

Luminous words

A Think About Health project



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Introducing Luminous Words

Dear TAH Members and Others,

This short booklet arises from a project launching the Think about Health website (<http://www.thinkabouthealth.net>).

The concept

This is an idea that came out of the Think about Health meeting on language in health care in September 2010.

We found that there were a lot of words that seemed essential to health care (not least the words 'health' and 'care') that seem in some way to be marginalised.

So we thought it would be illuminating, participatory, and fun to begin to create a kind of Angel's or Devil's thesaurus of words that we find important but neglected. Maybe we could create a list of luminous words and also of their tawdry or non-luminous equivalents, so have both an Angel's and a Devil's thesaurus?

We hope to build up a set of words fleshed out with a variety of contributions and in due course we might try to capture some of these in a more formal publication.

How does this work?

We invite Think about Health website users to nominate a word that they think is important but neglected in health care, then write a short blog about why they think this.

Other users are then invited to add their own thoughts, stories, narratives, poems, photographs, pictures and comments to the original blog in the spirit of being constructive – we are not particularly interested in creating flat contradictions or acerbic critique but rather in seeing whether we can positively rehabilitate and make more creative and illuminating the vocabulary around health without being anodyne, unrealistic or uncritical. Contributions around particular words do not need to refer to each other, but they can diverge and be tangential, and we would welcome words and comments that are illuminatingly opaque – the only criterion we ask people to bear in mind is that we are trying to be constructive, even if oblique.

We, Val Iles and Stephen Pattison, started the first entry around the heavily cathected word, 'vocation'. Why not take a look at what we and others have written and decide whether you would like to contribute? We hope that this is only the first slim volume of Luminous Words, and not the last.

Some indicative words that might be explored

Recognition

Together

Faithful
Principle
Pain
Sterile
Fecund
Unknown
Face
Legal
Statistic
Outlier
Variation
Duty
Conscientious
Equality
Sharing
Unselfish
Goodness
Fairness

If you want to discuss luminous words some more, or suggest one, please contact Val and/or Stephen in the first instance: S.Pattison.1@bham.ac.uk, v.iles@reallylearning.com.

We hope you will all want to contribute and at least look in on the site occasionally.

Stephen Pattison and Val Iles

May 2013

Vocation

by Stephen Pattison

Vocation and profession are both words that come out of religious life. Your vocation was your call from God to separate yourself off and pursue a certain 'higher' way of life and service; your profession was your public commitment to that way of living, perhaps accompanied by promises or vows like the Hippocratic oath.



Like Tony Blair, many of us 'don't do God' in public these days. We worry about the capacity of formal religion to oppress both groups and individuals. And who in the NHS really regrets the passing of veils and long robes for nurses, some of whom within living memory were still called 'Sister'?

We might be able live without the restricted life, the funny hats and the religious titles, but can we really fully live without the idea of vocation? Even if you don't believe in God and are indifferent to religion, might it still be helpful to see yourself as engaged in work that transcends self-interest, job descriptions and narrow contractual obligations? Someone who is in a sense 'called' to follow a particular path that will involve the whole of yourself, not just the bits that are specified as essential skills and competences.

Vocation adds something to labour and to work. Part of what it adds is apparently external importance, dignity and personal and moral purpose – motivation and ethical imperative, if you like. I don't just do this for money, I do it because it is important to society, important to individuals, important to my own sense of having a valued and valuable life. That is why I don't stop working when the shift ends or when I have fulfilled to the letter the tasks, terms and conditions of my employment. And I don't necessarily want someone to just give me more money for what I have done over the odds; I

want them to recognise that my work and identity as a professional has an intrinsic value to myself and others and that it is worthy of the highest respect. Something that I treasure beyond what I am paid because it is part of my identity and part of what makes me feel that my whole life as a human being has worth. When people put a price on it, they put a price on me and make me a wage slave, not a professional.

Vocation, the sense that there is something I must do if I am to live fully, is value added to human life and labour. It's free, it cannot be coerced, and it's compelling well beyond the bounds of religion – consider the nerds at Microsoft who work all night for the joy of solving a problem. Can we afford to do without it in health care? Would we want to receive and deliver the kind of health care that has no room for vocation?



