Whole person medicine: a community of doctors discovering a new way to practice

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Before retirement from academia I contributed to the theory and practice of action research in writing, teaching and research as Director of the Centre for Action Research in Professional Practice. I co-edited the first and second editions of the *Sage Handbook of Action Research*, and co-founded the *Action Research* Journal. I am currently engaged in a series of experiential co-operative inquiries exploring living cosmos panpsychism, regularly sitting with the River Avon and with invocation and ceremony addressing River as a community of sentient beings: 'If I call to the world as sentient being, what response may I receive?' I am writing about this inquiry in at Learning How Land Speaks. **peterreason.net**.

Summary

In 1982 16 doctors met in a year-long co-operative inquiry to explore the practice of holistic medicine through cycles of action and reflection. Five dimensions of holistic practice emerged from the inquiry: seeing patients as beings of body, mind and spirit in historical, social and political contexts; people as potentially self-healing agents; power sharing between doctor and patient; practitioners offering a wide range of interventions; practitioners' responsibility to 'self-garden' their own personal growth and self-care physically, emotionally and spiritually. The project contributed to the founding of the British Holistic Medical Association, and the ongoing debates about complementary medicine in the NHS, 'lifestyle medicine' and doctors' need to heal themselves.

History

In 1981, a groundbreaking official encounter took place at a conference organised by the British Postgraduate Medical Federation (BPMF) at the University of London, initiating a dialogue between conventional medicine and various practitioners of complementary medicine. At the same time significant numbers of medical practitioners were concerned to relate conventional medicine practice to the principles of holism. Meanwhile John Heron, assistant director of the BPMF had been running annual programmes of workshops for doctors focusing on communication, interpersonal skills, and educational, philosophical, and personal development since 1977.

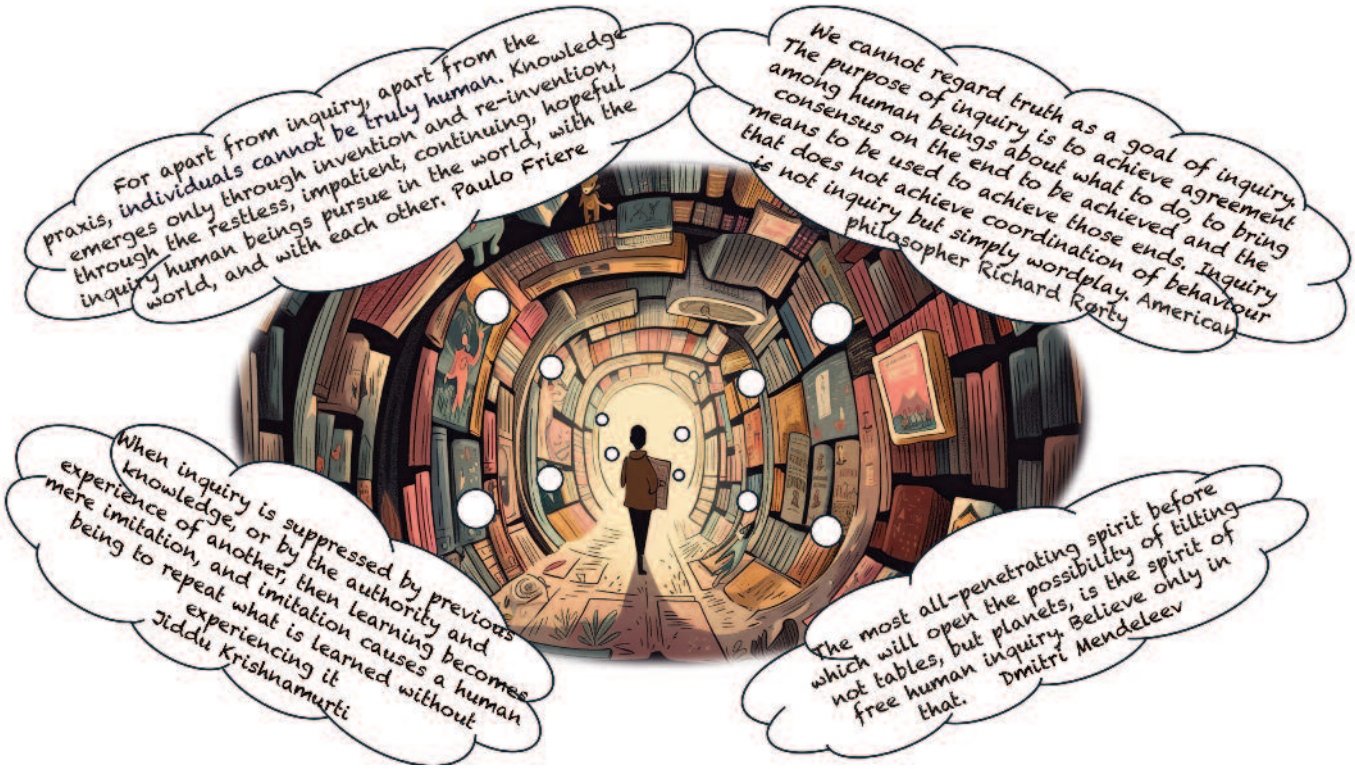
It seemed therefore by early 1982 that the time was ripe for a direct exploration of the practice of holistic medicine. The holistic medicine research project was initiated by John Heron, with Peter Reason joining as initiating facilitator. Through a letter of invitation and a series of pre-meetings to define the project, 16 medical practitioners joined the project, the majority in NHS general practice. To stimulate thinking and practice within the group visiting speakers whose work was clearly innovative in their field were also invited to contribute.

