer of 1982 was to decide who to invite. We brainstormed a long list of possible speakers, and from this chose the following: Dr Peter Mansfield, Director of the Templegarth Trust, which has carried forward some of the basic principles of the Peckham Experiment of the 1930's; Dr Murray Korngold, a psychologist, acupuncturist, and healer from California; Dr Alec Forbes, founder and Director of the Cancer Help Centre in Bristol; Dr Marco de Vries, author of The Redemption of the Intangible in Medicine (1981); Drs Elmer and Alyce Green, Directors of biofeedback research at the Menniger Foundation, and authors of Beyond Biofeedback (1977); Fritjof Capra, author of Tao of Physics (1975) and Turning Point (1982). All these attended with the exception of Dr de Vries.

The luminaries were invited to provide a three hour presentation at one of the two day meetings on any aspect of holistic medicine that was currently of interest to them. They were also invited to participate as co-researchers during the rest of the meeting time, joining the group in whatever way felt appropriate, contributing to the group's own activities. We found that some were able to join the group in creative ways, while for others participation was problematic. Some of the visitors were able to dialogue with the group in an exchange of perspectives. Others seemed able to do no more than re-iterate their own view-point. Again, some visitors could contribute actively and relevantly to the group's own activities, while one could only interrupt and interfere. The group for its part would readily confront those visitors who seemed to be insensitive to its ethos, but sometimes this confrontation became confused with scapegoating the visitor for the group's own internal difficulties. We shocked one, were experienced as rude by another, and occasionally wondered if we were giving enough care in receiving our guests. Nevertheless, the luminaries did fulfil the purposes for which they were invited: to inject new perspectives, refresh our thinking, contribute to our programme design, and challenge the limitations of our inquiry. We are grateful to them all for their time, interest, and involvement.

Research design and rationale. The broad design was outlined in advance and adopted at our first planning meeting. There were six cycles of inquiry made up of a two day workshop for thinking and planning, and six weeks of application on-the-job in the surgery. The inquiry ended with a four day workshop for final processing of all the data on application. Subsequent meetings were held for writing.

Co-operative inquiry moves several times around the cycle from reflection to action and back again, and it is important to choose an appropriate amount of time for each part of the cycle, and an appropriate rhythm of action and reflection. The two day meetings were times of concentrated reflection, the six week periods were times of extended action. An important part of the reflection process, which became progressively built in to the two day meetings, was a whole range of different validity procedures, including the development of a genuinely co-operative inquiry group.

At the first weekend we devised an overall model for holistic medicine, and a long list of possible strategies for applying it in practice. At the end of this two day meeting, and at the end of subsequent meetings, each participant wrote a "contract" which outlined the strategies they intended to use over the next application period. They also wrote a report of their experience of the six week's application, as well as reporting verbally at the next workshop. All these contracts and reports were copied and circulated to the other participants, and provided the data base for the project. The two day meetings used this data to refine both our conceptual model of holistic medicine, and the strategies we used in applying it.

Outline of the meetings. In order to give a flavour of the meetings without a tedious blow-by-blow account of each, we will give a brief account of the sorts of activities we engaged in; of the line the research followed as a whole; of the energy and activity level of the group.

A typical meeting would include most of the following:

Sharing experience of application in the last cycle, sometimes in small groups and sometimes in the whole group.

Conceptual discussion reviewing and revising the five part model of holistic medicine in the light of the shared experience of application.

Sessions on the theory and practice of validity procedures.

Group discussions to devise new strategies for the next cycle of application.

Time spent sometimes alone, sometimes in small groups writing individual contracts listing strategies each person would use in the next cycle of action.

Group process meetings to deal with interpersonal tensions and difficulties, and personal emotional distress. These were included in every meeting, and

were at least two hours long. Occasional co-counselling sessions were used for similar purposes. A full explanation of the research rationale behind these procedures may be found in Chapter Eleven.

Improvised rituals for opening and closing meetings.

Meditative and transpersonal exercises.

Role play to practice strategic interventions.

When residential, jogging, dream analysis, and other extra-curriculum activities.

Sharing food together.

A general climate during and between sessions that permitted warmth, hugs, openness, and support. This in turn enabled the group to accommodate and resolve episodes of quite severe confrontation and disagreement.

The line of research started by reviewing each persons experience and ideas about holistic medicine, and discussing this in small groups and as a whole until a model of holistic medicine emerged which was generally supported. This is the five part model discussed in Chapter Three. Following this we brainstormed a long list of possible ways of applying this model in the surgery, and after discussion in small groups each participant developed their own idiosyncratic plan and contract for the next six weeks. It appeared, at least to the initiating facilitators, that contracts should be idiosyncratic at least to start with to provide lots of diverse ideas and practices. We also brainstormed a long list of different ways of obtaining data, some of which were adopted.

The second meeting continued this idiosyncratic line: participants were working out and sharing different sorts of holistic medicine models, and preparing their strategy contract for the second cycle of action. This idiosyncratic direction was interrupted at the third meeting, when it was decided to form two sub-groups in the inquiry, one of which was to focus on power sharing interventions, and the other to explore spiritual practices in holistic medicine. Thus two separate lines of convergence were adopted which provided a useful counterpoint to the previous individuality and diversity.

Validity issues, which had been mentioned briefly at the earlier meetings only came fully into their own at the fourth meeting when they were for the first time very thoroughly discussed and consciously used (see Chapter Eleven). At the fourth, fifth and sixth meeting the two lines of convergence on power sharing and spiritual

practice were sustained, with regular feedback on and revisions of strategies used. Throughout these meetings too, the five part model was regularly reviewed, modified and elaborated in the light of practical experience.

At the final seventh meeting there was an overall collection and distillation of data from both the power group's work and the spirit group's work, together with a summary of our final position on the five part model, and a review of the adequacy of our validity procedures.

The life of the group started with enormous hope and enthusiasm: energy was high, people joined in and felt optimistic; plans were made; and friendship bonds begun. There was something of a downturn in morale by the second meeting, as the enormity of what we had taken on became evident, and as some of the different attitudes and approaches in the group became evident. But the energy level rose again with the formation of the power and spirit groups, since these seemed to provide a clear focus for what we were up to, and thus a new impetus to move forward. This energy was sustained through a lively and conflict-full fourth meeting until the fifth meeting, when a series of unresolved differences within the group and strained relations with the visiting luminary combined with external difficulties in members' lives to give a very depressing and debilitating meeting. The sixth meeting provided a way out of these doldrums as the group responded to both exhortation from within and encouragement from the visitors to that session, so that we were able to finish with some clarity about both success and failure. At the final meeting the group was energised by a deep and satisfying sense of achievement, together with a sense of excitement about writing up the inquiry.

CHAPTER THREE: THE FIVE PART MODEL OF HOLISTIC MEDICINE

In order to conduct inquiry into some subject we need a model. One drawback of a model is that it may inhibit further thought or restrict the direction of the inquiry by the preconceptions it contains. So it must be comprehensive, simple, and in its early stages not too rigidly or precisely formulated. A model gives a starting place for thought and a grid of reference points to understand and collate observation and ideas on the practice of holistic medicine, and also provides a shared set of concepts for the group as a whole to work with and communicate about. So again the model must be simple and comprehensive, so that all members of the group are happy that it contains that essential part of the reality which for them makes medicine holistic.

How did we seek to find such a clear, free, simple, comprehensive and uninhibiting model? It was done by getting each group member to review their own practice of medicine, the ways in which they felt it was holistic, and ways they could make it more so. We considered further what ideas we had about the basic nature of holistic medicine. We then presented and discussed all this in small groups of four or five persons to tease out common themes and crystallise common principles. These principles were then presented to the whole group and a further simplification took place until we arrived finally at five themes or principles which seemed to contain what we felt to be the essence of holistic medicine without constricting it in a too rigid structure. The idea was that these principles would be stated in minimal form on the grounds that at the start of an inquiry it is better to be vaguely right than precisely wrong.

These principles were generally and happily assented to by the group; indeed some surprise was expressed at the relative fluency with which they had emerged. All the principles were felt to be necessary and interdependent to such a degree that none could be disregarded, nor yet any one be thought supreme or primary. At different times and for different people one of the principles would be thought more important, but this would only change with time and circumstance.

The principles were first presented in circles on a flip chart with the following titles, which in fact were sustained throughout the inquiry.

Concern for the patient as a being of body, mind (including emotions) and spirit, seen in historical (developmental), social and political contexts.

The patient as a potential self-healing agent.

Power sharing between doctor and patient.

Ability to offer a wide range of interventions.

The doctor as self-gardening.

Original Version of the Model.

At our first meeting the five parts of the model were only minimally conceptualised as follows.

Concern for the patient as a being of body, mind and spirit seen in historical, social and political contexts. The person as a being of body, mind and spirit is a classic view which we invoked but did not at this point elaborate in any detail. Nor did we specify any definitions of mind or spirit except to indicate that by mind we certainly included feeling's and will as well as intellect. We also saw the wider context of the patient as of fundamental importance. There was some vague invocation of a systems account of the person necessarily being understood in the context of their personal history, wider cultural history, and the prevailing social and political structures. For some members this social and political context was primary; for others the person over against their context was primary.

The patient as a potential self-healing agent. What we meant by this was not only the obvious fact that the human body is within variable limits a self-healing organism, but also the more radical principle that each person as a mental and spiritual being has the potential capacity consciously and intentionally to facilitate healing in their body by a variety of internal and external actions. It was clear in our discussions that the range of such potential was unspecified and unknown, but it was assumed by us to be much greater than patient expectation and conventional medicine currently allow. At this stage in our inquiry there was no systematic review of the sorts of internal and external actions that an intentional self-healing agent might use.

Power sharing between doctor and patient. By this we mean shared responsibility for diagnosis and treatment. In diagnosis the doctor has the medical view, and the patient a personal view, and can understand and give meaning to their illness in terms of their own unique knowledge of their total life situation. In treatment, the doctor may have medicines, surgery, and other interventions to offer, and the patient can take responsibility for devising and practising internal and external behaviour that facilitate recovery. This is co-operative problem solving. It was clear in our first discussions that such shared power was only the middle part of a continuum from all power exercised by the doctor to all power exercised by the patient. Each part of the continuum, we decided, had its valid use depending upon the patient, the condition, the

doctor and other circumstantial factors.

Ability to offer a wide range of interventions. In our first discussions this principle seemed to cover at least three things: having a wide range of interactive skills, for example being able to move along the continuum of power, as above; being able to intervene appropriately in relation to body, mind and spirit, and historical, social and political contexts; and finally having competence in some aspects of alternative therapy – physical, emotional and spiritual – as well as conventional medicine. This principle in practical terms starts to define the holistic practitioner; of course, holism as defined in this bundle of skills transcends any individual's competence.

The doctor as self-gardening. By this we meant the principle of personal growth – again physically, emotionally and spiritually: the practitioner of holistic medicine needs to be holistic in their personal development, behaviour, and life-style, and to be consciously involved in the process of holistic self-development and social awareness. Even during initial discussions some felt strongly that this principle should be the primary one on which the other four hinged; others considered that it should be on a par with the other four. This issue of ordering continued to be debated through the first three cycles.

How the model was used. First of all we used the model to brainstorm at our first meeting a very wide ranging list of strategies or activities falling under its different principles. Secondly individuals used the model as a set of guidelines for selecting their own idiosyncratic strategies for application over the first two cycles. Third and centrally, when it was felt that our individual applications were too divergent and unco-ordinated we used the model at our third meeting to make a decision to focus on two parts of it -- power sharing and spirit. Fourth the model was systematically reviewed for its coherence, adequacy, and comprehensiveness in the light of our experience of applying it.

Developments of the Model.

The first thing that concerned us was the ordering of the five principles. As-mentioned above, at the first meeting some members felt that the doctor as self-gardening was the main principle on which the others depended. Others resisted this view, and saw all five as equal. But over the first two cycles at least four members of the group discovered in practice that attending to their own self-gardening facilitated the application of all the other parts of the model. They found that by attending to meditation, to developing their own emotional openness, to their physical fitness, they were more able effectively to put other parts of the model into practice. So on our

third meeting, when we reviewed the model there was, a vigorous debate about making this principle the central hub of the model; eventually on a vote eleven wanted self-gardening to take this premiere position, while four wanted to keep all the principles equal. For the remainder of the inquiry, for a significant number, self-gardening was experienced as the central principle, and was enshrined at our fourth meeting in the adage "The way I am is how I practise medicine".

Apart from this debate, the practical inquiry sustained the original view that the five parts were systematically inter-related, with no one part primary. We never fully explored and mapped out the sorts of interconnections between the five principles although one author of this chapter did develop his own account which is presented below.

The model was however elaborated in a number of ways, many of which are included later in the chapters devoted to each principle. For example, at the fifth session we discussed the notion of self- and peer- gardening, to emphasise the idea that the doctor needed the support and loving confrontation of peers. We realised that power sharing could be seen as being mainly about the demystification of professionalism. That self-healing included peer-healing in important contexts such as peer self-help groups, and that this principle also included important aspects of medicine as education for prevention as well as for treatment. That the whole person in context needed to be thought about particularly as a person with powerful emotions being activated in a family context. In addition we debated the name holistic medicine, which some felt to be a rather obscure name; the title Whole Person Medicine was suggested as an alternative.

The remainder of this chapter is devoted to a systematic elaboration of the interconnections of the five principles which was developed by one member and presented to the inquiry group.

Meditation on the Five Principles of Holistic Medicine.

Having briefly described and expanded the five ideas which were thought to be necessary for a complete and sufficient view of holistic medicine, one is in danger of falsifying the whole concept of holism by anatomising the idea and not looking at it whole. In order not to fall into this trap, and as an exercise in holistic thinking an attempt will be made to show how the five concepts relate to and work on and with each other to form a whole. Rather than calling them principles, ideas, concepts or pillars of holistic medicine, I will refer to them as bubbles, for that is how they first appeared on the flip chart at our

first meeting. The first part of this chapter has expanded the original short title of each bubble and fleshed it out with more detailed and complex ideas, but also each separate description can be referred back and forth from bubble to bubble in order to understand it more fully. What are these connections and how do they operate on and change the internal workings of each bubble and the model as a whole? is a problem I have set myself. During the unfolding of the inquiry the model was looked at a number of times and various structures, lines of force, and influence were noted - the synthesis presented here is my own way of seeing holistic medicine and to help me remember how it works together and what it contains. The bubbles are sufficiently elastic to be structured in other ways by other people for other reasons.

On close inspection the bubbles seem to be made of different materials and behave in different ways. They are of three types:-

1. People a) Patient as a Potential Self-Healing Agent.
b) Doctor as Self-Gardening.

Aspects of Reality

- c) Ability to offer Wide Range of Interventions.
- d) Seeing the Patient as a Whole Being of Body, Mind and Spirit in contexts of Space, Time and Relationship.

A Relationship

- e) Power Sharing between Doctor and Patient.

To express these differences visually one can give the bubbles different shapes, oblong for the people and oval for the aspects of reality and the relationship will look after itself. If the people are drawn opposite each other and the aspects of reality arranged between we arrive at the following diagram of the model - Fig. 3.

Now where is the relationship? If one joins up the two people by an information channel passing through the two aspects of reality, a fifth space or bubble is created in the centre, power sharing between doctor and patient.

Does this dynamic arrangement of the bubbles help us to understand the nature and working of holistic medicine? The channel joining doctor and patient is seen as a flow of information coming from the patient to the doctor: the facts, feelings, and atmosphere about the patient and his world both verbal and non-verbal, both conscious and unconscious, which the doctor must be able to see, comprehend and understand. The return channel from the

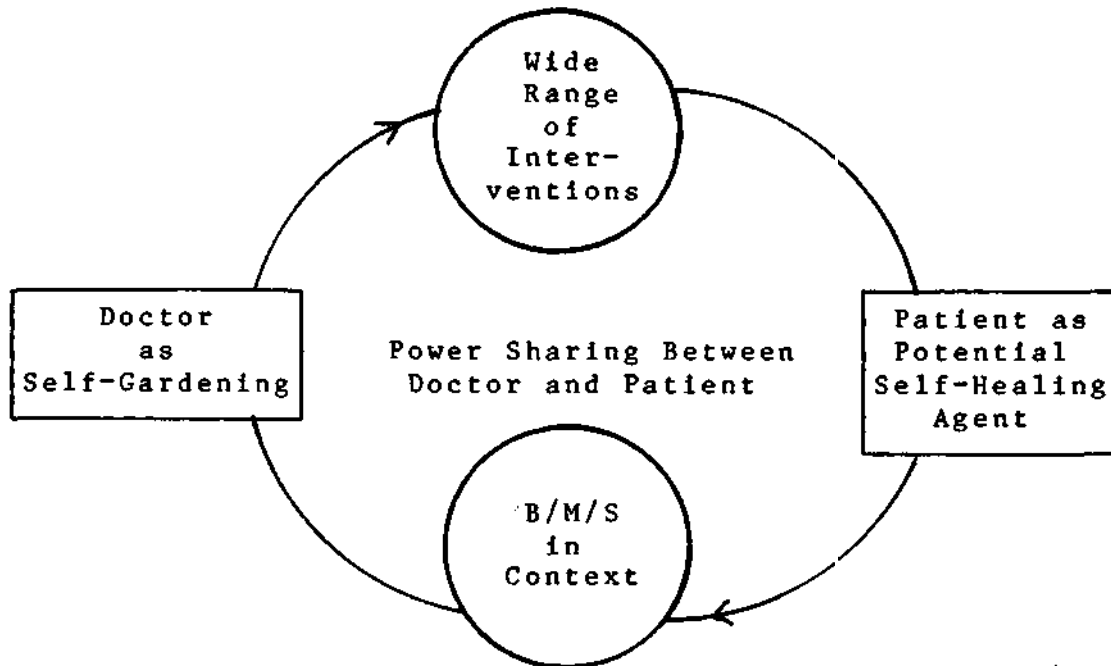


Fig. 3

doctor to the patient conveys this understanding as the first stage in a wide range of interventions which can be offered to the patient to choose from to assist their self-healing. The self-gardening of the doctor is necessary so as not to foul up and clog these information channels, so that he may see clearly and understand truly, and show himself and his understanding honestly, and that his knowledge is wide and covers all types of intervention. The patient's potential for self-healing must be present and mobilised so that he can show himself fully and honestly, believing and trusting in the doctor's genuineness, and have the courage to take responsibility for his health and make an appropriate choice of any necessary therapy. The information channels are in no way static, but constantly open and active, and the circulation of information goes through many cycles, not just one, and this circulation of information between doctor and patient, and patient and doctor constitutes the relationship which is power sharing and so creates the fifth and last bubble.

So the mode of holistic medicine can also be seen as the model for the doctor/patient relationship, as well as how the five bubbles work together and influence each other and also a mode of how the medical profession as a whole could relate to and work with the general public, their patients.

Holism aspires to see things whole, and we have just made a whole out of the five bubbles, and a further exercise would be to see how this whole relates to traditional medical relationships between doctor and patient and also to human relationships in general. As doctors are trained they learn to relate to patients first in teaching

hospitals and later as junior house officers in other hospitals. They are taught that the doctor must have the knowledge and skill; that the patient has an illness that needs help; that the doctor sees the signs and symptoms of this illness; that the doctor prescribes the therapy, drugs and surgery or other therapeutic procedure; and that the doctor must be in control. This is another model of the doctor/patient relationship - Fig. 4 -, which has a similar structure to the holistic model but an entirely different attitude.

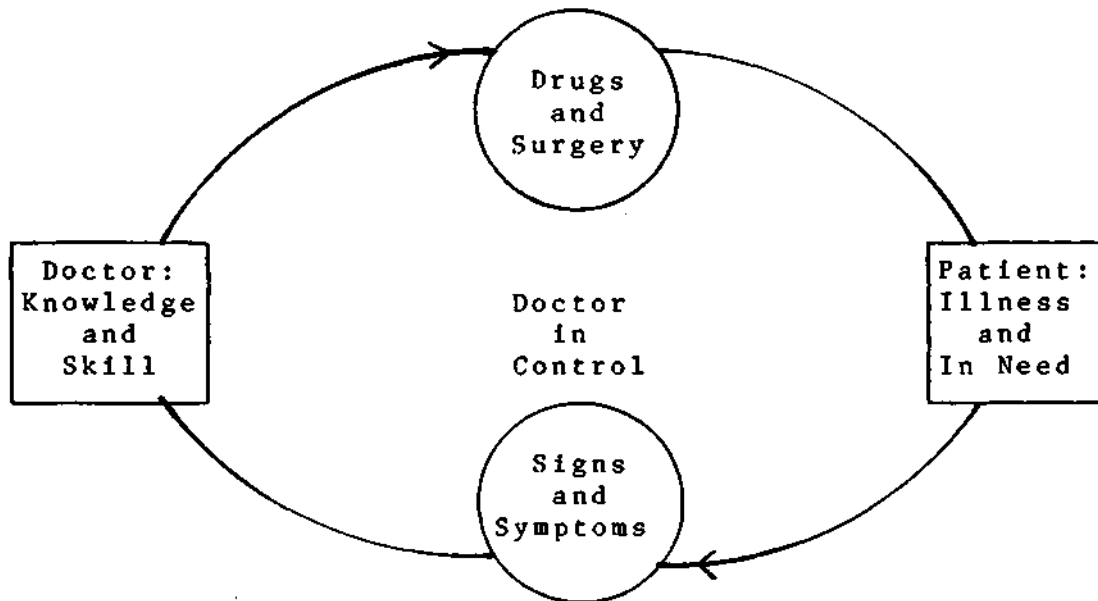


Fig. 4

The contrast between the two models and the different emphasis in each of the five areas helps a traditionally trained doctor to see, in a more clear and specific way, what changes will have to be made in his or her training, understanding and way of relating to patients. It shows how a change in any one of the areas must lead, like a chain reaction, to changes in all the other areas as they are all connected and inter-dependent. To change from doctor in control to doctor sharing power with the patient, requires changes in doctor and patient which leads to changes in how they see and affect each other. A similar chain of events would occur if the primary change was made in any of the five areas, and it is an interesting and instructive exercise to work them out. Choose an area, change it, and see what happens in the other areas.