Vocation

by Val Iles

Why does 'vocation' seem an old fashioned idea? One out of tune with today?

The preoccupation of the moment is economic growth. A growth fuelled by (in the West) a desire to, in the words of professor Tim Jackson: 'spend money we don't have, on things we don't need, to impress people we don't care about'. As he points out, we will need in future, if we are not to make unsustainable demands of our planet, to allow growth only where it does the greatest work, that is in the poorest countries of the world. That leaves the West either to live without growth or (if this is possible) to decouple financial growth from material growth. Either of these scenarios mean that we will need to pursue an 'alternative hedonism', that we will have to consider how we spend our time rather than our money, or that we spend our money on our time. Our time – us, our lives - could become important again, not merely a vehicle for the distractions of shopping and media, not merely a means of supporting our fragile and confused egos.

When we look behind our confusion we find a compassion that we are being taught not to trust. With the mantra of 'self interest' we are corrupting ourselves and our patients. Without the stigma attached through the ages to acts of selfishness and lack of concern for others we treat patients as 'grown ups' at times in their lives when their future expectations are turned upside down or they bear long term discomforts that require fortitude and courage. This allows us to behave entirely rationally, to offer care that is at heart transactional rather than covenantal, to care for them and not about them.

What we fail to recognise is that it is not only they who lose an important dimension from their lives. We too are diminished as we cut ourselves off from the challenge and the rewards of loving our neighbours as well as ourselves.

Down the millennia we've been encouraged to do both – care for others AND for ourselves. Ours is the first to laud the latter and describe the former in disparaging terms (co-dependency, utility).

Let us return to the road of sanity and restore a pride in a sense of vocation.

Quiet

by Iona Heath

Over recent years, the context for the use of the word noise has extended way beyond the audible to signify any disturbance that is intrusive or corrupting. This use originated in electronics but it has now degenerated into what is almost a cliché found extensively in, for example, the literature of photography and information technology. There seems to have been no parallel increase in the use of the precious word quiet.



In his evocation of the work of a rural general practitioner in *A Fortunate Man*, John Berger points out that 'with the exception of the one word 'gale', a passage from Joseph Conrad's *Typhoon* 'might describe the crisis of an illness, with the voice of Captain MacWhirr transformed into that of a doctor.'

'And again he heard that voice, forced and ringing feebly, but with a penetrating effect of quietness in the enormous discord of noises, as if sent out from some remote spot of peace beyond the black wastes of the gale; again he heard a man's voice - the frail and indomitable sound that can be made to carry an infinity of thought, resolution and purpose, that shall be pronouncing confident words on the last day when heavens fall, and justice is done - again he heard it, and it was crying to him, as if from very, very far - 'All right'.'

This is just what we try to achieve in the consulting room: the penetrating effect of quietness in the enormous discord of noises.

The pervasive fear of the imminence of our own mortality creates just this sort of noisy discord and this is multiplied by the noise, both literal and metaphorical, of contemporary healthcare. MRI scanners, waiting room announcements, telephones, computers, protocols, guidelines and imperatives of every sort all produce a different modality and pitch of noise and, within the

resulting cacophony, it is difficult to think at all, let alone to formulate a coherent way forward. The tradition of quiet in libraries – places of study and contemplation – is no coincidence. Quiet, both physical and emotional, is an essential prerequisite for thought.

Interviewed in the Guardian, the pianist Mitsuko Uchida was asked whether there was an art form that she didn't relate to. She replied: "Anything noisy. Even visual art can be noisy. It's not just a matter of colour: there are some fantastically colourful artists who are wonderful – Van Gogh, Rembrandt and his use of light. But there are other, noisy artists." She suggests that noise interferes not only with the capacity for thought but with perception and feeling as well. The persistent noise of fear, alongside the more prosaic interruptions of healthcare systems, emphasises the importance of defending the quiet of the consulting room. This quiet makes it possible for both doctor and patient to hear, to listen, to imagine and to think.