The doctor/patient relationship is inherently asymmetrical, that is the two members of the relationship have different expectations of the interchange. The patient perceives himself as ill and wishes for cure, which he seeks from the doctor who has the knowledge and wishes to be of service. This is fairly clear cut and apparent in Fig. 4, the traditional doctor/patient relationship, but in the holistic doctor/patient relationship of Fig. 3, where the doctor is self-gardening

and the patient is self-healing, one is drawn by the prefix "self" to scrutinise these compound adjectives used to describe the two people in the relationship; what do gardening and healing have in common? Creating the right conditions for change and growth, and supervising these changes to a satisfactory point of completion. In fact self-gardening and self-healing could be interchanged. Physician heal thyself. Patient carry on gardening, that is maintaining his own health by diet, exercise and personal development work. So in the limit the holistic doctor/patient relationship becomes symmetrical, both doctor and patient give and receive care, understanding, recognition and acceptance, for the doctor needs the patient to need his care; just as the patient needs the doctor to care. The relationship becomes a mutual one, of the generalised form of a fully personal relationship between two people, as illustrated in Fig. 5.

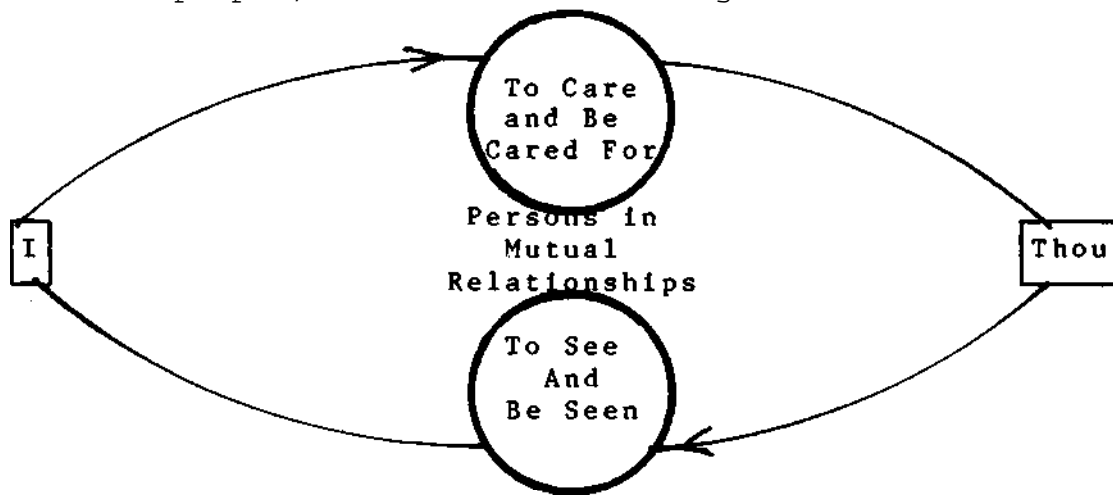


Fig. 5

The problem with diagrams is that they are always static, and to represent such a dynamic and changing phenomena as a personal relationship have definite limitations. But if Fig. 5 is seen as a moment frozen in time of an idealised two person relationship, with the information flowing round the two channels in a clockwise direction; seconds later the flow will be in the other direction, the I will be Thou, the Thou will be I; a full mutual personal relationship, symmetrical and equal in all respects.

This playing around with the model and finding the similarities and differences between holistic medical model (Fig. 3), standard medical model (Fig. 4), and full personal relationship model (Fig. 5), gives us one further diagram (page 30) descriptive of where holistic medicine stands, somewhere on a continuum between the standard medical model and a full personal relationship. The problem is where on this continuum and what factors control this position. How personal a relationship does a doctor, or a patient, allow a doctor/patient relationship to become? Some would say never, others would say always, and the truth lies somewhere in between depending on the

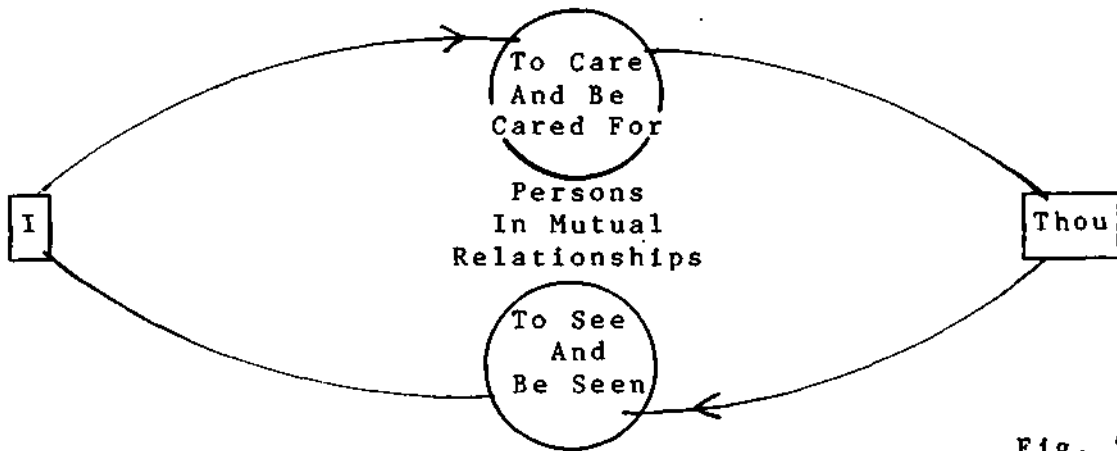


Fig. 5

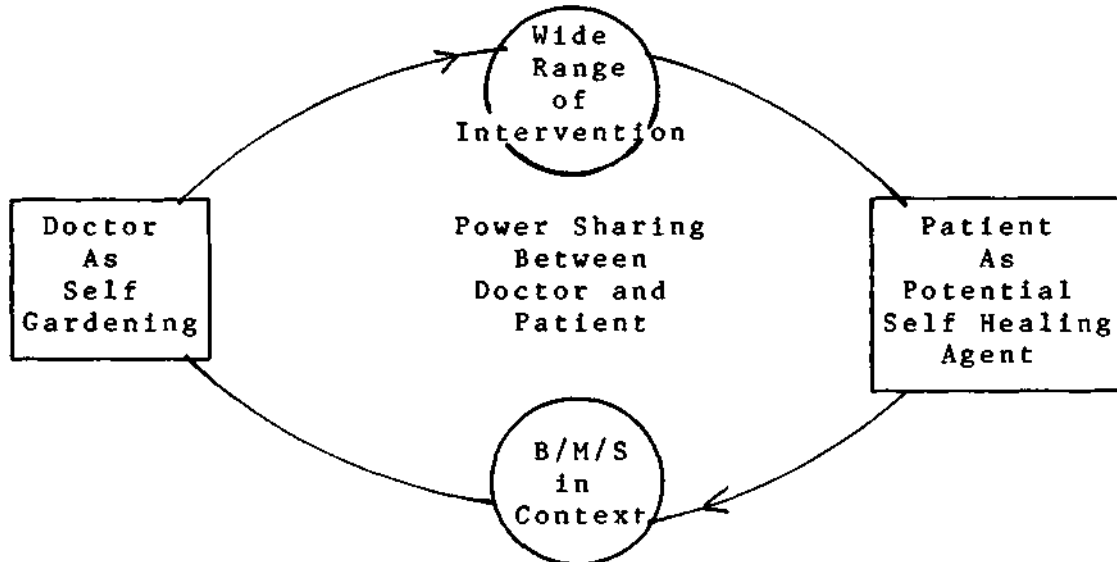


Fig. 3

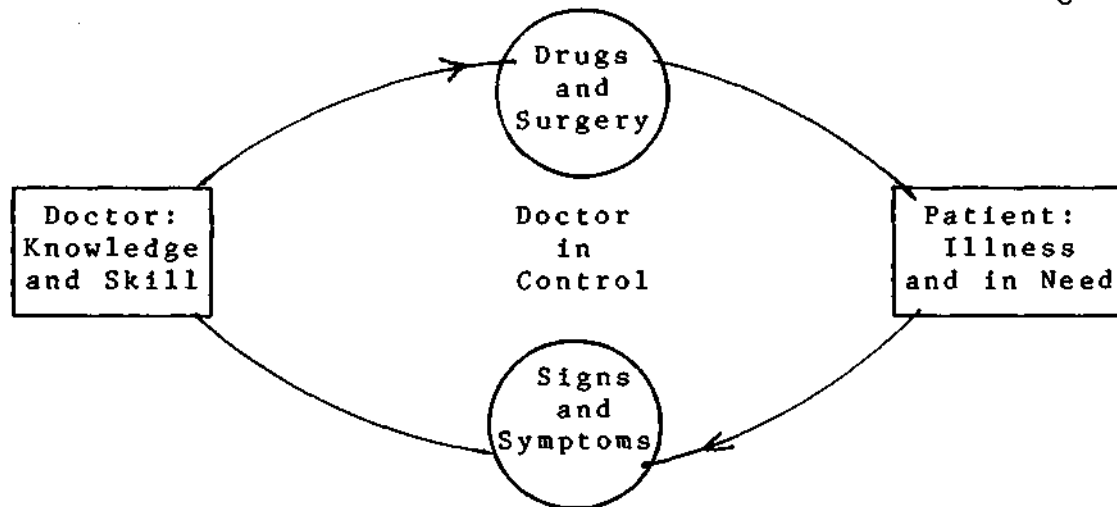


Fig. 4

doctor, the patient and the condition requiring help. For some problems it would be inappropriate to enter into the difficulties and commitments of a full personal relationship; for other conditions unless there is some personal commitment on the doctor's part there can be little hope of the doctor even understanding the problem,

let alone helping to find a satisfactory answer. Besides the problem of what is desirable, there is also the limit of what is possible, that is, what are the constraints on the establishment of a holistic medical relationship? It would appear there are two; lack of self-gardening in the doctor; a lack of self-healing in the patient. If these are overcome then the holistic model can rest anywhere on the line from a standard medical relationship to a full personal relationship, and that position should be where the doctor and patient are most comfortable and working with the maximum effectiveness, with the particular problem under consideration.

Models are made for playing with and this has been what I have been doing in this section of the holistic model. The games are fun and give new insights and ways of working but are not to be taken too seriously. Please play your own games with these models, they won't mind and neither will I.

CHAPTER FOUR: WIDE RANGE OF INTERVENTIONS

We did not in our inquiry ever systematically focus on this principle: it was formulated at the first meeting, elaborated at the fourth, and reviewed again at the final meeting. But of course members of the group were exploring the range of their interventions in their different ways in each cycle. And the power and spirit groups were each seeking to extend the range of members' interventions along particular dimensions.

The review of this principle at the fourth meeting, in the light of three cycles of application, confirmed and made more articulate the analysis of the first meeting: that interventions can range widely along at least three different dimensions; and these dimensions are independent, so the practitioner can move along any one without being thereby committed to move on the other two. At the final meeting this three dimensional view held firm in the light of experience of all six cycles.

The first of these dimensions concerns the different levels of the patient's being: interventions can cover the physical, the mental (including emotional), the spiritual, and take into account to a greater or lesser degree the appropriate context of personal history, social relationships, and economic, political, and cultural factors. This dimension alone is very complex: the practitioner can work (a) at one level to the relative exclusion of others; (b) at two or more levels concurrently; (c) at one level primarily in order to effect change in another level; and in each case taking context into account to a greater or lesser extent.

There are two big issues here we did not really get to grips with. One concerns the relative autonomy of the levels of being: how much you can intervene at one level with relatively little impact and effect at other levels. The reverse side of the same coin is the relative functional interdependence of the levels: how much you can intervene at one level in order to produce change at another. It seemed to be a working assumption of the inquiry that while there was some sort of borderline between the autonomous functioning of the levels and their interactive influence, this borderline may be variable and alterable perhaps to different degrees with different people. So that the extent to which you can influence patients' minds through their bodies, or bodies through their minds, and conversely the extent to which bodies and minds are relatively impervious to each other, will vary from patient to patient. In addition, we would expect this to vary at different times in the same patient as a result of education and training for intentional self-healing. Similarly the extent to which patients'

bodies and minds are relatively impervious to each other will vary from person to person. But this assumption of the clinically obvious never progressed into any systematic inquiry, so we can make no suggestions as to what factors determine such variability.

The other big issue we did not deal with is the systemic relationship between the levels, and how interventions at any one level will influence other levels. What kinds of influence do spiritual changes have on physical well-being, or physical changes on psychological health? One obvious question is whether the relationship is one of parity or hierarchy: in terms of functional interaction, does a physical intervention have as much power to produce psychological or spiritual effects as a spiritual intervention does to produce psychological and spiritual effects? If it does, then we have a relation of parity between the levels: there is no special direction of power and influence. But if spiritual interventions tend to have more influence and impact at psychological and physical levels than physical interventions will tend to have at psychological and spiritual levels, then there is a relation of hierarchy between the levels, and power and influence will flow more in one direction than in the reverse direction. These issues were never addressed.

One thing is clear: these two issues about levels of being - the autonomy-interaction issue and the parity-hierarchy issue - may both be different and have different outcomes when applied to practitioner interventions in the patient's being as against when they are applied to intentional self-healing by the patient as agent.

The second dimension along which practitioner interventions can range widely is the continuum from doctor-centred to patient-centred interventions (we had earlier referred to this as the dimension of interactive skills). At the doctor-centred end the doctor is making unilateral decisions about diagnosis, preferred outcomes, and treatment; acting unilaterally on these decisions; and unilaterally assessing outcomes. At the patient-centred end the doctor is facilitating autonomous patient decisions and actions about diagnosis, preferred outcomes, and treatment -- eliciting patient self-direction. In the middle, doctor and patient together engage in co-operative problem-solving about diagnosis, preferred outcomes, and treatment; and co-operatively assess outcomes.

This dimension was systematically explored by the power-sharing group, an account of which is given in Chapter Five. It is sufficient here to mention two broad practical guidelines that emerged from the inquiry, and to which all members concurred. First, it is appropriate for the doctor to have the flexibility to intervene at both ends and in the middle of this dimension. Depending on the patient, their condition, their life context, and on the timing and circumstance of the consultation, it may be

appropriate for the doctor to be authoritative and directive, facilitative of patient autonomy, or co-operative about problem-solving. And it may be appropriate to move between these different positions in the same consultation with the same patient. Of course, this requires considerable interactive skill: it involves having a range of different sorts of behaviour available, being competent in each, choosing when and knowing how to move from one sort to another.

Second, it was generally agreed that because of patient expectation of doctor's expertise, and also because of conventional medical training to deliver such expertise in an authoritative way, doctors tend to be limited in their behaviour to the doctor-centred end of the continuum. They find it difficult to practise the flexibility that has been commended in the previous paragraph. So the second practical guideline encourages doctors to experiment with and develop a much wider interactive style and flexibility of behaviour than is common: Chapter Five gives details of the different sorts of interventions the power group members tried out in making this shift.

We did not overtly explore the relations between these two dimensions. In one sense they are clearly independent: you can be doctor-centred or patient-centred when intervening at any level of the patient's being - physical, mental, or spiritual. But it was tacitly assumed throughout the inquiry that in another sense the two dimensions are inter-dependent: you cannot adequately command the doctor-centred/patient-centred continuum unless you can intervene, as and when appropriate, at all levels of the patient's being; and you cannot adequately intervene at all levels of the patient's being unless you have acquired flexibility in ranging over the doctor-centred/patient-centred continuum.

The third dimension along which practitioners' interventions can range widely concerns the use of specific clinical techniques. This covers the whole spectrum from medical techniques in conventional medicine, including drugs, surgery, and many high technology methods; to those used in the various complementary therapies such as homoeopathy, acupuncture, osteopathy, chiropractic, herbalism, and so on. This dimension received little formal attention during our inquiry, although a range of complementary therapies were in use. At least three members were using acupuncture prior to the start of the inquiry. One of these was also already using several other complementary therapies. As a result of the inquiry, one member took up acupuncture training, another homoeopathy; several others started finding out about complementary therapists in their localities and made some referrals to them.

While the level of interest in complementary physical therapies was not high in the sense of learning how to do

them, what was acknowledged was the patient's claim to have resource to them, and the practitioner's duty to know something about them - as distinct from knowing how to practise them - in order to make responsible referrals. This sympathetic attitude was leavened in some members by a creative scepticism: how could the claims of complementary therapies to efficacy be established by researching them imaginatively in ways that did not distort and misrepresent their modes of practice?

But complementary therapies were thought of not only in terms of purely physical or strictly medical techniques. We also considered that they included those concerned with psychotherapy and personal development, such as co-counselling, regression and cathartic therapies of various kinds. At least six members were familiar with and competent in one or more of these approaches prior to the inquiry. And because of the strong element of emotional and personal work sustained in our meetings, most members pushed forward the frontiers of the psychological and emotional interventions with their patients.

Further, complementary therapies were thought also to include practices such as psychic and spiritual healing. Members of the spirit group did explore at one of their meetings some of these techniques among themselves and touched a little on how they might be used for absent healing. They also used a range of spiritual interventions with their patients in their surgeries, and some of these were on the borders of formal spiritual healing (see Chapter Six).

What follows in summary outline is a cookbook of different interventions actually used by one or more members of the inquiry during their cycles of application. Some of these are listed again in more detail elsewhere: power-sharing interventions in Chapter Five, spiritual interventions in Chapter Six, interventions to do with patient self-help in Chapter Seven. The cookbook items are organised under the three dimensions for range of interventions presented in this chapter. But these dimensions are not mutually exclusive in action: any intervention is somewhere on the doctor-centred/patient centred range, and at the same time related to some level of the patient's being; if overt techniques, conventional or complementary, are also used, then necessarily all three dimensions are involved. So the classification below is rather arbitrary.

Dimension One: Intervention at Different Levels of Being

Spiritual level: Explicit and implicit invocations; spoken and silent prayer; asking questions about spiritual matters and belief systems; use of spiritual quotations; being present with; teaching spiritual self-help.

Psychological level; listening; counselling and psychotherapy (regression and catharsis); dreamwork analysis; interpretation of drawings; questions about the meaning of illness, about illness as a clue to a new life direction; use of self-disclosure to beget self-disclosure; hypnotherapy; logotherapy.

Physical level: conventional medical techniques; complementary physical techniques (acupuncture, osteopathy, herbalism, homoeopathy); use of touch (for physical healing, for psychological and spiritual effects); use of physical talismans (for physical healing, for psychological and spiritual effects).

Reference to all levels: making body/mind/spirit - ie three level - diagnoses; inviting the patient to engage with a presented map or model including body, mind and spirit.

Social context: family therapy, couple and relationship counselling.

Political context: initiating and joining alternative organisations; radical medical practice (Limes Grove); health food co-operative; co-counselling community.

Dimension Two: Doctor-centred, Cooperative, and Patient-centred Interventions

Co-operative power-sharing: admitting areas of doubt and ignorance; making letters of referral available for patients to read; change of seats role play -- patient becomes doctor and talks to doctor who becomes patient; doctor open to and eliciting patient's explanation of their trouble; co-operative decision-making with patient about choice of treatment and choice of referrals; asking patient to share their expectations of the doctor; skills sharing - inviting patients to participate in the use of various pieces of standard equipment, and in making basic examinations; making maximum amount of information pertinent to the patient's conditions available to them; becoming more accessible to the patient through change of clothing (more informal), change of environment (flowers, re-arrangement of desks and chairs, etc); humanising medical ritual; involving patients in practice management (Limes Grove); video review of consultation with patient involved with making it; asking for patient feedback.

Patient-centred: training patients individually or in groups in self-help techniques (visualisation, autogenic training, meditation, yoga, relaxation, self-hypnosis, nutrition, stress management, exercise); helping patients set up self-help peer support groups (co-counselling, obesity, quit smoking, patient participation, giving up tranquillisers, menopause); helping set up whole food co-operative; recommending books and pamphlets to patients.

Dimension Three: Conventional and Complementary Therapy Techniques

See above under Dimension One: this dimension simply takes a different slice through the same material.

CHAPTER FIVE: POWER SHARING

Introduction

"I was aware in the next minute after this refusal to change his tablets that he was probably going to attack me if I persisted. I remember thinking "Well at least it will be interesting!"....He grabbed me by the collar saying he was going to fucking kill me, that all doctors were the same. They'd done this to him to begin with and now they just treated him like a little kid.... He let go of me and began to cry. I gave him a 'scrip and phoned the psychiatrist. Later I cried too - a mixture of shakiness, fear and melodramatic exhilaration".

Issues about power are present in every consultation. They may not be so starkly visible as in the above example but patients and doctors still part disgruntled or satisfied, our objectives agreed or frustrated. There is no neutral position on these issues since we already are operating with certain assumptions and attitudes to our power. Despite this it is only rarely that these issues are made explicit. Doctors often see the problem as one of control - usually with the implicit assumption that they are the one who rightfully are (or should be) 'in control'. Patients more simply find it difficult to get what they want, and all too often have the loss of personal power inherent in their illness compounded by a sense of helplessness when facing the overbearing authority of their doctors.

For any holistic approach the issue of power is vital. The five part model which we elaborated during the inquiry touches on issues of power at every turn:

What does 'power sharing' mean in practice? why bother with it? Is it anything more than an irrelevant ideal?

If patients are seen as the main agents of their own healing what implications does this hold for the way our institutions run?

Use of alternative therapies involves issues about the monopolistic power of the medical profession as well as the personal assertiveness often required by patients in order to get access to them.

Medicine not only has an important spiritual aspect it just as clearly has political implications which greatly affect the outcome.

Nor is it easy to sort out how power actually affects different situations. Sometimes it is clearly appropriate for doctors to be completely in control, whilst at other times patients are all too often excluded from the decision making process.

The "power" group came together to look at some of these difficulties. The decision for two groups to separately look at the problems of "power" and "spirit" coalesced out of the general chaos of the first three cycles. Not only was power an issue which embraced several of the strategies that individuals had been working on it was also an important touchstone for many of us because of its solidity and obvious importance in any description of medicine. It is an appealingly 'real' issue which a wide variety of people within and without the profession agree is problematic. In contra-distinction looking at "spirit" appeared distressingly vague and mystical to some:

"If I was going to have recount what we were actually doing in this Holistic Medical thing to my partners then I for one wanted to be able to talk about something as real and (as I thought) hard edged as power. The thought of declaring my membership of a group dedicated to looking at spiritual aspects of general practice was too much!".

What Happened

Being in the group was exciting but chaotic. The only thing that of necessity we had in common was an interest in changing the distribution of power within the surgery. Beyond that our views, histories, personal and practice circumstances varied greatly. Even in our interest in power we did not easily agree. In part of course this variety constituted the resources of the group: out of the process of inquiry we would hopefully come to a consensus, consistent and valid at least for ourselves. Many times however it felt terminally confusing: we were all trying to pull our communal cart down the different roads of our individual prejudices using a map bespattered with preconceptions whilst loaded with an uncomfortable ragbag of notions about what research (old and new) ought to be.

Inevitably these discussions raised issues of power within the group itself. Generally inequalities of power and influence within the inquiry were dealt with by the whole group at the regular workshops set aside for looking at the way the group was interacting. Occasionally the issue was also discussed in the power group itself but since the emphasis of the group was largely on working out what we did agree on rather than generating a complete consensus, disagreement flourished at the edges of our discussion without causing any great problems.

The agreement that evolved grew mainly out of the practical strategies that we discussed and tried out with

patients; and in retrospect these pragmatic ideas are the kernel of what we produced. We did converge on a philosophical and conceptual agreement about what the important questions surrounding power were. The temptation now, writing the whole inquiry up is to emphasise this agreement, to try and lay out a lucid and coherent argument, tested and proven. The old research model exerts a lot of power - to be respectable everything should be neat and tidy, tied up with numbers and bound down with hard and fast conclusions. But the appropriate use of power cannot begin to be examined without attention to the subjective experiences and attitudes of the differing people involved. These subjective realities are elusive and are often ignored, or investigated by orthodox research with methodologies that are inevitably distorting.

What follows is an attempt to state the issues and difficulties as we eventually came to see them whilst remaining true to the stimulating, enlightening atmosphere of the inquiry and to the never fully resolved differences between us.

Dilemmas

Sharing power is a paradoxical idea. Implicit in the five part model and in our discussions is an assumption not only that power should be shared appropriately between doctor and patient but also that at present the balance of this sharing is swung heavily and wrongly against the patient. Yet are not attempts on the doctors' part to correct this balance themselves an exercise of power? Is not the desire to be dependent a valid choice for patients and who are we to say that our "power-should-be-shared" viewpoint should prevail? After all is not the power to make decisions with its attendant responsibilities what doctors are paid so much to do? Patients who are given a choice about differing opinions available sometimes say "Well you're the doctor, you decide". Is this a reflection of a culture-wide passivity or a legitimate request of a professional adviser? Expecting people to take major decisions when all they feel like is being looked after and dependent is perhaps an imposition of ideology just as dogmatic and cruel as the view that sees the abrogation of all power to the doctor as good and just (though there is good evidence from Pendleton that most patients do not want an authoritarian doctor).

At the heart of these dilemmas lie several questions: Is it possible to "give away" power especially to those who apparently do not want it? Is it correct to do so? Are there any times when this is inappropriate? And how are these "inappropriate" circumstances defined in such a way that they do not constitute an endless "cop out" clause for doctor acclimatised and socialised to the exercise of power?

The rhetoric of liberation implies that power can not be given away; that it has to be seized by those who are oppressed, and that any attempts to give it away through a liberal use of one's position are either doomed to failure or irrelevant since they will never be repeated by others. Happily it seems very likely that this concept of power is unlikely to hold true. The successful relinquishing of power is quite a common experience (for example between parents and growing children) and it seems very likely that power as it relates to doctors and patients is neither intrinsically oppressive nor a zero sum game in which my gain in power is by definition your loss.

These paradoxes and the complexity of the issues took up a great deal of our time initially. Despite agreement that patient's interests would be better served if we could jointly get to a state where they on average had more power than at present and ourselves less, there were wide differences about how to do this and how far this shift in the balance of power should go. At one end of the spectrum one participant (Roger S.) felt that his aim as a doctor was to make himself redundant, that ideally people should come to know what they needed and be so in charge of their situation that his role would become simply that of a technician. At the other was the view (John H's) that sometimes there is a need for the deliberate and charismatic use of the doctor's power. Doctors for example have an authority that can be used to give people permission or widen their idea of what is possible in a way that few others do. To refuse or deny this power because of ideological preferences is to refuse a key part of the doctor's role.

This kind of discussion usually centred around the question of how far it is justified to take the principle that people are their own best judges of what they need. Is giving people the Valium they ask for justified providing they fully appreciate the problems? Or is it our role to "protect" them in some way? ' And how to does this fit in with our own feelings about being asked to do things we may find ill advised or plain wrong, of imposing our own values.

In addition to the discussion of these issues there was the other thread of the inquiry, the practical changes that we agreed to try out in each of the intervening action phases. These varied enormously in form and success (for a list of all strategies tried see later in the chapter). At the time it felt as though our frustrating theoretical discussion had only a limited connection with these strategies and that in turn the experience of experimenting and the insights we gained only rarely helped to clarify our conceptual difficulties. However, it is clear in retrospect that both the need to work out practical alternatives to our orthodox ways of practising and actually carrying them out did help us to clarify the

problems. The repeated reflection-action-assessment cycles of a co-operative inquiry transformed what would have been a sterile talking shop into something that has changed both our personal practices and structured our theoretical discussions.

Using hindsight it is possible to see a degree of order in what we were doing that we only occasionally glimpsed at the time. Looking at the material produced by the power group three significant areas emerge:

1. The roots of doctors power and strategies that attempt to change these.

2. Effort to systematically increase the number of feedback loops to and from patients as a means of increasing people's autonomy.

3. The problem of assessment - what were we doing and how did patients feel about it.

1. The Roots of Power - Levelling & Demystifying Strategies

The sources of the power that doctors hold are legion. Some of the ones that we touched on were:

differences in class, age, sex, race and education

the politics of the wider society

inequality of income

particular knowledge and skills

control over access to drugs, referrals, sicknotes etc.

the need for sick people to imbue their careers with power

the power to define what the "real" problem is

Having someone of a different sex, or race or class as your doctor can either be a major factor or quite irrelevant. Occasions when it is important, for example when a patient wants to see someone of their own sex or when the doctor does not speak the same language as the patient, are common. Yet there is very little at an individual level that either person can do about such givens except live the occasions with sensitivity to the cultural or gender-determined blindspots of one's own perspective whilst avoiding retreat into a familiar but inappropriate guilt. Cultivating such sensitivity is of course vitally related to self-gardening.

Nevertheless on wider scale these things are not

unalterable givens but reflect selection at medical school. One major way to increase patients power that we did touch on would be to increase both the ease with which patients can change doctors and to broaden the composition of medical school. Within individual practices it is also possible to ensure that patients have access to doctors of both sexes.

It was self-evident to all of us that the politics of society have an enormous effect on the way medicine is practised and on the health of the population. Perhaps most important of all in preventing people taking charge of their own health in a truly holistic way are the inequalities in income and in education that determine the large gradients in ill-health whilst simultaneously decreasing the resources which people have to cope with them. The five part-model acknowledges this in its emphasis on the importance of the wider political and economic influence on ill health and on medicine.

In addition to the gross influence of politics on health the relationship between doctor and patient is also obviously moulded by the differential power accorded to doctors within the consultation which in turn reflects the distribution of power in society itself.

Our decisions on who should get a sick note or referral, or whether we are going to spend 12 or 25 hours a week in surgery available to patients all have political implications. We receive the wider mantle of power accorded by society and actively implement it whether we like it or not. Our power to control the interactions, to decide about disposal of resources between patients and to define what the problem "really" is all spring from the political values of our society.

We fully acknowledged these fundamental political constraints and at times, in small ways, did try and influence attitudes to them. One practice for example had offered a petition to patients in the waiting room asking for their support in changing a bill currently before Parliament that would have given access to doctors files to the police. During one of our attempts to get feedback from patients on the kind of doctor they wanted patients were asked what political role they thought appropriate for their doctor on issues such a nuclear weapons. A year previously at the height of the Falklands War one practice had displayed a notice expressing their disapproval of events.

These were small efforts but important both because of the recognition of the wider roots of our problems and because they signify a refusal to accept that paralysis of powers that so easily engulfs us as we look at the vast changes that are required for a healthier way of living.

Clearly then we are not going to be able to change the

world. But in a deeper sense changing the world for others is not really what we felt a holistic approach should be about. Part of the malaise of orthodox medicine is precisely because it seeks over-zealously to change the (individual) world of patients' illness. Ill people are done to, and "worked up", their problems defined by doctors who are perceived all too often as yet another authority and expert to whom obediently people must surrender their autonomy.

In a sense the whole of the rest of the power group's work was precisely about trying to find ways round these external political inequalities. At an individual level how we do something is just as important as what we do. What can we do within the consultation to balance the overwhelming initial inequalities which systematically distort our interaction with patients? If unwilling passivity is at the root of much illness then it is clear that experiencing being more in charge of one's illness is a major route back to health.

The following strategies that we evolved can be seen as attempts to level some of these initial differences:

(a) Change-of-seats role-play. On a variable number of occasions we all tried swopping roles with patients. The rationale for this was to try and make both players more aware of the constraints the other was working under. In practice these were always with people who knew us well and with whom their seemed to be difficulty getting to the heart of the problem. The results were very varied from bewilderment on behalf of the patient and embarrassed retreat from the doctor, to very positive changes. Typically it seemed to work best if we could get over our inhibitions and actually change seats and then role-play each other. Perhaps the most dramatic example came when one young man moved into the doctor's chair and briskly said "Well, young man, I think you're just worried about drinking too much and becoming an alcoholic". Here a matter that had been matter of factly discussed before and judged (wrongly) to be unproblematic was reopened and the patient's worries immediately brought to the fore.

Other advantages are that patients can experience the relative powerlessness of being the doctor and not having a pill for every ill. It can also be much more fun than yet another circuit of the question and answer round-about. Finally a little gentle and ironic overplaying can do wonders for both patient and doctor in understanding how they are seen by the other.

(b) Changing the environment. Many things about

doctors and their surgeries positively underline for patients that they are the ones expected to be passive. We tried to change such signals by dressing less formally and having more everyday furniture in the consulting room (see Roger S. personal account).

(c) In a similar vein several people deliberately started talking more about their personal lives. For example Paul H got married and Nuria had a baby during the year of the inquiry. Patients often knew of these events and were delighted to be able to ask the normal sorts of questions about them. By so doing the distance between doctors and patients is inevitably reduced, our foibles and feet of clay become more visible and patients are thus better able to assess our power and capabilities.

(d) Skill sharing. One root of our power is obviously our diagnostic skills. People by and large are intensely interested how practitioners come to think they have a particular diagnosis and seem delighted to be shown the evidence guiding suggestions about management. We tried offering the chance to learn such skills by for example encouraging people to take their own blood pressure, or look at their toddlers red ear drum. People can never of course fully become their own doctors and this was not the aim here. They can however become more skilled in listening to the signals of health or disease emanating from their bodies. The gratifyingly large and growing number of books and electronic packages around is testament to people's enthusiasm here.

However we felt that there was another equally important benefit in skill sharing because it can so dramatically demystify for patients the medicine that is being applied to them. Hypertension for example is suddenly seen as a fairly simple matter of listening to two noises and not something very complicated that only highly intelligent people can understand.

2. Increasing Autonomy - Access to Feedback Loops

As the power group progressed we came to realise that many of the dilemmas of power sharing can be side-stepped by aiming instead at increasing autonomy. "Patients should always go out more autonomous than they came in" (Roger S) - autonomy here being used in the sense of being in charge of oneself and one's affairs.

Shifting the focus from power to autonomy immediately defuses some of the arguments about when it might not be appropriate to share power. If someone comes in incipient diabetic coma then clearly "sharing power" is distracting and useless. Orthodox treatment itself should increase

their autonomy and ability to be in control. As they progress through their illness and come to terms with the many ramifications of diabetes, alternative skills of doctoring become necessary so that they can assimilate the information and skills they need and decide how they personally want to live their diabetes. Of course this happens already - such flexibility is in no way the prerogative of those aspiring to treat people holistically. The problems we were interested in was how could we routinely set the tenor and syntax of our consultations so that this flexibility occurred, so that patients did indeed come out of the surgery more in charge of their lives than they went in.

My autonomy as a patient depends in the first instance on my knowing what is going on. By systematically increasing the information available to patients we hoped to automatically shift the balance towards greater autonomy for them.

One thing that we tried out was routinely dictating referral letters whilst the patient was still present. The advantages of doing this are legion:

The patient knows what I as their doctor am telling the hospital about them and what my view of their problems is.

They can then go to the consultant uncluttered by all the common fantasies about what I might have written or the terrible diagnostic possibilities that we did not speak of but which they dread.

The doctor can check out details there and then.

The patient can give their consent to what has been dictated.

It is a simple thing to do which positively saves time as there is no pile of dimly recalled referral letters to be written.

Most importantly because of all these things the patient feels included, their active participation legitimated and desired.

Despite all this it is rare for doctors to write referral letters with patients. The reasons given for this (and which we initially felt too) are that it is sometimes necessary to include opinions about the patient's personality, or diagnostic possibilities as yet undiscussed with the patient. It is possible that these occasionally are valid for a few patients (though even this is arguable). In fact we felt that the real reason for our reluctance was our fantasy that such a joint referral letter might diminish our control. As it turned out such fears were unfounded. Power is not a zero sum

affair in consultations and by increasing the influence that patients have on such events not only did our work become easier and more enjoyable but also the patients themselves obviously appreciated it.

We tried a number of other similar strategies from routinely showing people letters from the hospital and lab reports, to encouraging them to read their notes if they wanted to. Their reaction to these innovations was almost universally one of interest and approval. For ourselves, moves in this direction were initially the occasional experiment followed by increasing frequency if the experience was positive. In this way we could gradually move to a system of opting out of sharing information on the occasions when we felt uneasy rather than our previous occasional opting in to include patients. We moved at our own pace in these innovations gently pushing forward what we felt easy and comfortable with rather than following rigid prescriptions. Slowly new procedures and routines emerged from our initial awkward, one-off experiments.

The skill-sharing, demystifying strategies outlined above can also be seen as attempts to increase patients access to information. Encouraging people to take their own blood pressure or teaching them that rib recession and increased respiratory rate are significant in their asthmatic toddler not only make their medical problems less opaque it also gives them new information with which to assess their situation. Most important of all perhaps it gives them the implicit message "it's OK to participate".

3. Evaluation

Focussing on autonomy rather than power as such helps to make the issues more accessible but does' not deal with all the problems. There can still obviously be a clash of viewpoint even within the context of consciously aiming to increase patients' sense of being in control. There are still going to be times when patients were going to ask us to act personally in a way we disagreed with - autonomy is not necessarily an overriding good.

In order to get over these problems what we really needed was another co-operative inquiry involving patients to assess what we were doing from their perspective. That this was impractical for us was clear, so what other ways of evaluating what we were doing could we devise? How else could we get access to the patient side of the story?

We evolved several strategies to try and gather this kind of information. Three doctors (Monty/Russell/Michael) devised questionnaires whilst others used more personal and unusual approaches. Two of us (Russell and Paul F) contacted particular patients directly and asked for feedback about their experiences as our patients. Other people (Paul H) videoed consultations and then reviewed

them with the particular patients involved. We all agreed to set up open meetings with patients to try and find out how they felt about the practice.

We attempted all this not with the naive idea that by so doing we would get to the holy grail of what a representative sample of our patients "really" thought about us. Nor that we would be able at the end to make any "objective" statements about what we had gathered. What did seem important to us was opening ourselves to the process of feedback, to say and be seen to be saying "Look I really want to know how you feel about the service you get".

These exercises felt very risky things to be engaged on - especially the ones involving personal contact. They seemed completely outside the normal communication between doctor and patient. This acute sense of being vulnerable became, for some of us, a touchstone for knowing whether we were indeed sharing power in any meaningful way. If I as the doctor did not at some stage feel vulnerable and open to feedback then it was a fair bet that I was not sharing power in any true sense.

"The big problem was to make myself offer the chance (to review the video of the completed consultation) - even with this highly selected group I was still very anxious... However it was worthwhile. We were much more like peers in the reviewing than we had been in the interaction itself - I suppose because I felt exposed and vulnerable"

The essence of all this is not so much what gets said as the revelatory sensation for the doctor of being, for once, one down, dependent and vulnerable. This felt sense of vulnerability is therefore one way of knowing whether power is truly being shared.

Doing this is not initially pleasant or easy:

"What's stopping me is the feeling that it's foolish, that it won't work and that I'll seem to be seeking my patients approval. It's the fantasy about what my colleagues might say that's stopping me".

We also discussed how to judge the appropriateness of sharing power. If a sense of vulnerability for the doctor is a touchstone of true power-sharing this still does not guarantee that such sharing is appropriate. Without full involvement of patients of the kind we never achieved the question of how to judge this is difficult to answer. Certainly allowing people to make their own decisions frequently feels unsafe for the doctor especially if they seem to be embarking on ill-advised projects. Sometimes however it was clear that developing crises were a necessary stage, that the resolution of a particular problem could not be short-circuited through some route

that to us seemed safer and more innocuous. Very often resolving emotional or life problems involves us deliberately choosing to face up to the contradictions of how we are living. People in the process of doing this may seem to a casual or anxious observer to be getting worse and not better, to be feeling more pain not less.

Inappropriate interventions may then follow ostensibly trying to reverse such "deterioration" but actually aimed at relieving the doctors anxieties.

Despite all of the above, by and large our attempts to involve our patients in assessing what were were doing were failures - they were perhaps the riskiest of the things we tried out and the ones, arguably that came closest to the crux of sharing power. In retrospect this was our biggest area of failing, perhaps not so surprising given the hesitancy and insecurity that all our other projects and innovations raised in us, but significant and regrettable.

Philosophical Issues

It may seem obtuse to leave the philosophical discussion of power till so late in the day but this reflects two things. Firstly this the order in which things actually happened - we did not set out with any agreed or clear philosophical viewpoints in mind and such progress and understanding as we did achieve conceptually came after, and because of, our practical experiences and the related discussions.

Secondly as we progressed through repeated cycles it became clear that although there were important philosophical issues at stake there were no inherently right answers. Others had been here before us and had come up with just as confusing a range of answers. In part this is because "power" is one of those ideas whose application is inherently a matter of dispute. Within a philosophical view "power" like "justice" and "freedom" is seen as an essentially contest concept, i.e. one's view of it is inherently tied to one's position and interests and there is no necessarily correct view.

Throughout the whole of the inquiry we were somewhat biased against using the writing of others. In part this was due to our sense of exploration and consequent pejorative feeling that other people's views would be preconceptions - this might be old territory but our vision of it was going to be completely new. Such a bias obviously runs the risk of reinventing the wheel (indeed of never inventing it!) and indeed it was foolish to believe that we were not already loaded with our own ready-made preconceptions. In retrospect the discussion of power sharing would have been helped by wider reading.

The essentially contested nature of power plays into

another difficulty that we recognised: our views of the world are all ultimately subjective. Within medicine there is a widely held but rarely explicit idea that there is only a single "objective" reality which can only be adequately revealed by the scientific method, a reality that exists "out there" and to which we are all slowly and painfully converging. In this belief patients are sacrificially reduced from living wholes to "objective" and measurable bits of "real" pathology.