The central human importance of quiet is perhaps underlined by the fact that it is one of the few words that is used in three grammatical forms: as a noun, a verb and an adjective. The role of the doctor is to provide a haven of quiet; by careful listening and active imagining, to locate and, as far as is possible, to quiet the fears and suffering of the patient; and to know and understand the power of a quiet voice and a quiet touch. Too often the practice of medicine becomes synonymous with activity but the soothing of suffering often has much more to do with a quiet accompanying, being prepared to try to be fully present when another human being is facing up to the arbitrary horror that scars lives. I have only to think, among countless examples, of the loaded quiet which precedes the revelation of abuse by a frightened adolescent.

In his poem *Night Duty*, the Swedish Nobel Laureate Tomas Tranströmer writes:

The language marches in step with the executioners.
Therefore we must get a new language.

Noise belongs to the language of the executioners; quiet belongs to the survivors.

Personal

by Jamie Harrison

Recently I was offered the possibility of having a ‘personal banker’, someone I was led to believe would be available to give timely financial advice and smooth any transactions that I might need to complete. It sounded good – a dedicated person (with a name) who would answer the phone when I rang, rather than finding myself caught in an automated system forever asking me to press a number, ‘followed by hash’, within an endless round of options leading nowhere.



So, I ask, have the banks for once got it right? – Could it be that a personal service provided by a ‘real’ person is the future as well as a reflection on the past, a time when the Bank Manager was a person you knew (and probably feared) – perhaps one of Alasdair MacIntyre’s ‘characters’ – and where others in the team were approachable folk who phoned you back when you left a message? How many of us can remember that?

I vividly remember Dennis Pereira Gray reminding us thirty years’ ago that, once doctors and patients lost the habit of meeting each other regularly (with the demise of what he saw as an individual GP’s Patient List), then neither would know what they were missing – it might be bad for doctors and it might be bad for patients. Of course, we must acknowledge that familiarity can breed contempt (or lead to the doctor missing the slow and subtle changes of disease – hypothyroidism is usually quoted here). Yet the ability to meet in the consulting room in both fair weather and foul might allow a depth of rapport and mutuality to flourish, even with the ‘heart-sinks’; at least you both knew you had to sort it out together.

Recent pressures to limit hospital working hours for doctors, with the resulting loss of the close-knit consultant-led team (firm), and the fragmentation of

primary care appointment provision (one perverse consequence of the 48-hour access requirement), mean that it is harder for clinicians and their clients to keep in direct touch – where ‘touch’ itself may add greatly to the healing and appropriate bonding that both parties need. In the personal interaction much of our shared humanity can be expressed and experienced by the kind word, the supportive glance, the held hand, the pulse taken, and the prescription (gift) offered.

In struggling to make sense of what might be termed the ‘hermeneutics of healthcare’ – how we seek to describe, interpret, and make sense of what goes on in the interaction between health-carers and their patient clients – the nature of the personal can be overtaken by the desire to measure transactions, rather than look for transformations. Michael Balint, in his book initially titled ‘The Doctor, His Patient and the Illness’, is careful to ask how we might see lives supported, even changed, through personal therapeutic interactions which may not fit easily into scientific medical models of diagnosis and treatment. To borrow an updating of his book title to the present day – now ‘The Practice, the Population, and the Public Health’ - reminds us that the shift to systematised medicine (to quote Illich) risks dehumanising all parties concerned.

I wonder if I rather like the idea of my ‘personal banker’ – she may get it wrong but at least we can get it wrong together. In seeking a person with whom I can interact – some one, who is available, takes me seriously and takes responsibility - I hark back to past ages of personal physicians who were there for you and told you the score; who travelled with you through life’s ups and downs (both yours and theirs), and who might journey with you to life’s end, what Illich (again) refers to as the *amicus mortis* – ‘one who tells you the bitter truth and stays with you to the inexorable end’ (BMJ, 1995).

‘Personal’ care can, of course, be as much an attitude of mind, as I seek to meet you and your concerns, even if for the first time, with a genuine and generous spirit. Yet how we organise ourselves within our healthcare settings would seem to make that either easier or more difficult. Where there is an emphasis on systematic care, the personal may be lost; too much personal discretion can lead to poor standards of practice. How to get the mix right? Surely one answer is to find ways of encouraging person-to-person continuity within proper frameworks of clinical governance, where the expectation and ethos is that persons really do matter.