That this belief in a single objective account of the world is inadequate became clear to us as this inquiry progressed. Some of the evidence for this belief is outlined in the chapter on the scientific basis for a holistic approach. The fact that power is essentially contested, that there is no single "right" answer about it underlines the philosophical difficulties inherent in a "single reality" view of the world. The scientific view is a useful but not exhaustive tool to help us make our way in a universe that we intrinsically and always construe personally. The world is constantly created by the meaning we give it.

In one sense this is not problematic. However at a practical level of everyday use and understanding we all find it hard to fully accept this relativism. In part this is due to the vehemence with which the medical ideology that we have all been deeply influenced by has proclaimed its useful but limited truths to be deeper and more profound than other ways of seeing health and disease. In part the realisation that reality itself is relative causes anxiety. It is hard to get one's bearing on this ocean of relativism, where there is no "objective truth" to hold on to and where an other's view of the world may be just as valid as my own. The more so since whilst there are many visions of reality they are not all equal but vary in wisdom, insight, effectiveness and imagination and we are still called to judge between them.

This relativism of viewpoint, the understanding that the world "is an inter-subjective ambiguity" is one philosophical reason why power is so important: given two conflicting views of reality power is the traditional means of deciding who's view shall prevail. Ultimately making power-sharing a reality depends on our understanding of and respect for the others experience and point of view. The key to this lies in our own self-awareness, in our commitment to the process of self-gardening.

Summary

At the end of the day our contribution to the sociological and philosophical discussion of power was limited. What we did do was devise and try out a series of unusual ways to equalise power within, and to a lesser extent without, the doctor-patient relationship.

Such attempts centred on levelling and de-mystifying strategies, increasing feedback loops to and from patients and trying to encourage feed back to doctors.

CHAPTER SIX: SPIRIT

Once we had decided that spirit is an integral part of the person - so that any consideration of a person as a whole would entail a consideration of their spiritual aspect, we were left with the problem, in this irreligious, godless and scientific age - what is spirit? The Oxford English Dictionary gives it four pages and 24 sub-sections, including "the animating or vital principle in man", "the soul of a person as commended to God", "active or essential principle or power of some emotion or state of mind", and "subtle or intangible element or principle in material things".

With this and more as the accepted meanings of the word "spirit", how can one person know what another person means by the word? With people with different cultures, classes and religious affiliations there are bound to be markedly different interpretations attached to the word, leading to misunderstanding and confusion. The Tower of Babel. And many people have thought so little about the subject and only have a rather diffuse idea as to what they mean themselves when they use the word, let alone what you mean when they hear you use the word. So if order cannot be achieved, the other alternative was taken, that of entering chaos. We all gave our own tentative personal concepts of spirit, talked about, discussed them, and tried to observe and report on what we took to be spiritual phenomena with our contacts with patients, and from this chaos tried to crystallise out some working ideas.

First to list some of the concepts that were recorded in the data returned by the group members at the end of the first two or three cycles.

Breath of Life.

Life.

Soul.

The life giving principle.

Breath of life conceived of as animatory body.

The immortal non-material part of man which thinks and feels, contrasted with body.

Life, will and consciousness thought of as being apart from matter and as never being associated with the body, and yet as pervading all things.

Essence of man's nature, imagined but not provable.

Man as an unique being, deserving of respect.

Man derived from a common origin and related to all other men.

Man as a reflection of God.

Man who may have meaning beyond the one he defines for himself.

Spirituality is specifically associated with the acceptance of a god principle in life.

God Within - Belief in being related to the Cosmos - inner guiding force within persons - conscience - intuition. God Without - Quality, Meaning and Pattern within the universe.

The meaning that the patients attribute to their illness (or their lives). Where have I gone wrong? How does it fit into the pattern of my life?

It's the quality that transmutes a matter of fact, workaday interaction into something "holistic". The therapist must be clear and very present in the here and now, so that the therapeutic interactions are appropriate for the needs of this client in this moment of time.

To be present, to be "in tune", to allow what wants to express, express through me seems to be meditation in action.

The spirit is the product of the mind in full human relationships with other persons, and places, the world, the universe, nature, the products of persons e.g. art, music, literature, drama, dance and ritual. The medium of this relationship is the flow of information from person to person in a feedback loop which is the relationship. The flow of information can be visual, or verbal, or touch, or smell and may not always impinge on consciousness.

The spirit is not the information, nor the message, nor the atmosphere, but something in the dynamic relationship. The spirit of a man is the sum of his relationships with others and the world. The spirit of a place the sum of the relationships with persons who know that place, made up it's history, it's visual and sensory effects on people.

The spirit group was formed at our third meeting in order to inquire into this cloudy area, the importance of which is acknowledged in principle but in practice is often avoided. The spirit group wanted to clarify through reflection and action what appropriate and effective spiritual interventions within the National Health surgery

would be like.

The genesis of the spirit group arose out of two factors. The first was a concern among members that it wasn't satisfactory to profess a commitment to holistic medicine as a concern for the patient's body, mind and spirit, if in practice spiritual interventions were systematically ignored. The second was the presence at the third meeting of one of our visitors to the project, Murray Korngold, who strongly affirmed the spiritual dimension in several ways. He put forward the theory and practice - via exercises - of the old Polynesian Huna system of the low, middle and high self, with its practical everyday use of prayer and invocations. He distinguished between psychic healing and spiritual healing: the former being the direct and lawful influence of mind on the body by visualisation, meditation, and so on; the latter being the effect, unpredictable and non-negotiable, of the free flow of divine grace and presence into the disease arena. He demonstrated powerfully in the large group and especially in the first meetings of the spirit group, an uncompromising use of spiritual invocations.

The group met at each meeting from the third through to the final and seventh. Its primary task became one of devising a range of spiritual interventions, going away to try them out in practice, report on their appropriateness and apparent effectiveness, refine the interventions further through this sharing and discussion, try them out, report back and so on. Interwoven with this practical intent there was a good deal of discussion of underlying assumptions, issues and principles: a kind of metaphysical mapping of the background to the use of spiritual interventions. In what follows we present first some account of the group's deliberations which hopefully will give some "feel" of our approach; we follow it with outline of the distinctions and principles which the group found clarifying and guiding as a background to practical work in the surgery; and then give a brief account of the strategies used by various members of the group.

The Spirit Group at Work

We started, not with ideas and theories and belief systems, but with practical actions which all doctors use in their everyday meetings with patients. How we prepare for a consultation, how we meet or greet the patient and how a consultation ends, these are felt to be in some way focal points in which powerful and often unappreciated effects were active. How do we clear our mind and centre ourselves in preparation for a consultation, having only just finished the previous one where we may have been deeply involved or emotionally affected? Is this process of preparation akin to prayer? The methods used by the members of the group, which they volunteered, were naturally varied but seemed to have some likeness to prayer or meditation, e.g. to see the next patient as

one's mother, or as Jesus; to mentally say "Be still. Know that I am God"; to think on the theme "God is closer to me than I am". Methods of cleaning the mind of the past and the ego - but yet, being entirely present and centred and open to what the patient has to bring. This leads naturally to greeting the patient; but this seemed less revealing, more to do with touch and smile and movement than speech or thought. Finally, how do we part from our patients? What form or words, what parting thought or feeling do we wish to leave the patient with? Examples were:-

"I'll be thinking about you."

"Take care."

"Wrap up warm."

"Make an appointment in two weeks."

"It's in the lap of the Gods."

"Don't let the bastards grind you down."

"Good luck."

"Peace be with you."

"God bless."

"Bye-bye."

It will be noted that many of these farewells (and that word is another one), might be seen as neutral - others have an element of calling on a higher power for help or supervision or care. A form of invocation.

So by studying such an everyday occurrence as a doctor/patient consultation it was found at times that both prayer and invocations occurred, so that perhaps spirit is always present in medicine, though often unobserved and uncultivated. We decided to capture invocations as this does involve the patients more directly than prayer, which was more related to the doctor's self preparation.

Invocation (IN-VOCARE = to call in, to summon, to consult, to petition, to ask for assistance). There is an implicit assumption that there is a power/or powers available to be called on by appropriate ploys, appeals, sounds, thoughts, actions or rituals. This power has a multitude of names, titles or metaphors, e.g. angelic hosts, wrathful deities, voices, totems, the metaphysical absolute, the Holy Ghost (Spirit), the divine singularity, guardian angel, the Almighty, Dunma etc., etc. The prayer is the same, only the name is different. We ought to use that name or metaphor that is familiar to the unconscious of the

patient, i.e. to the childhood training and experience.

With these guiding ideas in mind, next day we experimented with the uses of invocation, to get into the idea and feeling of the thing. This was a very useful experience as we all became very impressed as to how there was something going on which we could not exactly understand. For on trying an invocation in role play on a fictitious patient, though a lot of power was around, nothing seemed to happen. Perhaps because the invoker directed his invocation onto the person present and not onto the role he was playing. The person present was present in role and not as himself. So a further exercise was performed in which each group member concentrated on a real but absent patient who had been briefly described to the group. Again something happened - one of the group members, in tears, picked up a feeling that the absent patient did not wish these invocations to take place - and in the process she was deeply affected and the other group members also. So no actual or spoken invocation was made though many had been thought up and felt. And it was arranged that the patient under consideration should be reported on later.

The group then contracted to, in their practices, pursue the following activities:-

1. Mental act - have the intention to raise spiritual dimension with patients.
2. Practise explicit invocations at different levels from "have a good day" to "may you be whole in spirit".
3. Practise asking spiritual questions e.g. "do you pray?".
4. Endeavour to find out how practitioners can cultivate spirit as a result of self cultivation.

Six weeks later we reconvened to share what had happened to us in the realms of the spirit. We started by hearing about the patient who had been the subject of the group's thought six weeks before when each person had thought up an invocation. She had improved and was enjoying life more, though there were various physical and family reasons for this, but the spirit works in strange and mysterious ways. Interesting. In general the doctors reporting had found it much more difficult to follow the contracted practices than they had expected, though when they had done so they had often been pleased with the resultant effect on the patient or on the doctor/patient relationship. The cases where the doctors reported they had used invocation, or had inquired about spiritual matters, or in some other way had developed a spiritual contact with touch or ritual, had all been cases in which the doctor felt either the relationship had become blocked

or sterile, or very difficult complex cases where the usual medical interventions seemed pointless or feeble.

Many ideas and observations come to light in this discussion which are summarised below. And with these insights in mind, the group dispersed for a further six weeks in the field to continue to observe and report on what spiritual manoeuvres they managed to instigate.

The next group meeting was missing two of the doctors so clinical material was rather thin on the ground. Discussion was more generalised about the spaces which appear in consultations and seem to invite something more than a trite remark. How do they occur? How should they be used? Could they be planned for or created? Then again what to put into the space? Examples were given of doctors not so much thinking up and preparing an invocation, but using free floating attention, to be fully open to the patient in full presentation, verbal and behavioural, so that the doctor feels some sense of how the patient feels, and is able to interpret and make sense of this feeling and feed it back to the patient verbally. How is this sensitivity to be achieved? How is the doctor to trust his own feelings about his patients? Are they from the patient or a projection, or a prejudice of the doctor? Lots of questions, but few answers. And we looked again at the other question of the two different areas that were arising in our discussions: that of psychic phenomena, insights from nowhere, psychological tricks and manoeuvring, magic, hypnosis, visualisations; and that more transcendental area, out of this everyday world, where there was power and hope and danger, but not control or understanding, just intercession and hope - the area of God and the unknown. Were these two entirely different areas or points on a spectrum of experience from solid facts, to psychology, to magic, to the Almighty.

The tone of these latter meetings, though still involved and enthusiastic, seemed a little lost and disappointed in the difficulties of the enterprise and the formlessness of the findings. To rally ourselves and rekindle our spirits, two new projects were considered. One a firm commitment to bless the surgery or consulting room every morning to start each day fresh, cleansed and renewed, and a second more tentative suggestion to give pebbles to our clients as a talisman of power, protection or blessing for them to take away from the consultation. Both these ideas only came up in the final few minutes of the group and were not fully discussed as to their methods of implementation and what difficulties or inhibitions might arise.

At the next meeting six weeks later, some of the steam seemed to have gone out of the group, although we were still able to discuss enthusiastically the theoretical presence of spirit in the practice of healing; there was very little reporting or practical activity in this

region. This may be due to the realisation in the earlier meetings that this is not something that can be forced and made to occur as an effort of mind or will, but must be felt and performed in the right spirit. It required a special state of mind or will, but which could only be acquired with practice, patience and exercise and we were, many of us, new at this sort of thing, and by our scientific training given to a "healthy" scepticism about anything unknown, untried and untested. But spiritual practices require belief - not scepticism. How could we believe in something so inimical to observation and control? How were we to allay the critical Left Brain, and allow free flow to the intuition of our Right Brain? "Lord, I believe, help thou my unbelief." Many of us still seemed to be looking about to find out what place Spirit had in medicine, enquiring about the patients' religious beliefs, visiting healers and seeing how they worked, seeing healers at work in a church ceremony, inviting a clergyman in to bless the surgery. Of the actual suggested tasks at the end of the last meeting there was very little sign. One doctor had, after looking up the meaning of Blessing in the Oxford Dictionary, worked out a ritual that he had performed before each of his surgeries for the previous two weeks. The ritual was described as follows:

The Blessing of the Surgery

I close the door. I place my pipe on the window ledge, out of reach - not on my desk. Starting from the left hand side of the surgery, I slowly move across and around, touching and readjusting like an obsessional housewife, the arrangements of the place. The waste paper basket, my trainee's chair, the desk with my stethoscope, auroscope, prescription pad, note paper, certificate block - the patient's records for the coming surgery (carefully not looking at the name of the first patient), the sphygmomanometer, the desk lamp. I move to the instrument trays on a bench down the right hand side of the room and touch them and straighten them; the sink, the soap, the paper towels and the steriliser. I move to the examination room, the pillow, the sheet and the couch - all is straightened and made good. I go back to the consulting room, move and position the patient's chair and the chair for one other; my chair is then positioned. I move back to the sink and run cold water over my hands in a formal lustration and dry my hands on one - then two - paper towels, thrown formally into the waste bin by the sink. As I move back to my chair I take off my watch, sit down comfortably and watch the second hand of my watch progress twice round with my mind blank and breathing in a proper abdominal manner. I replace the watch and move to the door, which I open and say "We are off."

The blessing seemed to consist of a ritual cleansing of first the surgery and then the body of the doctor, and lastly his mind, in preparation for helping his patients.

A further record of a doctor blessing his surgery, though no particular ritual is mentioned: the use of ornaments and flowers make him mindful of love, and care for his room spills over and renews his love and care for his patients. As to the giving of pebbles, nobody has actually achieved that, though some thought was given to it by one member and some pebbles actually collected and prepared for later use perhaps. Instead another member had given a match, which had been charged with power to help or illuminate a situation when struck, to a number of patients who had then used them when they felt the need - as a one off burst, with some positive feedback from the clients that he used it with. As this was the penultimate meeting no new plans or contracts were made for new work or projects, but everyone was keen to carry on looking for what might be called spiritual phenomena in the consultation; continue cultivating the spiritual aspects of themselves; and think how their ideas and insights might be conveyed to a wider public and particularly the medical profession with such élan that there would be no rejection of what some might conceive of as foreign material entering into medical practice.

The final meeting of the group, after another six weeks, was mainly taken up with a personal review on the part of each participant, of their view of how the spiritual dimension extended into their medical practice and what methods were used to implement this dimension. Certain common themes seemed to run through the discussion as well as individual ways of coping and methods of work.

Distinctions and Principles

We turn now from the story of our inquiry into spirit to distil some of the ideas and principles with which we emerged. What follows is a set of 17 principles, points and distinctions which we believe have achieved a very modest pragmatic justification: they helped to make some sense of the practice of spiritual interventions, and of the efforts of such practice, by nine group members over a four month period. Of course, each group member was in a different degree and in a different manner involved in the sense of relevance of each of these points.

1. The psychic and the spiritual. It became clear that in the early discussions of the spirit group these two dimensions were unawaresly intermingled. In later discussions we included them both but were more clear about the difference. The psychic refers to the domain of extrasensory perception, of subtle energies, forces, powers and presences beyond the immediate range of ordinary consciousness and sense perception. The spiritual refers to the divine spirit that moves through creation. The psychic is another aspect of creation beyond, around and interpenetrating the physical. The spiritual is that creative presence out of which both the psychic and the physical become manifest. Human response

to the psychic dimension, or human activity within it, need not necessarily involve awareness of or intentional relationship with the spiritual. And conscious attunement to the spiritual dimension need not necessarily involve any awareness of or relationship with possible psychic concomitants of such attunement. Equally, however, aware relationship with the psychic dimension and the spiritual may run together in certain kinds of ceremonial, ritual or invocational activity. In this inquiry it became clear that we used the phrase "spiritual intervention" to cover the psychic, or the spiritual, considered relatively apart from each other, and to cover them both in interaction.

2. Psychic and spiritual healing. Closely following the preceding distinction, was the distinction introduced by Murray Korngold between psychic healing and spiritual healing. Psychic healing is entirely lawful and within the range of voluntary choice and effort, involving mental action to direct subtle energies for physical benefit. The mental action may be visualisation, concentration, meditation, invocation, affirmation. It may also involve physical action in the form of gesture and touch by the practitioner. It is concerned to set in motion the forces of the psychic or para-physical domain for physical healing effect.

Spiritual healing is a function of the evident presence of divine spirit in the practitioner-client relationship, and is not necessarily a consequence of voluntary choice and mental action. It may come unbidden, an unpremeditated and unsought act of grace. It may occur as an apparent consequence of prayer and aspiration and invocation. It may not occur even though authentic prayer and aspiration has occurred.

It is likely that spiritual healing if it occurs inevitably involves psychic concomitants, whether practitioner and client are aware of them or not. And it seems that if psychic healing occurs it is not necessarily the case that practitioner or client are in a state of conscious attunement to the working of divine grace.

These points and distinctions emerged as possible illuminating hypotheses to guide modest practical efforts at spiritual intervention. They were certainly not adopted by this group as "findings" based on healing experience.

3. The being-becoming paradox. Everything just as it is here and now is part of the divine being, so in a sense whatever is and whatever it is, is divine. If nothing falls outside the divine being in one aspect or another, then there is nothing that is not already divine. On the other hand, there is clearly a sense in which human reality as it so often is, is not divine, yet has the capacity to become divine, that is, to become more and more attuned to and included within divinity. The paradox

is heightened by the thought that practising awareness of the being part of it, facilitates the becoming part of it.

It was felt in the group that grasping the paradox might enable not only spiritual self-gardening in practitioners, but also spiritual attitudes in relation to and in intervention with the client. Disease may be seen as the divine as destroyer, and such divine pathologising as a potential source of creativity and deep awareness.

4. The paradox of self-acceptance and working on self. This paradox follows closely on the previous one. In relation to self-gardening, attunement to spirit is a combination of deep acceptance of self as one is, without effort, and of working on self to change one's consciousness and mode of being, with effort.

5. The emotional and the spiritual. Some group members considered that the emotional and the spiritual could perhaps too readily be confused. States of high emotional, or even sexual, arousal, that were purely secular in origin and in nature, could be confused with sacred states of divine visitation and presence. And this in practitioner or client or both. No-one reported experience of this in either role, but it was considered to be a useful cautionary and prophylactic principle, a protection against religious delusion.

6. The preparation-spontaneity paradox. Spiritual interventions can't be forced. They are essentially spontaneous movements of the spirit within the practitioner. They can't be concocted as a training exercise or intervention on the job. Yet spiritual training and preparation are possible through the regular cultivation of a variety of spiritually oriented states of mind and attention. So the paradox states that it is possible to prepare and train for spontaneous spiritual interventions.

Perhaps it is not such a paradox after all. The musician practises formally at one time, in a way that cumulatively facilitates spontaneous improvisation at another. The basic point is that whereas principles and rules may guide much of the preparation and training, spiritual interventions on the job are not just the conscious application of a rule or principle - they emerge spontaneously out of the quality and dynamic of the relationship. This clearly was a principle more firmly rooted in the intervention experience of group members.

7. Hierarchy and parity. Some spiritual interventions may mean that the practitioner temporarily assumes the role of an authentic and genuine hierarch, exercising charismatic authority, as when making an explicit invocation, initiating and conducting a piece of ceremonial. But flexibility is needed in being able to move easily out of this role into the parity involved

in cooperative problem-solving, in sharing responsibility for diagnosis, treatment and assessment of outcomes. Conversely the diffident practitioner may find flexibility in the reverse direction problematic, being shy of assuming charismatic authority. It was also pointed out that spirit might manifest at the heart of cooperative power-sharing, analogous to the Balint "flash".

8. Transcendence and immanence. The last sentence points to the distinction between transcendent spirit emanating and descending into human events; and immanent or indwelling spirit emerging within - at the base, the core, the heart of human events. There is transcendent God as descending light, resounding Fiat or Logos; and there is immanent Goddess as moving life, as the consummation of immediate energy, as the magic and moment of present relationship. Again this distinction was felt to be a guide to the range and complementarity of different sorts of spiritual interventions, encompassing the peaks and the valleys of human behaviour, from invocation to immediate felt empathy.

9. Spiritual interventions as a defence against incompetence. This was a cautionary guiding principle to the effect that spiritual interventions could be used degeneratively: as a way in which practitioners might avoid their inability to exercise appropriate physical and psycho-social skills. So the practitioner might go on about spiritual matters or make spiritual moves because of incompetence in doing what is really needed at the level of body and/or mind.

10. Spiritual imposition. Another cautionary principle which some of the group wrestled with in practice was the danger of the practitioner imposing spiritual values and beliefs upon the client in ways that would oppress the client's true inclination of soul.

11. Explicit and implicit spirit. Some group members developed a proper wariness about making the spiritual dimension in a consultation explicit. Leaving it tacit and implicit, unstated, helped it to grow. Making spiritual presence explicit in work or deed could detract from it.

12. Response and intent. How the client reacts to a spiritual intervention is very much a function of how the practitioner does it, of the spirit in which it is done - the feel, the tone, the quality, the timing, the empathy.

13. Permission-giving. There was general agreement in the group that one simple and basic kind of spiritual intervention was anything said or done that gave permission to the client to own and identify and talk about the spiritual dimension of their life. Such

permission giving counteracted a widespread tabu in our secular culture about the affirmation and exploration of spiritual realities.

14. The metaphor of spiritual spaces. The metaphor of a space or gap was used frequently and found by many in the group to be useful in illuminating the practice of spiritual interventions. First there was the notion of spaces or openings or gaps in the interaction with the client in which the psychic and/or spiritual were latent or tacitly present, and could be made explicit by some spiritual intervention. These were spaces or gaps in the temporal series when it opened up with potential for entry into deeper dimensions. Second there was the notion of openings between the two worlds, the world of ordinary sense perception and social inter-action, and the extra sensory psychic/spiritual world beyond. Such openings could be created by ceremonial, invocation, sound, gesture, appropriate questions and statements; or they could be noticed when they occurred naturally/supernaturally and then used to empower appropriate spiritual interventions. A temporal gap and/or an opening between the two worlds could also be used simply to empower empathic sensitivity to the client's unspoken reality. The time gap metaphor and the gap between the worlds metaphor are presumably different ways of talking about the same thing.

15. Different sorts of invocations. One group member put forward the following classification of invocations which some members found useful.

(A) Tacit invocations: ordinary greetings, farewells, pleasantries, validations of personal qualities or deeds, said with charismatic intent and tone, or with additional silent prayer.

(B) Explicit invocations. These are explicit by virtue of their grammatical structure and their content.

B.1. Benedictions (implicitly spiritual): May you be whole (implying whole in spirit).

B.2. Benedictions (explicitly spiritual): May the spirit make you whole.

B.3. Commands (implicitly spiritual): Be whole (implying whole in spirit).

B.4. Commands (explicitly spiritual): Be whole in spirit.

B.5. Affirmations (implicitly spiritual): You are whole (implying whole in spirit).

B.6. Affirmations (explicitly spiritual): You are whole in spirit.

Affirmations are said from the being pole of the being-becoming paradox mentioned in 3 above: they affirm the person as part of the divine being. Benedictions and commands are said from the becoming pole: they encourage

the process of becoming attuned to the divine.

16. The spiritual psychology of Huna. Many group members found the old Huna model of the human being from Polynesia useful as a working guide to practice. (a) The low self is the unconscious mind, the seat of the emotions, the store of memory and feeling, the store of mana or vital force or energy. (b) The middle self is the conscious mind: the seat of free will and reasoning power; the teacher and guide to the lower self. (c) The high self or superconscious mind: the connecting link to the Creator transcends memory and reason; guides and protects the free will of the middle self. If healing or treatment is needed the middle self can request the low self to send its vital energy to the high self to empower the prayer which the middle self puts to the high self. The low self can become beset by compulsive guilt. The middle self needs to forgive the low self, help it to let go of its burden of guilt. There is a primary and secondary guilt involved in an illness. The primary guilt is part of its aetiology. Secondary guilt is the guilt about being ill. The appeal of the Huna system is that it presented a working model of spiritual interventions, free of any doctrinal bias from within European spiritual traditions.

17. Spiritual interventions as "falsifiable" . One group member proposed as a test of the "validity" of a spiritual intervention the test question "Does it have heart?".

Spiritual Interventions Used

The first four points cover the original action plan devised at the first meeting of the spirit group, subsequent points cover a range of divergent strategies.

1. Having the intention to raise the spiritual dimension with patients. Most group members sustained this fairly well, subject to two limitations. Firstly, not all patients want to go into spiritual matters even if it is appropriate to their condition; and in some cases it would not be appropriate to their condition even if they were open to it. So some group members through trial and error learned when to exercise the intention selectively. Secondly, you can only exercise the intention when you are spiritually alert or "awake"; so such exercise is subject to fluctuations of the practitioners spiritual attention and inattention. Several group members reported on this fluctuation.

2. Practising spoken invocations. Several group members practised tacit invocation, that is, ordinary greetings and farewells and supportive statements said with spiritual intent. This was deemed at least valuable to the practitioners in raising their level of awareness and intention in ordinary social transactions. Five group

members, each on at least one and at most on a small number of occasions, ventured forth to use explicit invocations, where the form of words used indicates that something extra-ordinary is being said. One backed off, after the first attempt, because of his own felt awkwardness, and because of no evident patient response. The others were more confident, feeling a positive impact on the immediate relationship with the patient. But no-one used explicit invocations in more than a discreetly modest number of instances.

3. Practising the asking of spiritual questions, which clearly leads on to a discussion of spirituality with patients, and of the role of the spiritual dimension in their lives. This was clearly the intervention most widely practised by members of the spirit group. It was used with the elderly, inviting them to share their perspectives on death and religion. It was used with those in life crisis and depression, inviting them to consider their lives in terms of direction and meaning. It was used where the relationship with the patient had become blocked and seemed to be getting nowhere; and in difficult cases where anything else seemed irrelevant. It was also used selectively in quite ordinary cases to raise consciousness, give permission, initiate new possibilities for self-help. This simple intervention was reported as causing a new upsurge of energy in the relationship with the patient, creating a new level of openness and trust. Questions used were wide-ranging, but basically simple in form: "Do you pray?", "Is the spiritual aspect of living important to you?", and so on.

A. Cultivating spirit as part of self-gardening. Group members practised reading appropriate literature, periods of meditation, periods of prayer, contemplation, reflection, deep relaxation, the practice of inner alertness in everyday life.

5. Self-preparation before the start of a surgery, between patients. Members used various forms of meditation, prayer, centering, mind-cleaning, imaging, to get ready to be appropriately present for the first person, or the next person. "Be still and know that I am God." "God is closer to me than I am".

6 Using touch. Most members reported on the use of touch and holding either for support with spiritual intent, or for healing, or for both. For some this was a relatively rare intervention, for others more frequent.

7. Being present and being with. Three members mentioned this as a spiritual intervention. There seemed to be two sides to it. On the one hand, being present as a person, full, congruent, real, honest; and on the other hand being present for and with the other through an empathic indwelling of the other.

8. Silent prayer and silent invocation; being a channel for grace, healing. Three members reported the use of silent, i.e. mental, prayer or invocation in the presence of the patient. Another two spoke of the experience of being a silent channel for God's grace and healing.

9. Teaching spiritual self-help. Two members teach meditation to patients, one of these also self-hypnosis.

10. Spoken prayer. One member prayed aloud for a patient who was dying and at the patient's request. One member used absent prayer for healing.

11. Use of spiritual quotations. Passages from the New Testament were read by one member in a few cases; another member regularly uses parables, anecdotes from Zen or Sufi or other literature.

12. Blessing the surgery. Four members experimented with blessing the surgery before the start of the day's work with some brief ritual.

Thus the outcome of the spirit group's inquiry is a tentative set of principles and a modest set of practices and probably most importantly a deep conviction in every member of the group that there is a central place for the spirit in holistic medicine, which can be felt and expressed but not grasped and defined, as one group member wrote after the end of the inquiry:

"I have thought extensively about the spiritual element of the consultation which I now believe to be a very important although not usually acknowledged. The spiritual element in particular acts where ordinary forces cannot act. For instance, there being an important spiritual element in the will to fight illness and to survive, in spite of overwhelming odds. It is present when hands are held to express comfort or reassurance, or give permission to grieve, or when the seriously ill patient is touched and prayer is made to help to give them strength to bear their suffering. The ability to help is enhanced by the two minutes for silence, contemplation and prayer, for instance, for patience and skill before surgeries and at the start of each day. This enables a centering upon the surgeries which are to be performed. I cannot define what spirit is. I sense that it exists and is more important than anything that actually happens in the consultation, and it is something outside us all which can be incorporated to give additional help. I very clearly witness it leaving people when they die. I do not know where that spirit goes."

Some of the ideas and practice of the spirit group may seem to some people rather far fetched and distant from the everyday working of general practice and because of this it may seem easy to dismiss the spirit in medical

problems. But it should be remembered where the group started from, a study of what doctors actually did in their everyday consultations and how this led on to a study of invocations and blessing the surgery. Also if any of your patients have medical problems which also have a relationship aspect there will be, willy nilly, a spiritual dimension to it. Just think of a few everyday medical problems; abortions; vasectomies; death; children leaving home; psycho-geriatric problems; divorce; home confinements; bereavements; battered wives; in fact it seems all the real problem problems have a strong element of the spiritual. For if a relationship is involved and there are thus more than one way of seeing the relationship then the problem has a spiritual dimension, which if the doctor can enable their patient to deal with it at that level will get a quicker and cleaner resolution of that whole problem.

What effect had the group had on its participants? How had they changed? How had their practice changed? The group was highly self selected, first by showing an interest in holistic medicine, and then opting to study spiritual matters, but in spite of this there seemed still some shyness or reticence about discussing spiritual matters. Thus one very important effect was the relief felt by the members in finding out that other members of the profession were concerned with this aspect of medicine and had felt its difficulties and thought about its problems; and as the group matured the support for each other enabled each to make much more progress in the handling of this type of work, because of the knowledge that others were doing it, and thus it was not so outlandish and strange as one had previously felt. The group only met on five occasions though most of these were double sessions, and a great deal of other work was also being done in parallel, so only the edge of a very great subject was touched - much of it as yet unexplored from this side, that is, the aspect of health/disease and the spiritual.

Besides the excitement, enthusiasm and interest, with which we started, it was very soon realised how powerful and apparently uncontrollable its effects could be, causing us to hesitate and move slowly - though being very willing to talk about it we were rather hesitant to practise in this area when patients were involved. This was perhaps very sensible but made for rather slow progress and left us with few solid findings in the end, but a great deal of personal growth and change in the group members, which will affect the way they practise in the future, which is perhaps the way the spirit works in oblique and mysterious ways. It was rather like studying or looking at something with a central scitomata. If you look straight at it, it disappears, but if you look at it sideways you can see it more clearly but never clearly enough to really feel you have seen it in all its detail and power. You have to be satisfied with that for if you stare at it, it will disappear again.

CHAPTER SEVEN: THE PATIENT AS SELF-HEALING AGENT

The acceptance and encouragement of powers for self-healing was agreed as one of the five essential principles of our model for holistic practice. Of seventeen participants commenting on their own concepts of holistic medicine at our first workshop, all said something implying recognition of its importance. Personal statements at that time included: "Encouraging patients to solve their own problems"; "The encouragement of self-help"; and often referred to the various forms of psychotherapy in which the doctor aims primarily to facilitate the patient's recognition and solution of their own problems. We decided that a model of holistic medicine must recognise both the actual and potential intentional capacities for self-healing in the patient.

The self-healing powers of the body are well recognised. At the level of everyday human observation there is the self-healing of wounds and the unaided recovery from viral infection for which orthodox medical science has found no specific treatment. We all have evidence of complete recovery, leaving no trace of illness and also the repair processes that leave their mark as scars. And our everyday human observation also tells us that there are limits to this self-healing capacity of the body: common sense shows us that a person who loses a limb does not grow another one, and medical science shows us that the severed spinal cord does not regenerate. Injuries, infections, poisons, cancers sometimes kill.

"The patient as potential self-healing agent" implies much more than this. In adopting this concept as one of the central five in our model of holistic practice we are suggesting that human beings have far greater powers of intentional self-healing than is usually recognised by either doctors or patients; and also that a major part of holistic practice is to enable this potential human capacity to be actualised.

It must be said at this point that we did not as an inquiry group devote much specific attention to this aspect of holistic practice: other issues like power sharing and spiritual practice rightly or wrongly seemed more important to us as areas for systematic exploration. However, this hypothesis of human agency in self healing was throughout the inquiry an important backdrop for our other endeavours, and we frequently referred to it in the context of other discussions. For example, the spirit group realised early that no amount of attunement, invocation, or prayer would bring about healing in a patient who did not want it, and the power-sharing group recognised that power could in many ways never be given

away, only taken in an act of self-empowerment. Because intentional self-healing had a limited status in the inquiry, this chapter must necessarily be brief and suggestive only, although we believe that we can point in some important directions for future inquiry.

As we had just implied, the notion of self-healing agency is intimately connected with the other aspects of holistic practice. In particular it underlies the ideology and practice of power-sharing, for without the possibility of self-healing the doctor would be in no position to share power, as is the case in certain emergency situations. Intentional self-healing also overlaps with self-gardening, as the self-healing patient and the self-gardening doctor reflect each other: the doctor's holistic health requires the same care and understanding as the patient's, and similarly they often need assistance in their own self-healing. And of course, the self-healing person, as a unique being of body, mind and spirit, and in their own particular context, will require a range of interventions and relationships to assist in the actualisation of their healing potential.

So there was no convergent work aimed at exploring this aspect of our model. What evidence there is is plucked, rather like gathering wild flowers in a cultivated field that have sprouted up of their own accord, haphazardly, while other work was going on. The principle was there, receiving most attention in its relation to other aspects of the model, but also quietly influencing our homework activity. For this chapter we have gathered this scattered work under five headings which we list and discuss below, starting with the more "orthodox" and moving toward the more "alternative".

Encouraging intentional self-healing as part of orthodox medicine. The manner in which a patient is received and related to by doctors and other professionals is critical: if the doctor takes the role of all-powerful healer, then the patient has little choice but to be dependent on their ministrations: this is what is likely to happen in social settings such as the double blind trials, which manage to ignore and suppress intentional self-healing completely. On the other hand the doctors manner and style may in itself invite the patient to recognise and exercise their self-healing capacities, as in the following example:

"When I see a patient, my working model is as follows. Having greeted the patient and asked them to sit down, or after I have sat next to them on the bed, I leave a silence, which the patient always fills by telling me his problem. This I listen to without interruption. Then there is another gap or space after which the patient has more to say or I ask what he or she thinks is the cause. Without my saying so, you know what the answer is here: "I don't know but..." One of my hobby horses is about not

making a diagnosis, or at least not telling the patient. Far better, I believe, for the patient to make his own diagnosis -- often a mixture of thoughts and feelings and questions about himself rather than a word. No sooner are we into cause than we are into prevention. Some suggested causes will come from the patient, and some perhaps from the doctor to be accepted or batted away. With my asking the question, "What have you tried already?" when it comes to treatment, there is a large preventative element. So often I feel that all I need to do is endorse the patient's self-treatment or that of her child. I may confirm, if it means anything, that the chest is clear, and gradually the patient or mother will learn and grow in confidence that the steam inhalations she has been giving is all that is needed. Next time, she will know what to do and may be do it earlier as she learns. This encouragement of self-dependence is part of my way of teaching which I believe is a vital part of the healing process."

The doctor as educator. This was accepted by every member of the group. In many practices this education is evidenced in practice premises and waiting rooms and by practice policies in many different ways. Several publish their own pamphlets, newsletters, or magazines explaining practice policies and including health information, accounts of certain illnesses, and advice. One such, entitled "Look After Yourself" discussed the interacting risks of smoking, overweight, fat in diet, exercise, low salt and high fibre in a simple and straightforward way.

And of course the interaction in the surgery can be educational. "I spend a good deal of the time explaining what I am doing as I go along and, as far as physical conditions are concerned, I complement verbal explanations with splendid picture books like The New Atlas of the Human Body. I use Susan Goodman's You and your Child to illustrate important points in child development, when such a problem has been presented. In these activities I look on myself as an educator, but over the years I have come to see little distinction between the meaning of the words 'education' and 'therapy'."

But education can go far beyond this. Dr Peter Mansfield, one of our visitors and himself a family doctor, drawing inspiration from the Peckham Experiment, was instrumental in founding, the Templegarth Trust as a charity "To promote knowledge of the nature of health and help communities devise appropriate means of cultivating it". The Templegarth Trust, established in his locality, is an involvement which he regards as independent from illness-orientated medical practice. The information in the pamphlet states "The only rules are: no mention of doctors, nor of our own diseases; all discussion to be towards practical things ordinary people can do to cultivate health".

After his visit one participant in the inquiry wrote, "I welcomed evidence of his capacity to initiate health groups and then withdraw leaving them to continue with their own life and vitality. Professions try to hang onto skills that should properly be encouraged in all. Knowledge of how to preserve one's own health clearly cannot be the prerogative of professionals".

One of our participants, in private practice, puts energy into organising and conducting workshops with an emphasis on positive health measures and practical education in the acquisition of health promoting skills. He announces these in a pamphlet entitled "Helping Ourselves". This includes a varied programme of lectures, group activities, study days and residential courses, covering Alternative and Holistic Medicine, Yoga, Nutrition, Co-counselling, Meditation, Relaxation and Self-hypnosis, Exploring Personal Relationships and Well Being.

Another participant is active in a wholefood co-operative which is "running smoothly despite frustrations and inconvenience of having 50-60 people in the house two days and evenings each month. Sometimes I felt that the co-operative side was lost, people treating me as a shop-keeper. On the positive side - interaction between people, opportunity to discuss diet and health with members/patients outside the confines of the surgery in an informal way. Considerable amount of consultation/counselling, interchange of ideas."

Clearly no doctor can handle all this work aimed at health promotion alone; much could be initiated and carried on without the help of doctors, but they can play an important part in starting up projects or in their encouragement and contribution of skills when they are needed.

Doctor as client-centred facilitator. All members of the group used "psychotherapeutic" skills. "Counselling" is a less threatening word for some participants, while "honest discussion with insight and expression of feeling" may be better still. All involved in such endeavours recognised that they are simply helping the patient to identify sources of their distress, accept what is unalterable, and make what adjustments lie within the patient's powers. It is a process of personal education. As well as one-way counselling where the doctor is facilitating the patient's self-direction, patients may use co-counselling to facilitate and enable each other. The beauty of co-counselling is that it involves a reversal of roles that clearly indicates that every human being can benefit from face-to-face interaction and loving acceptance of another. Special skills and experience are involved in this work, but they can be acquired without medical training. On many occasions the doctor is involved in a helpful and healing way with patients undergoing the inescapable distresses of life, and this involvement has healing potential in itself.

A part of the doctors role in the promotion of self-healing will be at times to do no more than "see it through" - to offer presence and human support so that the patient can take the power to exercise self-healing. And sometimes this must include the recognition and owning of powerlessness on the part of the doctor to do anything other than support. Some possibilities in the encouragement of intentional self-healing are illustrated in the following two examples.

A 60 year old woman presenting with tension and insomnia. On psychotropic drugs for 16 years. The brief record of family and past history indicated chronic emotional disturbance. The doctor offered the traditional diagnosis of Chronic Anxiety State, but went on to attempt a more holistic diagnosis:

- 1) Body - Tension in muscles, very poor sleep. Tiredness.
- 2) Mind - Fear of being inadequate. Fear of change and loss. Unable to show feelings.
- 3) Spirit - Lack of faith in the goodness of life.

His action was to inform the patient of Holistic Counselling and Creative Therapy and to give her an Autogenic Training pamphlet.

She responded by attending the Holistic Counselling service. Whatever the outcome, clearly the doctor was attempting to encourage the patient's own powers of healing.

"A demented 95 year old, deaf and partially sighted, paranoid and suspicious. Imagining little men were crawling into her flat and who the Trainee had looked after. Delighted to see me after a space of several months. I put my arm around her and her face changed. "The flesh was bad and dropping off, you can see I have no face", she was saying. And her face changed. "It will be all right now, my face will be all right" as she felt the hand on her back. Perhaps no one had touched her for some time. She fell and had to be admitted to the GP unit where she was tended and cared for by the nurses. And now, even the maids taking her tea would touch her as they put the tea down. She is looking more relaxed now and has decided at long last to come into a home where she will not be alone with her fear. She said yesterday, "You see, Doctor, when you're old and alone, everything seems terrifying and gets out of proportion". In the past she had been treated with Modecate when she was demented but we have managed without this time, I hope the improvement is maintained. But perhaps it has nothing to do with people touching her or bringing reality to her world. With this old lady appropriate intervention enabled her to take more charge of her life".

Self-help groups. We realised during the research that the notion that a person is a potentially self-healing

agent needs to be supplemented by the view that this self-healing can be greatly facilitated by peers; and indeed the view that self help groups can do much that professional help cannot is increasingly common currency. While we as an inquiry group did not systematically explore, self help groups and the role of doctors in relation to them, it is clear that they can play a major role in holistic medicine. Some of our members did set up and encourage a range of different self help groups: for example a Quit Valium group, Quit Smoking group, groups for menopause, obesity, co-counselling, and assertion.

Teaching specific skills to enhance self-healing. Again, although we did not inquire into them in any systematic way, different members of the group were involved with teaching their patients a variety of specific techniques which are aimed at enhancing and releasing a person's capacity for self-healing. These included visualisation, self-hypnosis, autogenic training, relaxation, meditation, yoga, exercise, diet, and general life-style management. Many of these skills are within the reach of doctors without enormous amount of extra training. Some of them may better be left in the province of "alternative" practitioners.