Judgement

by John Gillies

The phone call came about midnight on a cold March night. I was the GP in the out of hours car. The caller said that her husband Billy, who was 45 years old, had had a large curry and several pints of beer and was having bad indigestion. It had happened quite a lot recently. He had taken his antacid tablets but it hadn't got better yet. Could I suggest anything? Inwardly, I thought about suggesting less beer and a Chinese instead of a curry but restrained myself. The history certainly fitted with a digestive problem and yet....



I diverted the car to the small Border town where they lived and assessed him 15 minutes later. Billy had time to tell me that he was a joiner, smoked 20 cigarettes per day and that his father had died of a heart attack when he was 49. He then, in mid-sentence, suffered a cardiac arrest. I ran back to the car, got the defibrillator and after two DC shocks, he came round and 30 minutes later was in hospital. He made a full recovery and went back to work after six weeks.

Without a doctor, nurse or paramedic to wield the defibrillator, Billy, self-employed joiner, son, husband, father of two primary age children would have died. His survival relied on two individuals making the right judgement. His wife thought that his indigestion was somehow not the same as his usual Friday night indigestion. I was alerted in something in her tone of voice, and, (I am ashamed to say rather grudgingly), visited him. No great credit to me; all doctors have all too vivid memories of when they get it wrong, but that was a rewarding night to be a GP and to make the right judgement.

However, the idea that judgement by doctors in individual cases is an essential part of decision making has been systematically undermined over the past twenty years, to the detriment of medicine and patient care.

About fifteen years ago, at the start of the period when medicine began to be driven and dominated by the development and use of evidence, in the form of guidelines or protocols, a senior member of the profession announced at a physician's conference:

'We are now in a time when the phrase "in my judgement" becomes unacceptable in medicine.'

He meant that, with the advent of good quality evidence for many conditions, there was no longer a need for doctors to make judgements on the basis of anything other than this straightforward scientific evidence. I was unhappy about this statement then and am now even more so.

The development of high quality evidence has been very important in improving the prognosis of many people with diseases like diabetes, coronary heart disease, asthma and many cancers, and this has contributed a lot to the increasing longevity of those of us lucky enough to live in the western world. In my professional lifetime, the outlook for those, for example, with breast cancer or heart disease has improved out of all recognition.

However, three problems remain:

The first is that in most clinical trials, the evidence for treatment is derived from a highly selected population of patients and extrapolated generally. The fact is that in many cases, these facts (the evidence) don't tell you what to do, because, as Prof Jonathan Rees has said, the patient in front of you was not in the trial.

The second is that the very success of these treatments now means that we have many people in the UK who suffer from several conditions. The combination of diabetes, high blood pressure, arthritis and obesity in elderly people for example is very common. It has been pointed out by more than one authority that when we treat all the diseases that individuals have according to the evidence, we subject many to dangerous polypharmacy. We will also bankrupt the NHS.

The third (from which the first two problems arise) is that we treat people as their diseases: an elderly man with angina, a middle aged woman with breast cancer. As Joanne Reeve has written (about generalism in general practice), we need an approach to the individual patient that is both biotechnical and biographical, that looks at the evidence but also at the context of the patient, situated in a family, a culture and a community. This approach also implies taking into account the patient's autonomy, her expressed thoughts and wishes.

Only by acknowledging the importance of judgement can we overcome these problems. Only judgement can help us assess the patient's history and signs, assess whether this disease guideline should be considered for that patient with the disease. Judgement is needed more than ever now start discussing with older people which treatments to start, which to stop, based on what they wish for their lives—their goals, not the goal of achieving some sort of spurious physiological or biochemical normality. And finally, we need judgement to make these crucial decisions about when to say things, how much to say, how much to tell, how much to listen. This can only be based on understanding, to a greater or lesser degree, who the patient is. Martha Nussbaum called this attending to the priority of the particular, not the general or universal.

However, things are getting better. Sir Michael Rawlins, Chairman of NICE, said this year that guidelines are mainly for guidance and are not diktats. Sir Peter Rubin, GMC President recently wrote to all doctors acknowledging that we make difficult decisions often with unclear evidence, which requires judgement.

So how do we make these judgements? As Gadamer and others have pointed out, we need to look for the signs of illness in the voice, the eyes and the demeanour of the patient and their relatives, not just in the purportedly objective data about her disease or illness. My story suggests that that also applies to those telling us, as clinicians, about the patient. To do this, we need to engage our emotions as well as our intellect, make sure that our antennae are open to what is behind the patient or the relative's words, be, in essence, human beings first and doctors second.

To do this well, I think that we need practical reasoning, or what the Greeks called *phronesis*. For another day...

Flourishing

by Val Iles

I love the idea of these luminous words and I hope I can convey some of the luminosity of the word flourishing. This is all the more important because, like so many others before it, flourishing is about to become dumbed down, diminished, made tame, in this case by its inclusion in the positive psychology market. I won't be able to do it justice, but perhaps I can enthuse you to re-explore it for yourself.



Flourishing is one of the translations of the Aristotelian concept of eudaimonia, and in that context carries a sense of things abundantly embodying the essence of their thing-ness . A lark, a sunflower, a sandstone rock, a human – each of these can flourish, and in their flourishing they contribute to the world in different, essential ways. And perhaps not merely a human, but this human, this human that is me, or the human that is you, so that abundantly being me will be different from abundantly being you.

For Aristotle, flourishing as a human involved (among other things) practicing the virtues: making judicious and sensitive decisions about what a courageous act, an honest behaviour, a loyal decision would be, here in this situation, and how it may differ there in another, using the master virtue of phronesis, or practical wisdom. So flourishing is something that can be taught and fostered (we'll leave aside his attitudes towards women, slaves and the ugly!).

At about the same time as Aristotle (two and half millennia ago) Siddhartha Gautama (later termed the Buddha), drawing not so much on logic but on exquisitely detailed observations of his body/mind (perceiving the two as one), articulated a concept that is perhaps best translated as awakening. His fundamental insights are usually described as the four noble truths and can be (inadequately) summarised as follows:

Life inevitably involved dukkha.

Dukkha is often translated as suffering, but has meaning across a spectrum from unsatisfactoriness to anguish. The point is that life is inevitably not the way we would ideally like it to be.

The cause of dukkha is our craving for things to be permanently good or satisfactory, when actually:

nothing at all is permanent and

life has to include many sadnesses and distresses or it is not life.

Since our craving arises from two mistaken beliefs (that we do not have everything we need to be content within this moment right now, and that there is something over there that will make us content) we can reach a point of cessation of craving by

fully understanding and accepting rules number 1, 2 and 3 and living a life based on that realisation.

Is awakening another way of describing flourishing? I suggest that it is at least closely related, and indeed, with its strong advocacy of the non-dual nature of mind and body that it relates also to the origins of the word hale which has given us health, well and whole.

We can also think more conventionally of flourishing and of the kind of nutrients that we require to flourish. And then we can use research methods to ascertain them. For humans these appear to include, in addition to the meeting of our physical needs many social and emotional ones (including the need for security, for deep acceptance, for social relations, for some form of status in a group, for a sense of development, for a sense of purpose). And if we cared about flourishing we would focus our resources and our energies on ensuring that these were available to all.

With these three concepts of flourishing in mind, we are ready to ask the question: have we, in health care, lost our focus on flourishing? On helping people be hale, be content, be at ease? In our craving for longevity, have we forgotten that its importance is as a prerequisite for flourishing and not as an

end in itself? Have we diminished our lives and those of others (and of other species) in the process?

How would it be if every health care interaction was literally that – a two way exchange with the purpose of encouraging the flourishing of both? Surely not only the nature of the conversations would be different but the outcomes would be also.

Might we teach and foster practical wisdom and an understanding of virtue ethics? Might we encourage practice in the 'four immeasurables' – compassion, empathetic joy, loving kindness and equanimity – based on 'mindful' observation of our body/mind reactions to situations? Would we fight for the opportunity for all to have the conditions in which they can flourish?

Should we open a debate about the role of health care: should it be more about flourishing than longevity?



Humility

by Jane Macnaughton

‘there’s nothing so becomes a man as modest stillness and humility’
Shakespeare, Henry V Act 3 Sc 1.