Dilemmas There are of course dilemmas and choices in all this, both for doctor and patient. Primary is the dilemma of choice - when to treat with an external intervention, and when to rely on and work with the patient's self-healing capacities. And when to do both. With major and life threatening conditions such as cancer it may be most difficult for both doctor and patient to choose between a radical and maybe disabling orthodox treatment which is almost certain at least to extend life even though the patient may be completely passive in this; and a more unorthodox approach aimed at mobilising the patient's intentions and ability to heal themselves. And at the other end of the scale with minor illness it may appear that external intervention may relieve unpleasant symptoms, but many doctors and alternative practitioners refuse to treat the symptom of a condition, and prefer to encourage their patients to take increased charge of their life-style. Any standard form of intervention in the face of a particular disease automatically deprives both healer and healed of the experience "What happens if you don't do this?" How many doctors know what happens, and in what proportions, if you don't cut out an inflamed appendix? How many doctors now know what happens when a depressed patient is allowed to be depressed and not brought out by artificial means?

Finally we return to the role of self-healing in relation to others parts of the model, and in particular to the self-gardening doctor. If the doctor is to understand and act with others in such a way as to facilitate the emergence of their self-healing capacities, it is

essential that they understand and are in contact with the same capacities in themselves. The self-gardening doctor is a mirror to the self-healing patient and their capacities to heal themselves and others will grow together.

CHAPTER EIGHT: THE DOCTOR AS SELF-GARDENING

A view which emerged quite rapidly in our first meetings and which was generally assented to was that medical practitioners are conditioned by their training and by the whole medical culture to use their role defensively. This means that the way medicine is practised is a defensive denial of certain anxieties and distresses within the doctor, so that a good deal of denied distress is acted out in ostensibly legitimate therapy. As one of our members wrote, "In order to understand and act humanely with others, it is necessary to feel sympathy with oneself. Otherwise the healer will inevitably foist his or her own 'unaware projections' upon the patient, and attempt, unwittingly, to attack the patient, or solve the patient's problems in his or her own terms".

This view that professionalism is in part both a defence and a projection was not in our view peculiar to medicine, but symptomatic of our culture as a whole, and its lack of any model of emotional and spiritual education. Precisely because the medical profession has such high status in our culture, its members are caught in an invidious "Catch-22" predicament: as the most senior helpers in our society, they are not supposed to have any problems, and therefore they cannot admit to themselves or others the very real problems they do have both individually and collectively. It has thus proved peculiarly difficult for doctors to seek psychological help and to practise with any depth and insight the ancient precept "Physician, Heal Thyself".

The emergence of innovative humanistic psychotherapies over the last few decades has enormously enabled medical practitioners to break out of their professional defensiveness. In particular, it is the realisation that psychotherapy is better construed as emotional education, desirable and available for all adults, which gives permission for doctors to step out of the shadows of repression.

From the beginning of the inquiry, some of our members considered that self-gardening, or "Physician, Heal Thyself", was really the hub of the model, on which all other four parts depended. But at least a quarter of the group considered that it was still only on a par with the other principles. What is clearly important, however, is the experience reported by several members through the first four cycles, that it was attending to their own self-gardening which gave them confidence and competence to apply other parts of the model, and also to stand against orthodox expectations of partners and patients in practising in new ways.

It was certainly widely held that self-gardening was

essentially interdependent with the principle of the patient as potential self-healing agent. In order to be sensitive to the cues for encouraging the autonomy and growth of the patient, the doctors need to be familiar with and able to work with the same sorts of cues in their own growth and development.

We all espoused the view that self-gardening could occur at different levels of being - the bodily, the intellectual, the emotional, and the spiritual; and also in the context of personal, professional, and political relationships. We did not take any view as to which level of self-gardening was or was not the most primary: it was rather considered that each member was the proper judge of whether jogging, meditation, co-counselling, or influencing and changing social systems was most important at that time in their lives. There was considerable tolerance within the group as to the scope of individual self-gardening.

It is clear from the personal accounts that the experience of participants in the inquiry was in itself a fundamental self-gardening event, with its particular combination of reflecting on professional activities integrated with emotional and interpersonal work in the context of a warm, supportive and confronting community of peers. Indeed, one of our members lovingly caricatured the inquiry group as a personal growth group for doctors, and for some it did seem that over some cycles their preoccupation with self-gardening distracted them from the content of the inquiry. In the reverse direction, however, the intensity of some members' commitment to self-gardening also made them deeply committed to the inquiry process, and to making fundamental changes in their practice of medicine.

For some, the emotional opening involved in the self-gardening component of our meetings had powerful effects on relationships within their families and their medical partners. One member discovered the energy to confront issues within his family which had lain dormant for years. Another worked through longstanding differences with his Senior Partner. A third discovered deep resentment at the way his medical education had alienated him from his working class roots, and agonised over whether to move away from his comfortable middle class practice into a radical co-operative in a city centre.

On the negative side, it was the view of initiating facilitators that insufficient self-gardening was done during our meetings in the way of dealing with some of the underlying distress embedded within professional defensiveness and the conventions of the medical role. This issue is discussed further in the Validity Chapter.

Self-gardening Processes Used on the Project

Reading through all the many reports of work done on each

cycle of application, it is interesting to see what a spur to self-gardening the inquiry process was, and what a variety of initiatives were undertaken by different members. We give here a brief resume of these initiatives roughly categorised under body, mind, spirit, and social context.

Bodily self-gardening. Eight members mention that they were spurred to take up for the first time, or re-instate, or devote more time to, various forms of physical exercise: jogging (the most popular), swimming, calisthenics, exercise bike. The cultivation of breathing, relaxation, and dietary control were also mentioned. One member gave up smoking, but with a later relapse to a pipe instead of cigars.

Mental (including emotional) self-gardening. This further subdivides into personal growth activities, aesthetic activities, and increasing knowledge and skill.

Personal growth. The peer self-help method called co-counselling was most widely used for personal growth: seven members reported using it - for processing negative feelings to do with work and personal life; for exploring early childhood development and the impact of family history; for dealing with tensions arising in relation to establishment medicine and the mechanistic medical model; for dealing with tendencies to compulsive work; and so on. Four members reported working on their relationship with their spouses. Two people reported starting a diary.

Aesthetic activity. There are a small number of references in members reports to artistic involvements: reading poetry, enjoying paintings, taking up drawing, visiting architectural sites in France, and (another member) in the Middle East, putting up abstract paintings in the surgery, spending more time on the delights of cooking.

Increasing knowledge and skill. Seven members reported starting to do a lot more reading - of four main sorts: books and papers on spiritual themes, on alternative therapies both psychological and physical, on conventional medicine, on various aspects of holism. One member started study for the MRCGP, two others enrolled for counselling courses, and three more commenced inquiries, respectively, into acupuncture, homoeopathy, and autogenic training.

Spiritual self-gardening. The inquiry initiated in some members and enhanced in some others a commitment to various forms of spiritual development and action. Nine members specifically report on meditation as a central form of self-gardening, and three of these mention yoga

too. No details were given of what sorts of meditation people were practising. It was the one form of self-gardening mentioned in cycle reports by the greatest number of members. Others mention: prayer, the use of affirmations and invocations for personal enlightenment, the use of chanting, the use of visualisation, attending spiritual readings, practising the presence of God, applying for instruction for practising the presence of God, applying for instruction for Christian confirmation. Finally, four members particularly reported increased awareness of mindfulness, encompassing shifting personal energy levels (for two) and changing dynamics of relationships (for another two). See also, of course, Chapter Six on Spirit.

Self-gardening in a social context. Seven members reported that the inquiry moved them to spend more time with their spouses and/or children. For some time this included doing meditation, yoga, swimming, walking together. As already mentioned above, four members set up special sessions with their spouses to work on issues in their relationship, to do a body/emotion/mind/spirit review, to rearrange time-boundaries. For one member at least the inquiry initiated a major transformation of family relationships and attitudes.

There seems to be little doubt that self-gardening activities receive a considerable boost from belonging to peer support, work, and inquiry group. Motivation is enhanced by the spirit of sharing and common endeavour; energy and enterprise is released. Peers provide a community of values that sustains the sense of meaning in personal development. Hence the embarrassing question: how many of these manifold self-gardening activities have been sustained since the end of our regular series of meetings?

CHAPTER NINE: PARTICIPANT ACCOUNTS OF THE PROJECT

This chapter consists of personal accounts of the project by four individual participants who wished so to contribute. They clearly represent separate idiosyncratic experiences and as such are allowed to stand on their own with little editing. The aim of each account is to show how our individual lives have changed as a result of the project.

Personal Account 1

This report is a little premature in that the last mammoth weekend is to come in which I hope many ends will be tied up, or at least shortened.

To define the limits of Holistic Medicine is a paradox, for if man is to be seen whole his environment and context must be included, which extends to the edge of the universe and perhaps beyond. But the group made valiant efforts and extended my concept of whole person medicine into the arena of man's spirit and has left me the problem of finding out what that is, and how much is it a physician's job to be involved in spiritual problems and manipulations; and if not who to refer them to in a godless world. Seeing the patient as a self-healing agent is very rewarding, if only it were true, but usually rather than self-healing they have a "need to be ill" (c.f. George Groddeck "Meaning of Illness"). I suppose one must first remove the need to be ill to render them self-healing - this may require an alternative therapy which has perhaps not been invented.

There was little direct study of alternative therapies, though our fellow group members could inform us of alternative therapies that they practised and the visiting luminaries gave us other side lights on the subject; there was no organised investigation or study of its efficacy. The availability of it locally I will have to look into myself. Although this was planned in the early cycles it has fallen by the way side but can always be revived next year.

Power-sharing was very fully looked at by half the group - but as yet no firm criteria have been adumbrated and to me it really appears as an aspect of every doctor/patient relationship - and the amount of power sharing depends on the nature of the relationship. It is a two-way affair and cannot just be willed by the doctor. The last area which was much considered was the doctor as "self-gardening" person. This was perhaps the easiest area to study as it is not really dependent on the patient but entirely in the hands of the doctor, so easier for him to control and know about and indulge in.

Personal growth and development is a thing that happens to all of us whether we will it or no, but is best understood, controlled and directed than let happen willy nilly under the pressures and vicissitudes of blind fortune. This is true of everyone and why doctors should make such a meal of it, and see it as part of their professional remit and use professional time and resources to pursue it I found a little irritating, as I felt the time would be better and more profitably spent looking at the vagaries of patients, their ills and behaviours and the multitude of alternative therapies and their modes of practice and means of action. But this is a reflection of my reasons for joining the project, which were not to effect change or understanding of myself. Being past fifty this was pointless: better to learn about what exists and how to make best use of it.

So what changes have occurred? To get an objective view of this I have asked my trainee (who has just completed her year with me, is leaving the practice on the 16th July, and has this day heard she has passed the MRCGP's exam - so is free of my influence and patronage) to write an account of any changes in her trainer over the year she has worked with me. She has read all my letters to Gordon, "The Stones of Power", and witnessed my daily blessing of the surgery, and been bored by various holistic reminiscences. The result of this, her last and only teacher-imposed project, I have not yet seen, so before I do I had better write down some subjective view of how I have changed over the last nine months.

I have never seen myself as a spiritual person, more an atheist without conviction or a lazy agnostic. Baptised and confirmed in the Church of England, going to church at Christmas and Easter, supporting my wife in her parish duties, seeing the children were all baptised and confirmed as a prophylactic vaccination against any attacks of religious mania in adolescence. Unfortunately my eldest son became a primitive Baptist while away at Nottingham University, but it is a very harmless form of adolescent rebellion. If any of my patients showed religious interests, had a tendency to prayer or asked spiritual questions, I would listen and direct them elsewhere, feel a little uncomfortable and move on to the more solid ground of psycho-dynamic psychology. After listening to Murray Korngold, taking part in the spirit group discussions, thinking about the problem and rationalising it into a matter of meta-information processing, I have become more reconciled to considering my patients' spiritual needs and if not attempting to supply them, at least integrate them into the chaos of their psycho-dynamic world and the discomfort of their bodily distress.

In a number of co-counselling sessions, and through the feelings engendered and displayed in the encounter groups I have come to know and accept myself at a slightly more

profound level despite, or in spite of my well organised defences in depth. I had always known I had a neglected little child inside me - but to meet him and feel with him was an experience. I had always known I had a block in my psyche to prevent my sensitive core being touched, but to meet and see that long white wall in my head (or heart) was another revelation.

To be privileged to witness and feel the inner workings of the minds and spirits of the other group members in the encounter group was an education which one would have to search diligently for in the deserts of the usual post-graduate medical curriculum. The group's power to contain it, and love to elicit it, and care to control it was breath-taking and beautiful, an enabled me to make that little progress mentioned above towards self understanding.

I have with the encouragement and honesty of other group members been able to begin to trust my insights and feelings about the patients, which in the past I have felt to be true but seldom risked using them or even testing them. Having now made this break with my all too rational past, I hope to learn and develop these skills further but fear without the encouragement and regular re-inforcement from the group may well slip back into my well tried and semi-rational psychologising. I touch my patients more, a little more, not because I think I should under the influence of the group, and not because I feel it will do them good, just that I find myself, I have observed myself, touching my patients more. In some ways I am more self-revealing of my life and my family and my world to some of my patients, when it feels appropriate and not in any planned way; it just happens.

I bless my surgery every morning, as set out in Chapter Six, and I think I will continue to do so, as a constant reminder of this group's insights and experiences - to remind me every day of what I have learnt and have yet to learn about holistic medicine. This use of ritual has made me think again about how, when I first took up general practice, I decided to save my skin and my time by not ritually washing my hands between every patient, and not swabbing injection sights, as bacteriologically it was useless and therefore a pointless ritual. I have come full circle to see that rituals are not pointless. I have not yet started swabbing the arm before injections, though I may come to it.

I have set my heart on an adventure of controlled folly with my stones of power, which are now all prepared but not yet used. My mind is dragging it's feet. My sister thinks the patients will see it as strange. My wife helps and supports but has given a number of very strange smiles. My trainee has tried to understand, but is I feel relieved to be moving on to a more traditional practice. I have not dared to tell my partners. My brother is

intrigued but does not really believe it. Without the constant re-inforcing support of the group it may only get done because I have promised myself to do it against all reason as an educational exercise and a research project into the ineffable clouds of unreason that surround the practice of medicine.

I have read "If You Meet the Buddha on the Road Kill Him!" by Sheldon B Kopp; "The Book as World" by Marilyn French; a woman liberation author on James Joyce's "Ulysses", where Mr Bloom as everyman, meets the whole world, in a day in Dublin (literature attempts to be holistic); "The Evolution of Human Consciousness" by John H Crook; and to follow it, as it's apparently natural sequel, "The Origin of Consciousness in the Breakdown of the Bicameral Mind" by Julian Jaynes - with a title like that who needs to read it!

Personal Account 2

I am a forty year old white male doctor. My background is working class and I had the misfortune to go to a London teaching hospital. The traditional medical education I received was my first introduction to the profession. Initially it was frightening and disturbing but I learnt to adapt, and on qualifying, the workload left little time for questioning what I was doing. Following several years in hospital I became a General Practitioner firmly entrenched in the traditional doctor mould and out of touch with my working class background.

I practise in a semi-rural environment from a purpose built health centre with five other partners. We are a teaching practice for the local medical school, have a trainee, and offer a high standard of medical care. I have been in this situation for eleven years.

Several years ago I began to feel ill-equipped to deal with the problems presented to me. My medical training seemed inadequate and inappropriate. Many consultations had a "warlike quality" about them, a battle between the person trying to convince me that they were ill and myself trying to slot them into rigid categories, giving advice and talking too much. I began to look around for a different model on which to base my medical practice, and after experiencing some humanistic psychology, humanistic medicine and personal growth in the form of co-counselling, I joined the co-operative inquiry into holistic medicine.

In the following account I want to try and share some of the feelings, excitement, joy, despair and uncertainties I went through and I am still struggling to resolve.

I became aware of a growing anger towards doctors based on their attitude towards patients. How angry were my patients when they came to see me? They had to come, they

were ill - how did I use my power? I began to look critically at myself in a three-piece suit giving an air of confidence; if not actually behind a desk, then across the corner of it. I was surrounded by my instruments, stethoscope often around my neck. I was fully dressed and the patient often undressed. I kept control, dispensing knowledge, advice and prescriptions. Was this showing power? How easy was it for the patient to get past all these obstacles to retain some control over what happened to them. I found that if I listened carefully to the person's account of their symptoms, in the majority of cases all I needed to know was contained in this account. I did not need to go through the catechism "Is the pain worse on exercise, or on taking a deep breath, or have you coughed up any blood etc?" I simply had to give attention, provide a safe atmosphere, give space and time. This was extremely difficult to do; I was no longer in control.

The first practical step was to do away with my desk and my suit, but it was so difficult. Gradually I was beginning to trust and gain confidence in the other people in the co-operative inquiry. We met every six weeks - for me it was a recharging of energy realising that I was not so isolated. This isolated feeling had been with me since I qualified. Now I was allowed to express these feelings; I was listened to, other people had similar doubts and fears about the profession and the medical model. This served as a great source of strength; my desk went, my suit remained in the wardrobe and what happened? My partners became uneasy; the staff laughed to hide their feelings and my patients made no comment. They accepted these changes and gradually over the months seem to be much more relaxed. History taking became easier, diagnosis did not seem so central to the consultations, and treatment came to consist more of joint planning.

My next step was to show patients replies from consultation requests in order to involve them in decision-making about their treatment. This I am sure many doctors do anyway, but I decided to write a letter to the Consultants letting them know what I was doing. The following is a reply from my local Consultants' Committee:-

"I am writing to you in my capacity as Chairman of the Medical and Dental Consultants' Committee because on a number of consultation requests received from you you have mentioned, as a postscript, that the Consultant's reply to your letter could be shown to your patient, as you suggest this might help to improve patient/doctor relationship.

"A number of my colleagues have expressed some objections to this procedure. In particular they feel that they would be very guarded in their letters to you if they thought that you would show such letters to your

patients. Whilst they accept your freedom to do so in this respect, they asked me at a recent meeting to write to you expressing their views regarding this situation.

"They feel in particular that communications between doctors are in fact confidential, and would wish to preserve this, and so be free to express their views about your patients to you in the usual way.

"I hope this explains our views and that you understand our opinion.

Kind regards."

The sentence added was not a postscript but in the actual letter and it was this "In an effort to involve the patient in the decision concerning his/her illness he/she may be shown your reply to this consultation request".

The object was not simply to improve doctor/patient relationship, but to allow the patient some responsibility concerning their illness.

The reason given in the letter for preserving confidentiality seemed to be that the Consultants would be free to express their views about the patient. What was the fear behind this? After all hasn't the patient a right to know what has been said about them. Were they questioning my judgment as to the appropriateness of disclosing information, and if so, why not state this in the letter? There was also an interesting typing error over their/your patients, as if the actual patient could not function as a person able to make decisions about themselves. Again isolation and fear were the feelings experienced.

As the group progressed the conceptual model of holistic medicine emerged. The possibility of practising this in the NHS in my present situation seemed more and more remote. I was paying lip service to the ideas; I wanted to change things, I was in too much of a hurry. An opportunity arose to talk to a group of newly qualified doctors and medical students on the subject of holistic medicine. They had formed a society at the medical school called "Questioning Medicine". I talked about our group and the conceptual model so far; the response was overwhelming "Why isn't medicine like this? Our training neglected practically all the ideas that you expressed". There was a tremendous enthusiasm for the concept. Agreed the group was self-selected, but, why I wondered, wasn't medical education altering.

The more I examined each concept and the possibilities of putting them into practice the more depressed I became. For example, power-sharing, one aspect of holistic medicine. I began to realise it was obviously political, not simply a matter of discarding my suit and doing away

with my desk. How can I really share power earning substantially more than the majority of my patients? I had to look at my role as a GP in a much wider context. Society obviously valued me as a doctor by the amount I received in salary. There was a question of my role in pleasing society, dispensing out prescriptions to avoid crisis which may lead to change. I became overwhelmed and despondent and began to look around at how other practices worked. I visited two "radical" practices which seem to go part way to dealing with the problem highlighted by the holistic medicine inquiry, but as yet I am still in my original practice struggling along. I have continued to change, initially in superficial ways but slowly at a much more deeper level. Where this will lead I do not know. I think the way medicine is progressing has got to change, the balance has got to be altered, but the force to change it, I think, is going to come from the consumers, and not, unfortunately from the doctors - I may be wrong.

Personal Account 3

My reasons for attending the holistic medicine inquiry were many. Firstly, I had felt for sometime that there were a wider range of interventions that I could usefully use to help people, even in the 8 minute consultation of the National Health Service. Secondly, I was curious about how co-operative inquiries functioned.