It is a characteristic of medicine that from the outset it incites in its recruits a deep desire to belong: outsiders wish very quickly to become insiders and to take on the characteristics that that entails. In my first few weeks as medical student, having come from the very different intellectual environment of the arts and humanities, I was shocked at the signals that were being given out to us eager and impressionable young people. We were the ‘elite’, set aside from our university peers by the intensity of our curriculum; we had to get down to learning a massive array of technical terminology ‘so the patients could not understand us’. Admittedly, times have changed in medical education, but the sense of being set apart from a wider world is initiated at university where the intellectual environment is not expansive especially in the early, most impressionable years. Unlike in philosophy or literature, there are no alternative views to put forward about the structure of brachial plexus, you just have to learn it.



With this start, building on single-minded effort to achieve entry to medicine, and followed by hard grind to get through it, It is all too easy to become taken

up with the importance of the profession and the centrality of it to one's life. It is with some shame that I have to admit, some 25 years on, that I am only now becoming to realize just how much of an insider I became. Working intensely now with an research group from a different disciplinary perspective, it is like scales have fallen from my eyes and I find myself genuinely understanding that for many people the attainment of improved health might not in fact be a value that trumps all others in their lives.

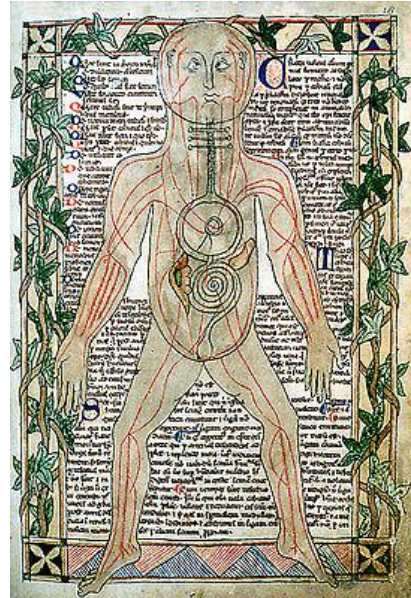
It was only recently too, coming fresh to preparing a session on medical professionalism for our first year medical students, that I was aware that I was once again achieving the valuable perspective of an outsider. I read through the Royal College of Physician's report *Doctors in Society: medical professionalism in a changing world* (RCP, 2005) and came to the bit which lists the professional values that doctors are expected to be committed to in their day to day lives. These are: integrity, compassion, altruism, continuous improvement, excellence, partnership working with the healthcare team. This list did not feel right – these are all good things but the tone was self-congratulatory. Something was missing. I was wanting to warn my students that the important thing to remember about professionalism is that it is in the eye of the beholder: of course it matters if your colleagues think you act professionally, but it matters a lot more that your patients do. And this list seemed to be all about a doctor's perspective and not a patient's. What is lacked was the humility to be aware of this lack, but also the humility to see that that it needed to include humility!

Humility is not an attribute that we normally associate with a powerful professional group like doctors, but it is at the very basis of what good doctoring is about. Good medicine at the coal face essentially involves paying close attention, setting aside preconceptions about what you as a clinician think this illness means for the patient and really listening to what it is that the patient has to say. That is the way to accurate diagnosis and to treatment that achieves the outcome that the patient wishes. Good professional leadership entails a very similar process. Unless we listen to what patients think good professional practice means, we will not be able to provide it, and in our increasingly consumer-orientated society, the gap between expectation and delivery will widen. Humility involves setting aside personal and collective professional egos and assuming an attitude that Shakespeare referred to as 'modest stillness'. In that attentive silence we will discover how best to respond.

Wonder

by H M Evans

Wonder, wondering and states of wonder abide among life's joys. Like humour, health, music or poetry, wonder requires no justification; but unlike them – unlike even health – we do not ourselves make wonder: rather we stumble upon it. Wonder is a transfiguring encounter between ourselves and the world, in some aspect that we did not expect, or did not fully understand, or did not know we knew until then. While wonder lasts, the world is subtly changed, or we are changed, or both.



If in its larger sense 'health' refers to a life that goes well, years to which life is added, then in that larger sense wonder upholds health. Confronting something wonderful, our sense of ourselves is suspended and we become intensely mindful of the thing wondered at – a glorious vista, the helplessness of an infant, an un-looked for explanation, an act of selfless love, a glimpse of how reality is 'put together', a sense of the ipseity, the 'this-ness,' of things. Relinquishing our sense of self, we let go of our limitations and impediments in favour of immersing ourselves fully in the experience of wondering. In wondering we are sometimes as fully and as authentically occupied with the world as it is possible for us to be.

Even so, wonder need not be comfortable. Astonishing selflessness in others stops us short because deep down we know that morally we ourselves would invariably fall short. Physically, wonderful things inspire through their implacable power – Atlantic rollers thundering onto rocky shores will both mesmerise us and tear us to pieces with the same pitiless rhythm; the Moon's filigree beauty is possible only in a lethal vacuum. The organic processes of life demand that lives end: as Dylan Thomas put it:

The force that through the green fuse drives the flower
Drives my green age; that blasts the roots of trees
Is my destroyer.

Even in terms of ordinary health, a glimpse into the body's interior (familiar enough in our technological age) reminds us that our ordinary on-going experience of nothing-in-particular arises from the routine working of preposterous carnal complexity. Our existence is the existence of self-conscious meat, whatever else it is – and it is difficult to think what else could move someone to wonder, were they unmoved by this thought.

It has been suggested that the word 'wonder' shares roots with the word 'wound'. Whatever its etymological pedigree, there is something suggestive about that connection. To wonder at something is to see it outside our frame of ordinary expectations and certainties; as though these have been momentarily ripped from us, leaving us free – and vulnerable – to see the world anew, raw, un-skinned. Or it is to see through a rent, an unexpected gash in the façade of reality, to glimpse some structure (perhaps we take it to be purposeful, being the meaning-making creatures that we are) underlying the world of daily familiar life.

In his poem 'Ambulances' Philip Larkin's gaze alights briefly upon a form of existential wonder at our own mortality – a wonder that is overlain simultaneously with understanding and terror: children catch sight of the white 'wild' face of someone desperately ill being stretchered into the back of an ambulance before being driven off; they momentarily glimpse our – and their – finitude...

And sense the solving emptiness
That lies just under all we do,
And for a second get it whole,
So permanent and blank and true.

Wonder illuminates some of the most intense aspects of living – perhaps it also offers an alternative to rage at the 'dying of the light.'

Presence

by Elizabeth Barrett

I chose this word because, although I know what it means, it has started to mean more to me as time goes on.

I have done some training in facilitation and coaching over the past two years and am struck by practitioners' habit of taking time to 'become present' in the room at the start of sessions. This is necessary with groups as well as individuals.

This is certainly not a new idea and I am not claiming that it is. It is common practice in religious groups to have an opening prayer or a meditation on arrival and departure. I don't think, however, that we pay enough attention, in the Health Service, to the idea of the need to work at being 'present' with purpose.



It is difficult, as a general practitioner, to maintain the discipline of entering into the presence of every patient who comes in the door. We are obliged to control the conversation in order to collect information. We need to look at the computer to check medication and previous consultations and find a host of other information, and this can remove us from the patient's presence for chunks of time. Each time attention is removed from the patient, the connection needs to be made afresh.

A more general removal can be the result of being busy, anxious or having unwanted interruptions. However, I suspect that the most powerful block to being present with patients is the set of assumptions we have before we even meet. These are particularly powerful because they are difficult to recognize and acknowledge. The most bitter dissatisfaction is sometimes the result of a clinician inadvertently revealing their internal assumptions about the patient and, thereby, blocking their own presence with that patient.

Having worked with the PCT for a couple of years, I am aware of the unsatisfactory nature of many meetings, and how hard it can be to have real

conversations with others. There are hundreds of reasons for lack of meaningful presence in large organizations, but the NHS rarely allows time for reflection on such soft matters, despite the huge waste of resources involved in unhelpful or dysfunctional meetings.

I used to be a put out when patients left the room saying 'Thank you for your time, doctor'. I thought it probably meant I hadn't done anything useful, but they were acknowledging the time I had wasted on them. While I still have a slight twinge of self-doubt at this remark, I now hope that it sometimes denotes an acknowledgement of presence.