I had recently studied humanistic psychology following several years of Balint groups. I followed this by a year looking at alternative interventions for relieving emotional distress, such as behaviour psychotherapy, and family therapy, assertion and sexuality training. I had become a trainer and needed to look at the sort of medicine that I practised in greater detail in order to be able to explain it to a trainee. This was also a year in my life when I was eager to look at myself, my life and my job and how they all related. I had had a vivid dream of riding a horse across the plains to the distant hills. I was going so fast that I could not read the words on the signpost which pointed to three distinct routes towards the hills. The year of holistic inquiry seemed to be part of this onward rush not looking at alternative routes in order to reach ultimate goals, and I had no idea what the ultimate goals were. My partner said that she had experienced me rushing ahead never looking back at her trying to clear up the manure as it fell behind the galloping horse. We never reached the hills either. There were 16 men and 4 women in the enquiry. They seemed to be very well versed in philosophy, and academic arguments, or very skilful in alternative interventions. I felt both awkward and ungainly in both body and spirit entering into a new inquiry into holistic medicine in my middle age, but very excited by some new ideas and concepts.

Firstly, was the concept of self-gardening. Where was the

time in a busy NHS practice, and a family and home to care for too, to find time for self-gardening?. The family preferred their old diet and there did not seem much time to look at my own health. The idea that the way I practise medicine is the way I am was a powerful new concept. I do care very much about the effects of my medicine and treatment on others, and I had assumed that the way I was feeling in my rushed day had no impact on others. There is no doubt that the mad rush had an effect on both patients and colleagues and I began to realize how important it was to be at peace with myself. Balint had talked about the doctor himself being part of the treatment and I saw that in order for the doctor to be an "effective medicine" he or she should be at peace in spirit and mind. This required constant vigilance and practice as had been noted by others and is certainly a powerful challenge.

It was not until the inquiry split into two groups, one studying power-sharing, and the other the place of spirit in consultations that I discovered that by allotting a few minutes of quiet prayer to be more patient and understanding and to know what people were saying it was possible to be more fully present for people and to be more receptive to their needs both spoken and unspoken. I learnt about the importance of touch and how helpful it was to me when faced with an untreatable problem to touch that person and pray that they be helped by powers outside my own. Korngold had likened spiritual healing to turning on a powerful electrical beam. We also witnessed Alec Forbes using spiritual healing. The use of prayer to help these people gave me another tool to use. I am not sure how the recipients experience it. I had not dared to ask them. I began to feel more able to intervene in other ways when I visited a dying patient one morning. She told me that she dreamed that she was falling into a pit and her husband had pulled her back. I said it must have seemed as if the pit was death and she said "Yes, I wish he (my husband) would let me go. I am so tired of living". That evening there was an urgent call from the husband and as I drew up to the house I heard the teenage daughter crying for someone to help save her mother. I went to the bed to find the husband cradling his wife in his arms but this time I called the teenage daughter to the bedside and the four of us formed a close circle while we watched the mother slip away and the girl had time to kiss her mother goodbye and tell her how much she loved her. It was all so quiet that the sleeping toddler in the room was not awakened and the remainder of the family came in after death and kissed the woman goodbye.

Another time a demented deaf and partially sighted old lady was talking about her face crumbling away and other delusions. I suddenly felt her loneliness and bewilderment and put my arms round her. Her face relaxed and the sanity came back in to her, and I realised how mad her half world must seem when she lived alone in a flat

with no relatives and few friends and certainly nobody to hug her. How easy it was for any of us to become insane under these circumstances. Leaving a gap in the consultation and raising issues of spiritual belief opened up new insight into people which had previously been ignored. Two of my partners are committed Christians and I had felt very hesitant about looking at spiritual beliefs from the place that I was in. I was aware that there is something outside us and within us all, that is very important. It is partly the essence of that person which leaves the body at death, but I find it difficult to define what exactly it is. Certainly it is the spirit within that gives people power to fight their illness and survive the ordeals of life.

There was the question of power-sharing. I had felt for sometime that creating a partnership with the patient was usually the best way of dealing with any problem. I had not really thought of the patient as a potential self-healing agent in any great depth. Now I had to look at ways of sharing power and ways of helping problem people have greater understanding of themselves and of alternative ways of keeping healthy and ways of treating disease. We started encouraging the Health Centre Users' Group. We looked at ways and means of making the Health Centre a centre for encouraging good health rather than a centre for treatment of ill health. We already had some self-help groups and discovered that although people with similar illnesses had a lot to teach each other in coping with that illness they still benefit from outside help from people who had knowledge, who care and are objective about their particular problems. We found that on the whole people do not want to think about their health until forced to do so. My trainee tried changing chairs with a patient complaining about stress-induced indigestion which had been investigated but no organic caused was found for his complaint. As the patient became the doctor he suddenly saw how his symptoms were stress-related and how only he could take steps to alter the stress. There was little the doctors could do to help him without his own co-operation.

As the year proceeded I felt more and more muddled by what I was learning and only now am I pulling out some of the threads. Firstly, I have learnt how important a first-class up-to-date knowledge of medicine and treatment are, so that intervention used can be based on a sound diagnosis and knowledge of as many as possible available treatments and interventions and also the relative values of these for the disease and for that person in that particular time of their lives and that particular environment. Secondly, I have learnt that a number of people do not want to help themselves, and expect a magic answer for all their problems. I have learnt about the power of looking for the spiritual element in consultations and a little of the power of prayer. I have occasionally experienced how it can be to be absolutely

present for a person In a consultation, sensitively tuned into their needs. I have felt more able to relate to people with greater openness. I have learnt a great deal about how other doctors and healers see their jobs and what their ideals are. It is difficult to know how much I have really altered in my attitudes during this year of holistic medicine or how my practice has altered. I think probably very little. I am now however aware of far more ways of helping people. I feel that the time has come to go back to look at the signpost again and rethink which route I should be taking. I am still not sure what the ultimate goal should be.

Personal Account 4

As I write this account from a feverish bed, it seems as though the events of the project are far behind me and yet many colourful images remain in my memory.

I am 29, born an only child, single, male and white; I was the youngest member of our group and had a fairly traditional medical training. I qualified in 1978, giving me less clinical experience than most of the other participants, but I had for two years or so been quite involved in personal growth work, (est, massage, co-counselling etc.).

I have not usually been shy in coming forward with my feelings in groups and I do find the technical clinical side of my work a drudgery at times, preferring to be a sociable friend rather than a parental authority in relation to my clients.

At the time of the project I was working mainly in a small psychiatric unit in central London; work which I always enjoyed. I had no experience of general practice, but would do as soon as the project finished.

I well remember the flutter of excitement I felt during the first briefing meeting of the group, in a rather austere room at the British Postgraduate Medical Federation. These were the people I was to travel with on the exploration of ourselves, our patients and the, as yet, uncreated five part model.

All went generally well for me. People were open, warm, willing to talk... laugh...cry.. or shout, as well as to present ideas, feedback data and jog/swim/massage with me. People listened often.

I knew one member of the group through a mutual friend and another from a past hospital job, and it was not long before I was aware of the vast resources both personal and professional we had in the group.

This realization, together with a knowledge that my then

psychiatric post was short-term, combined to make me wonder if I had something to offer the group in a special sense. An idea began to crystallize which I shared, initially in an informal way, and later as a formal proposition with the rest of the group. I had time on my hands and providing I was able to support myself financially, I was willing to offer it to the group. I felt it was important to find out certain data for our inquiry process; for example, how is power being shared with patients in reality - especially as I was in the power group - and what impact has self-gardening had on our relationships with clients?

My proposition was that I would visit individually each member of the group for a period of say two days. During this time I would try to do several things. I would make observations of their working lives and try to get direct feedback from patients about whether they felt their doctor had changed his/her approach to them as a result of the holistic project and whether for better or worse. I would then, in a co-counselling format, give my friends the information and let them respond as they wished. My intention was to make the whole process co-operative and in the spirit of the project, through full feedback of any emotional distress which such a potentially threatening situation must surely evoke.

There was a growing interest in eventually putting our ideas and findings to a wider audience; an interest which led to this book and I therefore consulted a good and honest friend of mine to help me clarify my ideas in the form of a letter which was suitable for distribution to T.V. or newspapers. The contacts with the media that I made were of a preparatory nature, to gauge the level of interest and the replies I received from them were of an interested but brief nature, asking for further details.

Although I had discussed my ideas in the group briefly before, I had not until I faced them all on a sleepy Friday evening beginning of the meeting at Windsor Great Park, done more than that. I had also prepared for them a list of my possible expenses, including of course, cost of the final product - a long typed study of each practice and practitioner.

I began to describe my proposals. There was a very uncomfortable silence - I felt as though I had made a mistake at school but didn't know what it was. Then the silence broke and an angry tirade seemed to ring around the stately room..."Why did you do it without telling us?" (writing to the media).... "This is not co-operative" ... "the media will misrepresent us!" I quivered and shook. One group member, sensing my distress, intuitively came and embraced me. I cried. I was a child, and I didn't understand.

The angry sounds dispelled and a long and difficult

weekend began. I think we were all in rather a low state. Our visiting luminary seemed unable to understand the emphasis some of our group put on the expression of negative emotion in the moment. Some of us seemed unable to see his view of the importance of transmutation of negative feeling by visualization etc. He did not believe in "splurging out" negative emotion and said this was destructive. My views on the matter didn't seem very fixed.

My child-like nature had surfaced at times that weekend and got quite a rough ride. The marks didn't disappear immediately either. Now that I have learnt more to recognise and live the child-like part within me and give him the chance to play more often, it less often surfaces inappropriately when I need to act from an adult stance in the world.

"A young child has a perfect, indiscriminate universal love for all things. As he grows older he makes the mistake of supposing that some things are friendly and others are antagonistic to him" (Brandon, 1976)

CHAPTER TEN: CONTEXT AND CONSTRAINTS

Holism does not exist in the abstract but is bounded, determined by and determining, a particular context. For us as participants our particular circumstances defined not only the place we were starting from but also what we perceived to be possible.

Perhaps the most notable limitation of the inquiry was that with the exception of Elva, John and Peter we had all undergone a medical training. This condition was imposed from the outside and is part of the wider social and political pressure exerted by the medical profession. The inquiry therefore lacked a full-blooded contribution from both patients and alternative practitioners practising outside orthodox medicine.

The status, money and power that flow to all doctors from the way in which our society is organised is another of the givens of this inquiry. A partial attempt to deal with the political implications of this is given in the Chapter on Power-sharing.

Furthermore with the exception of three participants all the doctors were primarily based in full time NHS general practice. In many ways this was a great strength since not only does it provide a security free from financial pressures, it also meant that we were all closely aware of the realities of general practice and it is this ordinary, work-a-day world in which our strategies were tested out.

Nevertheless working within the NHS imposes many constraints: we were all in partnerships which contained the usual spectrum of cooperation from frosty rigidity to open-handed welcoming of new ideas. In addition the only real way in which general practice is structured from the outside by the state is through the Statement of Fees & Allowances, a voluminous and constantly updated red book that defines numerous aspects of GPs work from how much you get paid, to the maximum floorspace for a surgery that the state will support. The style of all of us was thus intrinsically bound up with our particular mix of partners, the balance we wished to achieve between earning money and spending time with patients or family and the everyday demands of the practice.

Within this flux of conflicting pressures general practitioners do however have a considerable degree of freedom - far more in fact than that vast majority of their patients still fortunate enough to be working, or for that matter the staff that they employ. This can be seen by the very large range of different strategies that we experimented with. In addition that old alibi, lack of time, is often the direct result of decisions made by the

practitioners themselves. British GPs spend less time in face-to-face contact with their patients than in any other European country. Over 40% spend less than 15 hours per week actually with patients either at home or in the surgery. Thus for very many GPs "lack of time" is a condition they themselves impose on their patients. Whilst occasionally pressures of time are a real constraint they are much more often the direct result of the way we choose to practise medicine.

The relationship between orthodox doctors and alternative practitioners is also confused and set about with constraints. Until the last 10 years doctors could be disciplined before the General Medical Council for associate with non-medically qualified practitioners and even now this is subject to regulation. Orthodox doctors are still currently legally liable for anything that may befall patients whilst they are under the care of alternative practitioners to whom they have referred them. For their part, of course, alternative therapists do not have access to the professional and financial security provided by the NHS. While we were aware of these difficulties between orthodox and alternative practitioners we made no attempt to deal with them.

Finally, of course, and in their way most important of all, are those internal constraints that define the way we see the world and shape our fantasies of what we can conceive of as possible. These dreams and fears surfaced through the whole text of the inquiry, and can be seen weaving their way through the whole fabric of this book.

CHAPTER ELEVEN: AN ASSESSMENT OF THE VALIDITY OF THE INQUIRY

In Chapter One we have made the point that validity within co-operative inquiry is centred on the critical, informed and discriminating judgments of members of the inquiry group. In this chapter we will say in more detail what we mean by this, and give an account of the validity procedures we used in this inquiry. Having done this, we shall present our assessment of the validity of our work.

Critique of Validity in Medical Research

We shall begin with a summary critique of traditional notions of validity in medical research. We do this because it is too readily assumed that methods such as the double-blind cross-over trial, or the questionnaire survey are the only really proper ways of conducting inquiry. In particular, the randomised clinical trial is regarded as an exemplary way of controlling for internal validity. It does this through the matching of patients who are to be the subjects of the inquiry, the random assignment of matched patients to treatment group and control group, and appropriate statistical analysis of the results. This whole approach is based on the traditional view, which we rejected in Chapter One, that there is one "reality" which can be known objectively and we refer you again to the arguments advanced in that chapter.

The matching of patients is the first specific procedure of the controlled trial. It is usually done, and it is reasonable to argue that it can be done, in terms of external criteria such as age, sex, social class and measurable pathological variables. It is problematic to match patients in terms of their personal history and subjective experience of their disease process. This subjective dimension of the disease condition is on our view of reality essential to a proper understanding of it and of patients' response to and involvement in forms of treatment: knowledge, disease and treatment are objective/subjective in their natures.

Random assignment of matched patients is an essential condition for the orthodox research model since the statistical procedures used are based on the assumption of random groups. From our perspective it is open to major objections. It is ethically offensive: it contradicts the moral right of patients to fully informed self-determination in the selection of available treatments: and it contradicts their right to exercise intentional healing power, since this presumably would interfere with the experimental design by introducing extraneous treatment variables.

It often is argued that these ethical objections can be

overcome If the patients give their fully informed consent to involvement in the trial. We are not happy with this argument for a number of reasons: if the patient consent is sought on the basis of really full information this giving of information becomes a treatment and test condition in its own right, which may thus cloud the experimental effect; if consent is sought and a significant number of patients drop out of the trial, then accrual to the trial is no longer random but skewed in favour of those who opt in. But most importantly, would a rational being, if given full information about the drug to be tested, the outcomes expected, the possible side effects, and the nature of random assignment, consent to abandon self-determination in the selection and management of treatment to engage in such an alienating enterprise? A rational being would only be part of such an experiment if there were no other way of making a choice between treatments, and if such participation expressed a self-directed approach to the management of their disease. We are also concerned that consent is rarely sought on the basis of really full information: the conventional medical research culture exploits the Cartesian passivity of patients and never makes it clear to them that they are implicitly being asked not to exercise their internal agency or self-treating power during the course of the experiment. Finally, just because informed consent tends to undermine both the management and methodology of the trial, in this country it is sometimes not sought at all.

The random allocation of some patients to a control group, who would in many cases receive a placebo rather than a treatment of any kind, raises a further set of ethical issues. If the practitioner believes on the basis of available clinical evidence that a treatment is effective they will be acting un-ethically if they withhold this treatment from those patients in the control group and will find it morally impossible to conduct a classic experiment. It is still open to them to seek comparison in a control group of patients not under their care, and forms of research design need to be developed which can accommodate this. To our knowledge, the practice of the present medical research ethos rules this out.

The statistical methods used erroneously assume homogeneity of patient populations and thus the results often cover over important individual differences obscuring interactive effects between treatments and personal characteristics. This does not help with the all important practical question "What is the treatment of choice for this individual patient?".

It is important also to realise that all this careful methodology employed is aimed at ensuring internal validity; that is to say, it is aimed at the question, did the treatment actually make a difference? The question of external validity -- that of deciding to what other

situations and conditions the treatment can be applied - can only be answered inductively, and is always logically problematic (Campbell and Stanley, 1963). Furthermore, the very special experimental and test conditions are in themselves powerful variables which call into question the generalisation of the observed effects to treatment situations where such variables no longer apply.

A final point. Conventional method is always seeking to eliminate the placebo effect, that is to say, find treatment effects which fall outside it. On a holistic view, it makes more sense to harness the undoubted healing power of the so-called placebo and to develop a research model which seeks to uncover the integrated effect of physical treatment with effect of belief and expectation. We would hypothesise, for example, that a physically effective drug, given charismatically and with due attention of ritual and ceremony, would have a more powerful healing effect than the same drug administered double-blind. It may be that the actual physical effects of certain treatments such as acupuncture are consequent upon their integration with belief and expectation on the part of both patient and practitioner.

Validity in Co-operative Inquiry

Co-operative inquiry claims to be a more valid approach to research because it "rests primarily on a collaborative encounter with experience" (Reason and Rowan, 1981b). This is the touchstone of the approach in that any practical skills or propositions which arise from the inquiry can be said to derive from and be congruent with this experience. We have argued above that this approach to inquiry makes much more sense in the context of the multiple view of subjective/objective knowing that we outlined in Chapter One. The validity of this "collaborative encounter with experience" in turn rests on the high quality critical, self-aware, and informed judgements of the co-researchers. And of course, this means that the method is open to all ways in which human beings fool themselves and each other in their perceptions of the world, through cultural bias, character defense, political partisanship, spiritual impoverishment, and so on. As we have argued earlier (Heron, 1972, Reason and Rowan 1981b) co-operative inquiry is threatened by unaware projection and consensus collusion.

Unaware projection means that we can fool ourselves. We do this because to inquire carefully and critically into those things which we care about is an anxiety-making business which stirs up our psychological defenses; we may then project these defenses onto the world we are supposed to be studying (Devereaux, 1967 identifies this as similar to countertransference in psychoanalysis). If you have invested, as in the present inquiry, half a life, years of education, practice and commitment into being a doctor, to

set this aside to explore new attitudes and ways of practice is a formidably difficult act. It is much more comfortable to hold onto the world view we already know, and so it is easy for our defenses to give rise to a whole variety of self-deceptions in the course of the inquiry, so we cannot/will not see the new truth.

Consensus collusion means we join with others to support this tendency: the researchers band together as a group in defense of their anxieties, so that areas of their experience which challenge their world are ignored or not properly explored.

We have developed a number of procedures which serve to counteract (but not eliminate) these threats to validity (Reason and Rowan 1982b, Heron 1982).

1) Research cycling, divergence and convergence Research cycling means not being content with testing an idea through experience and action once, but taking an idea several times round the cycle of reflection and action. The basic effect of such research cycling is to provide a series of corrective feedback loops, but it may also clarify and deepen the central ideas of the inquiry (Heron 1982). Divergence and convergence are complementary forms of cycling. We may choose to explore one aspect of our inquiry area in closer and closer detail over several cycles; or we may choose to diverge into different aspects so we can see phenomena in their context; or both.

This interweaving of convergence and divergence over several cycles has the effect of knitting together various strands of the inquiry and is quite different from the notion of the critical experiment in orthodox inquiry. It means that while any one piece of data for conclusion may be tentative or open to error the final outcome is a network of inter-related ideas and evidence which together have a holistic or what Diesing (1972) would call contextual validity.

2) Authentic collaboration It is clearly not possible to do this kind of research alone; the diversity of viewpoint, the loving support of colleagues, and the challenge when we seem to be in error are all essential. Since collaboration is an essential aspect of inquiry it must in some sense be authentic: it must not be a relationship over-dominated by a charismatic leader or a small clique, but rather the kind of experience in which each person can in time find a place to be themselves, to make their own contribution, and to celebrate the differences among all concerned. Our experience with a variety of learning groups makes us know that it is possible to facilitate the emergence of intimate collaboration with appropriate amounts of both support and confrontation; and we know that this also takes time, willingness, and skill.

3) Falsification We have mentioned above the need to build in group norms which will counter tendencies to consensus collusion. We need what Torbert (1976) described as "friends willing to act as enemies". We have found the Devil's Advocate procedure helpful in this. The Devil's Advocate is a member of the group who temporarily takes the role of radical critic: they are charged with the paradoxical duty of challenging all assumptions the group appears to make, all occasions when practice and ideology appear to diverge, all occasions when the group appears to be colluding to bury some issue, and so on. The Advocate may be appointed as a part of a regular session; or special sessions may be arranged where the Advocate's role is evoked and systematically exercised - such as when critically challenging tentative findings (for a good example of this see Heron 1984). We have found it helps if the Devil's Advocate has some symbol of their authority - something can usually be found which can be used as a "mace".

4) Management of unaware projections We argue that unaware distress will seriously distort the inquiry and some systematic method is used which will draw the distress into awareness and resolve it. Devereaux (1967) suggested that the researcher should undergo psychoanalysis; our own preferred approach is co-counselling (Jackins 1965, Heron 1979) which is a method of reciprocal support through which each person, working as client in a pair relationship, can explore the ways in which their own defensive processes are being caught up with the research thinking, action and collaboration. Whatever the method, a collaborative inquiry in our view must adopt some systematic way of inquiring into and mitigating the distorting effects of hidden distress.

5) Balance of action and reflection Collaborative inquiry involves both action and reflection, and somehow these need to be brought into appropriate balance. Too much action without reflection is mere activism; too much reflection without testing ideas in action is mere introspection and armchair discussion. The right sort of balance will depend on the inquiry in question.

6) Chaos From our early inquiries we came to a conclusion that a descent into chaos would often facilitate the emergence of creative order. There's an element of arbitrariness, randomness, chaos, indeterminism, in the scheme of things. If the group is really going to be open, adventurous, exploratory, creative, innovative, to put all at risk to reach out for the truth beyond fear and collusion, then especially in the early phases of the inquiry divergence of thought and expression is likely to descend into confusion, uncertainty, ambiguity, disorder, and chaos, with most if not all co-researchers feeling lost to a greater or lesser degree.

There is no guarantee that chaos will occur; certainly you cannot plan it. The key validity issue is to be prepared for it, to be able to tolerate it, to go with confusion and uncertainty; not to pull out of it anxiously but to wait until there's a real sense of creative resolution.

7) Open and closed boundaries This aspect of validity became apparent to us in the course of this inquiry. It is evident that some inquiry groups may be concerned entirely with what is going on within their own direct experience and have no interaction, as part of the inquiry, with others in the wider world. But in other groups the inquiry will involve members in interaction with those who are not part of it.

In this latter case, when members of the group purport to speak for experience which involves other people, there needs to be some comment or feedback from these other people. Thus in the case of inquiry with doctors, if patients, nurses, receptionists, family members, and others on whom the inquiry activities impinge cannot be involved in the inquiry group, then ideally they need to be invited to give essential feedback on these activities and to comment in some way on the extent to which the findings conform to their experience.

Summary Programme for Our Use of Validity Procedures

The validity ideas and procedures we have outlined were introduced to the group by the initiating facilitators progressively throughout the project. In the early stages, John and Peter took sole responsibility for keeping an eye on these issues, keeping track on their use, raising validity issues with the group and for writing them up. As the project progressed, there was increasing internalisation of both the ideas and the procedures by group members, so that they were raising issues for themselves. However, at no stage did any group member systematically write an account of validity issues in the inquiry.

Before the inquiry started, Peter and John had agreed to introduce the issue of distress distorting the inquiry process at the first meeting, and to suggest to the group that we regularly include in our meetings a "process session" along the lines of an encounter group, at which we could look at both interpersonal tensions and personal distress that might be distorting the inquiry process. These process sessions took no less than two hours, started on the second evening of the first workshop and were continued systematically on each meeting throughout the project. Thus from the beginning this very important principle of managing countertransference was raised in the group and a means for its management adopted.

At the first workshop John briefly reviewed the nature of

validity issues in this kind of inquiry, and gave a fuller account of these at the second session. It is clear that on both these occasions the group members were not fully ready to internalise these concepts so that they could put them to use in the inquiry.

At the third meeting, John and Peter agreed to raise with the group the specific issue of research cycling, divergence and convergence: the inquiry during the first two cycles had pursued the idiosyncratic diverging interests of the individual participants. We pointed out the choice that the inquiry group had before it, of continued divergence or the introduction of some measure of convergence. It was at this stage that the group decided to converge on two specific issues, the definition and exploration of "spiritual" interventions, and the issues involved in power sharing, which we have described in detail elsewhere. Members agreed to continue to explore their own idiosyncratic interest while at the same time focussing some attention on these two issues. In choosing this path we attempted to ensure that the inquiry did not diverge into more and more scattered issues, thus failing to look at any issue more than once; while at the same time allowing for individual choice and not excessively focussing our work on a limited range of issues. This combination of divergence and convergence was pursued until the end, and was reviewed at the sixth meeting to see whether we wanted to set up a new project for the final cycle. Two new projects were proposed at this stage, one was not taken up, and the other was adopted but proved to be inconclusive.

The fourth meeting was a critical one for the management of validity. Prior to this meeting Peter and John realised, to their surprise, that while they had been busily recording the progress of the group with regard to the validity procedures, they had done this without sharing their assessments with the group at all. And so they decided to initiate another full account of the validity theory and procedures, and to circulate all their validity notes on the previous meetings with the group. The group was more ready to receive the ideas, and participated in assessing the conduct of the inquiry in the light of each of the procedures. Specifically we raised issues about authentic collaboration, and whether some group members were excessively dominant, which was a question which stayed with us to the end of the project. Group members started systematically to use the "Devil's Advocate" procedure to challenge assumptions so that Devil's Advocacy became fully integrated as a regular procedure from then on. And we discussed the balance in the project between action and inquiry.

Also at the fourth meeting we developed and introduced the idea of closed and open inquiries, and the group undertook to gather patient feedback.

The fifth meeting included formal sessions on distress aroused by the inquiry, on authentic collaboration, and on the Devil's Advocate procedure.

The sixth meeting included a fully fledged joint review of all validity procedures, and an important review by each individual of the ways in which distress had distorted their inquiry process. The final session included a full joint review of the validity issues in the project as a whole.

Evaluation of How We Used Each Validity Procedure

1. Research cycling, 2. divergence and 3. convergence. There was a total of six cycles of roughly six weeks each. And two major items were taken throughout each cycle: the five part model of holistic medicine, and the strategies involved in implementing it day to day in the surgery.

The five part model was devised at the first meeting from our combined prior experience and reflection on the nature of holistic medicine. It was evoked from a series of group discussions, and from these deliberations a group consensus quite readily emerged. The model was informally and implicitly under review at all our subsequent meetings; but it was formally reviewed for comment and modification in the light of experience at work during the third, fifth, sixth and seventh (final) meetings.

At each formal review, experience seemed to confirm the systematic interdependence of all the parts of the model: no one could be considered effectively for long in dissociation from the others. At the third meeting, the importance of self-gardening became paramount for many, and eleven people voted to make it at that time the central principle of the model. At the fifth meeting, more systematic refinements were introduced into the whole model, several principles being stated with more clarity and sophistication.

The project started with intentional, idiosyncratic divergence, each person following their own interests in their strategic action plans through the first cycle. Everyone wanted to continue their idiosyncratic strategies into the second cycle with varying degrees of development and change. This seemed to be right: it sustained creativity and commitment and enabled the group as a whole to range freely over the whole field of possible holistic strategies.

This divergence was sustained by all members throughout the entire project, but by the third meeting the strain of our divergence began to be felt as a certain vagueness and diffuseness of endeavour. So it was agreed at this meeting that we start two strands of convergence: one

sub-group undertook to focus on power-sharing strategies, another sub-group on the use of spiritual interventions. These two lines of convergence were sustained by their respective sub-groups until the end of the project. Thus a balance was sought between divergence and convergence in our research cycling.

An important issue concerns the use of data. How well was data on strategic application in the surgery collected and recorded? How thoroughly was it shared in the next meetings? How intentionally did shared data inform planning for action in the next cycle?

Experiential data were collected as follows. At the end of each meeting participants made a contract or action plan which stated explicitly what that person would undertake in the way of holistic strategies throughout the forthcoming cycle. These contracts were circulated to everyone. Each person reported verbally on what they had actually done in the cycle at the subsequent meeting, and wrote a report on that work which was also circulated.

At the second and third meetings, where divergent strategies were being reported, we had a brief initial round of sharing at the start of the meeting, followed later by more detailed sharing in small groups of three or four. In the last four meetings, sharing of idiosyncratic strategies was overshadowed by regular systematic verbal sharing of the strategies used by members of the power-sharing and spirit sub-groups. But divergent strategies continued to be reviewed in individual written reports.

Now the notion of recycling implies that the data gathered in one cycle is used to inform action plans for the next cycle. This, we found, could occur in two ways: on the one hand through an explicit, rational, intentional sort of transfer involving debate and deliberation and decision; on the other hand through a tacit process in which the transfer is more subliminal and unconscious. Both these processes occurred. The tacit process pervaded transfer in the second and third meetings when we were concerned only with divergent strategies, and we surmise continued to be the mode of transfer for these strategies throughout the project. The process of transfer was much more explicit in the power-sharing and spiritual intervention sub-groups, when what had been tried out in a previous cycle was intentionally used to clarify its further development in the next cycle. There was also, of course, tacit transfer in these sub-groups too.

In an ideal co-operative inquiry project we would expect high quality experiential data and high quality recorded data; together with a sound balance between tacit transfer of learning from cycle to cycle and explicit transfer. Measured against this ideal, while the quality of the experiential data was certainly high, the quality of the

recorded data was very variable as between members and over the set of reports of each member. This was perhaps because we never agreed on any one method of recording data: from start to finish each person kept records in their own way. And we would like to have seen a more conscious balance between tacit and explicit transfer of learning from cycle to cycle. In fact, this distinction between tacit and explicit was not made until after the inquiry. Had it been made from the outset, we could have handled the balance with greater awareness. We should stress that in a wide ranging inquiry, covering several major holistic principles and their strategic application, it is probably essential that a considerable amount of transfer should be tacit. In a pioneer co-operative inquiry of this sort, making too heavy a demand for exactitude and excellence in any one part of the enterprise could undermine commitment to the whole. It is better to do the whole thing with only a modest competence in the parts, and sustain commitment to the end, than to seek high competence in each of the parts and exhaust everyone before the thing is half completed.

Finally, an evaluation of research cycling, divergence and convergence. The five-part model stood up very well, at the tacit level of transfer, to research cycling; but our view is that it was deepened and refined explicitly only to a modest degree. Partly, of course, this is a function of the time available. The balance between divergence and convergence we judge to have been good, with convergent lines of inquiry introduced early enough for several cycles of convergence to be sustained. But while the convergent strands were well developed over several cycles, with data and learning made explicit, well shared and recorded, the divergent strands were left almost entirely in the later cycles in individual hands with little sharing and mutual learning taking place, at any rate explicitly - except in so far as members read and digested each others' written reports.

4. Authentic collaboration. In reviewing how far our inquiry was collaborative in a genuine sense, we need to consider the degree to which each individual was able to make their own contribution to the process, and also how much this individual contribution was able to interact with and influence the contribution of others. There are three heads under which we need to review this: the nature of leadership and facilitation; the influence hierarchy; individual contribution at the reflection and action points of the cycle.

4a. Leadership and facilitation. The project was quite clearly started by John Heron, who generated the original idea and at an early stage invited Peter Reason to join as an initiating co-researcher. For John this was a development of his work on educational innovation in postgraduate medical education, together with a decade of exploration of alternative research methods. For Peter it

was similarly a development of his work with organisations and professions, and his commitment to the development of more valid forms of human inquiry. Thus the initiating facilitators' world-view and prior commitments had a major influence on the inquiry from the start.

John and Peter's role in the inquiry was multiple and complex; they were attempting to be research initiators within a new inquiry paradigm; group facilitators; and contributing co-researchers. Given their influential combination of roles and charismatic style, the question is to what extent did power become genuinely distributed throughout the group?

At the first meeting John and Peter alternated their role of primary facilitator, actively managing the group process on a basis of genuine consultation. At the second meeting Peter was absent and John as facilitator became caught up in some control anxiety in this role which generated in participants a certain amount of counterdependence. He sought to resolve this by proposing that the role of group facilitator be rotated among members. This proposal was readily accepted and was adopted for the rest of the project, different members taking shorter or longer periods in that role as the agenda, their own preference and the group will required (two thirds of the group took this role at some time). In our view, we were right to devolve leadership early in this way, even though one of the outcomes was that the group process was at times confused and chaotic. John and Peter retained a lot of influence with respect to facilitative interventions from the floor about how to structure our meetings but decision making and group management clearly became a collective responsibility.

With respect to initiation of research processes, Peter and John retained a high influence level throughout the project at critical inquiry points: raising questions with respect to validity issues; initiating decisions about convergent and divergent strategies; and reviewing the five-part model of holistic medicine. Overall they retained the clearest view of the nature of the inquiry method and the strategic processes within it; while most members had internalised its main structure, ethos, and key notions - as evidenced by their contribution to decision about inquiry method - some few members of the group remained mystified about its detailed aspects, and somewhat sceptical about its claim to represent a genuine alternative to orthodox inquiry.

The initiating facilitators and researchers were themselves non-medical people. They participated as different sorts of partitioners - ie as humanistic group and individual facilitators - and so were part of the inquiry. It is possible this different kind of professional work which they processed through the inquiry

meant that their interventions about the whole inquiry process were less relevant and effective than they could have been if they had also been engaged as general/medical practitioners.

Whatever the extent of the influence of the initiating facilitators, the inquiry, while not perfect, was collaborative in spirit, and certainly sufficiently collaborative for its findings to represent the collective view of the inquiry group.

4b. Influence hierarchy within the group. The question about differential contribution rates and dominance within the group was raised during the process session at the first workshop. The whole issue then lay dormant for the next two meetings, although it was clear that some members were much more influential than others: in decision-making sessions in particular a clear pattern of high and low contribution rates was emerging. At the fourth meeting consciousness about this was raised in a validity review, but it was not until the fifth meeting that it was brought fully into the limelight with an exercise in which we lined up in accordance with ourself perceived contribution rates. At the fourth meeting also high contributors quite intentionally sought to give space to low and medium contributors. Nevertheless, the low contributors on the whole insisted that contribution value was not the same as contribution rate, and some of them were unhappy at artificial attempts to equalise contribution rates.

Two particular points need to be raised about the womens' contribution in the group. The first is to question whether womens' influence on the culture of the group was ever adequately represented and sustained, particularly within the process group, which was on one occasion likened to the performance of stags at bay. Also general discussions within the group were beset by male competitiveness about air time and influence. One outcome of this was that the men in the group tended to rush past and interrupt the women in their attempts to gain air time. We believe that raising consciousness about this, and specifically pointing it out when it happened, did to some extent ameliorate this problem; but it was anyway made more difficult by the imbalance of gender within the group, there being only four women members.

Clearly a limitation of the inquiry is that whole series of important decisions were much more influenced by some members than by others, and particularly by men rather than by women. This however is counterbalanced by the fact that no-one protested that their influence on decisions was ignored, suppressed, or inadequate. It is an unresolved issue as to how many people were passively carried by the influence of others, and how many found that their genuine aspirations were voiced by the influential. Indeed it is an open question as to the degree to which both high and low contributors were

pathological and distorted in the way they functioned in the influence hierarchy.

4c. Individual contribution. By its very nature, the design of the inquiry gave space for constant individual contributions in making personal action plans for each cycle, in implementing the plan, and in writing regular reports. These reports were always distributed among the whole group. Feedback and verbal reports at our meetings, both in the large group and in sub-groups, were often done on an "equal time" model, so that each person made a contribution. Furthermore, the element of divergence built into each cycle meant that there was always scope for idiosyncratic action plans alongside those agreed collectively. Therefore, in terms of contract, implementation, data gathering, and feedback of data there was a very high degree of participation by all members.

One important way in which the thoroughness of individual contribution fed collaboration was through this circulation and reflection on each others' written reports. Others' reports were frequently influential on members' thinking and action.

Taking all the above into account, our judgement is that a first stage of genuine collaboration was achieved. That is to say we passed over that imaginary dividing line that separates an other-directed group from a self-directed group. Nevertheless there were clearly further degrees of collaboration which could have been achieved: there could have been a much more thorough going internalisation of the research paradigm; there could have been greater participation in decision making, a less steep influence hierarchy, and a more even gender balance in the culture of the group. However, the findings of the inquiry are adequately based in authentic collaboration.

One conclusion from this is that the establishment of full collaboration in an enterprise of this kind would be a remarkable achievement given the educational, political, research, and professional conditions out of which people emerge in our society.

5. Falsification. Falsification involves devising strategies in the group to counteract tendencies to consensus collusion among members to ignore issues, views and evidence that arise within the inquiry and are at odds with the ideas that guide the inquiry. In particular in this inquiry falsification could focus on the assumptions of the five part model, and on the nature of the strategies used to implement it. It could also focus on the validity of the inquiry method per se; or, given the validity, on the thoroughness with which we were implementing the method.

The issue of consensus collusion and the importance of attempting falsification was not presented at all during

the first three meetings except for a very brief reference in an overview at the second meeting. These issues were presented much more thoroughly at the fourth meeting, the importance of falsification was underlined, and the procedure of "Devil's Advocate" recommended to the group. This procedure has already been outlined. It was instantly taken up at this meeting and at every meeting thereafter was quite regularly adopted in a spontaneous way by group members who felt moved to challenge what was being said or planned.

The Devil's Advocate procedure was used in roughly equal amounts in the four categories mentioned above. Our judgement was that tactically it was used adequately, in that individual members views and assumptions were challenged and confronted. However, our view from a distance is that we failed completely to use this procedure strategically: we did not carefully and systematically set up a full Devil's Advocate procedure, in which major portions of our thinking and practice were thoroughly challenged and either thoroughly defended or abandoned. For example, the spirit group could have systematically reviewed the work of the power sharing group, and vice versa (it was done casually); or the Devil's Advocate could have taken each part of the five part model and the model as a whole, and reviewed it for conceptual, ethical, and practical difficulties with other group members giving either an argued rebuttal, or acquiescing in the rationality of the critique and so on.

In addition to this, some of the Devil's Advocate degenerated into mere prankishness and mischievous boat-rocking.

It is arguable that in terms of this very important criterion of validity the project was inadequate. It could perhaps be said that the group was prematurely persuaded by the soundness of its ideology, and that during the inquiry we colluded in assuming that our use of the Devil's Advocate procedure was adequate, so that the whole tendency to consensus collusion invaded the very use of the Devil's Advocate procedure itself. This is probably the most severe critique of this project's validity that we can make.

6. Countertransference. As recounted above, we attempted to take charge of this issue from the start: we built into the project regular process sessions to explore interpersonal and intrapsychic disturbance and also arranged regular pair sessions using co-counselling approaches. The process sessions dealt mainly with interpersonal issues although at the fourth meeting an important descent was made into archaic, more deep seated personal distress.

This distress originated in hurts incurred during the socialisation process that had made people into orthodox

doctors. Thus deep seated rage toward oppressive medical teachers was expressed and abreacted, along with anger toward fellow professionals. Also anger and grief toward parents who had channelled development toward the profession, conditioning the child to continue to be a "good boy" by becoming a doctor. Associated with such rage and anger is the child's inhibitory fear of the oppressor which keeps the anger suppressed.

Did we deal adequately with this distress? It is probably the case that although this material was modestly worked on and certainly seen, not enough work was done on it to empower members to make the kind of innovative changes in practice which their work situations could have tolerated. Thus we would argue that there was an underlying fear - about the challenge of the project to established ways of being and ways of practice - which was inadequately dealt with.

This relatively unworked distress, we hypothesise, is responsible for the consensus collusion we earlier reported: the group colluded in espousing a kind of ideological perfectionism which was neither properly challenged nor adequately carried out in practice. There was thus in the inquiry a neurotic gap between the image of the ideal practitioner and actual practice. To an extent we failed to manage the distress adequately, and therefore pretended an holism which we failed sufficiently to apply.

This is a valid criticism to a degree. It can however be rebutted to a certain extent by pointing out ways in which this gap between professed ideal and actual practice was bridged: some members raised spiritual dimensions of disease with their patients, blessed the surgery before seeing patients, made explicit invocations to patients, swapped chairs, abandoned the doctors authoritarian roles and shared power in several ways. Many members also made a serious practical commitment to the principle "Physician heal thyself". All of this is evidence of a shift toward the practical expression of the ideal model.

7. Open and closed boundaries. The question we must address here is whether the activity being inquired into affects people who are not part of the inquiry group. Clearly in our inquiry the latter is the case since the holistic strategies being inquired into had an impact on large numbers of patients. We would argue that when the boundary of the inquiry group is open in this kind of way feedback from those affected outside the group is an essential part of data collection.

We addressed this issue at the fourth meeting and agreed that we would collect data from select patients, and practiced this using role play on asking patients for feedback. The reports on cycle four showed that about one third of the group had gathered feedback from a very small

number of selected patients; but little was done with this data, and the issue really was not followed through. This does seem to be a major limitation on the inquiry's claim to validity. Nevertheless, it is clear that members of the group collected an enormous amount of experiential data from face-to-face interaction with patients during surgery consultations; and this data was very thoroughly shaped in feedback sessions with the group.

8. Chaos. In introducing this idea above, we argued that chaos is a precondition for the emergence of truly creative order. But by its nature, chaos cannot be systematically generated, it can only be accepted and lived through if and when it occurs. Each person's tolerance of chaos is probably very different, and no doubt there are nineteen different views of the degree to which our inquiry was more or less chaotic. Our own view is that the degree of chaos was minimal; indeed, it might be argued that as initiating facilitators we ensured that the process was quite orderly. On the other hand, some individuals reported a good deal of intrapsychic upheaval and disorder, particularly as they embarked on their self-gardening. There were fluctuations in messiness and crispness in group process; and fluctuations of confusion/depression and clarity/eagerness in the group as a whole.

Looking at this from one perspective we can argue that there really was not enough chaos to generate a new order; that the group and its members would have to go through an almost psychotic degeneration into disorder if they were to re-create a genuine holistic practice. From another point of view we can argue that the project as a whole is so complex and with so many interpenetrating strands that it was as disorderly as it could be without completely falling apart.

Validity in Our Inquiry as a Whole

To summarise the above sections, we have argued that the inquiry as a whole has some claim to validity in terms of research cycling, the management of convergence and divergence, degree of authentic collaboration; but that its validity could seriously be held in question with respect to the management of falsification procedures, of countertransference, of feedback at the open boundary. There is no one simple "objective" view of the overall validity of the inquiry. And there is a sense in which each reader needs to take their own perspective on this issue.

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