Death

by Andrew Edgar

Death is a style icon.

In the middle ages, the memento mori carried a significance. The tombs of medieval bishops and abbots might have two effigies. The upper one would be the man as he was in life, resting in full ecclesiastical regalia. Beneath lay the carving of a rotting corpse, still not quite a skeleton. The spectator is reminded, not simply of death, but of the inexorable decomposition into nothingness of one's mortal remains. Renaissance paintings of St Jerome in his study frequently showed a melancholy scholar tapping his fingers on a skull. The scholar's genius, for all its universal significance and endurance, threatened to crumble before the conundrum of personal morality



As the philosopher Heidegger noticed, humans are unique, not in that we are mortal, but in that we know we are mortal. Yet modern culture dedicates itself to denying that mortality. We live, as it were, in a 'never say die' culture. We will say 'pass on', we will describe someone as 'late' or even (and especially in the case of parrots) 'ex-'. We may say 'kick the bucket', 'wring up the final curtain' and 'join the choir invisible'. But we never 'die'. We of course no longer stroll on a Sunday afternoon around the local cemetery as once we did, and thanks to the triumphs of modern medicine we encounter death infrequently in our everyday lives, except when it happens to distant people on the television news.

The visual equivalent of this is perhaps the recurrent of the motif of a skull in Damien Hirst's work, through the spin pictures and culminating in the diamond encrusted 'For the love of God'. But this is the memento mori reduced to a trade mark, as empty of significance as Bass' red triangle. The image lacks the threat of decay and corruption familiar to the medieval and Renaissance mind. It blandly points to something that we cannot quite grasp. As such it remains

comfortingly this side of mortality, leaving us undisturbed. Death is a play-thing that need not disturb life.

Death was nineteenth century medicine's final enemy. Surgery and the pharmacopeia would defeat it, and in a peculiar way they have. Death has been hustled away from our ordinary lives, and enclosed, along with the lepers and lunatics, in its own asylums. The problem is of course that we are then left drastically ill-equipped to deal with death on the odd, but inevitable occasions, when it is let out.

Not every medical decision is a matter of life and death. Many now are calculations of the quality of lives that will run their natural course regardless. But, when life and death decisions have to be made – and they may be made not simply in the dramatic interventions of surgeon and the A&E team, but also as the manager allocates and re-allocates inevitably scarce resources – the trade-off no longer quite makes sense. We have lost the cultural resources that are required to think through death, either as an evil or as a good. The medical profession dogmatically assumes that it is an evil, and politicians were happy to rank hospitals according to their mortality rates. Yet, conversely, as a trade-marked commodity it is available as a personal consumer choice (in Swiss euthanasia clinics, if not elsewhere).

The superficiality of our culture's attitude to death serves us badly, be we patients or medical professionals. In the trade-off between life and death, it is not simply that death makes no sense, for nor does life, if it is no more than the absence of something that we cannot grasp anyway. Perhaps a reproduction of a St Jerome, or a photograph of an abbot's tomb from Tewkesbury Abbey, should be in every doctor's and health care manager's office, just as a start.



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Images

Vocation

Coptic gave stele, c. 6th century (photograph: Andrew Edgar);
Domenico di Bartolo, *Healing the Sick*, 1441–1442.

Quiet

St Anne, 8th century fresco, National Museum in Warsaw

Personal

Cycladic figurines, Badisches Landesmuseum, Karlsruhe, Germany
(photograph: Martin Dürrschnabel)

Judgement

Rembrandt, *A Scholar in his Study*, c 1650

Flourishing

Statue from a Buddhist monastery, 700 CE, Afghanistan
Reclining Buddha (n.d.), Thailand.

Humility

Anonymous, *Ear operation*, 1195.

Wonder

Anatomical illustration showing the veins. England; late 13th century.

Presence

Edvard Munch, *The Sick Child* (Lithograph) 1896

Edvard Munch, *The Sick Room*, 1893

Death – Reliquaries, Poland (Kashubian) (photograph: Andrew Edgar)
Bernt Notke, *Danse Macabre*, c. 1500.

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