Research design and rationale

In traditional research, the roles of researcher and subject are mutually exclusive: the researcher only

contributes the thinking that goes into the project, and the subjects only contribute the action to be studied. In co-operative inquiry these exclusive roles are replaced by mutual relationships, so that everyone involved works together as both co-researchers and co-subjects. Everyone is engaged in the design and management of the inquiry; everyone gets into the experience and action that is being explored; everyone is involved in making sense and drawing conclusions.

Co-operative inquiry is an iterative process in which co-researchers develop their understanding and practice through cycles of action and reflection. The process emphasises the significance of many ways of knowing, drawing on an 'extended epistemology' – extended, that



is, from the rational-empirical categories of traditional research. This epistemology embraces *experiential knowing* through meeting and encounter; *presentational knowing* through aesthetic, expressive forms; *propositional knowing* through words and concepts; and *practical knowing* in the exercise of diverse skills, physical, interpersonal, attentional, and/or political. These forms of knowing are brought to bear upon each other, through the inquiry cycles, to enhance their mutual congruence, both within each inquirer and the inquiry group as a whole, with an emphasis on the primacy of practical knowing (Heron, 1981, 1996a, 1996b; Heron & Reason, 1997, 2001, 2005, 2008).

The broad design for the programme was outlined in advance by John and Peter and adopted at the 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 clinic. The inquiry ended with a four-day workshop for final discussion and processing of the experience. The two-day meetings were time for concentrated reflection, the six-week intervening period for extended action.

The progress of the group

The inquiry proper started with a two-day residential meeting at a retreat centre. After orientations and further introduction to co-operative inquiry, the participants drew on their experience to evolve a five-part model of holistic medical practice which formed the starting point for all our future work.

At the end of the first day we met for an evening session as an encounter group. As initiating facilitators John and Peter were aware of the personal and inter-personal tensions that could arise in inquiry groups and were committed to providing an arena in which such issues could be aired and explored. There were tears and laughter, intimacy and distance, clarity and bewilderment. This encounter session provided a lively start to this aspect of the inquiry and contributed to the development of a genuinely co-operative group.

A model of holistic medicine

The model we developed in the first meeting provided the template for the inquiry over six cycles. It sketched out five dimensions of holistic practice: each dimension, and the model as a whole, were developed in the light of

practice, although the overall scheme proved robust and helpful throughout.

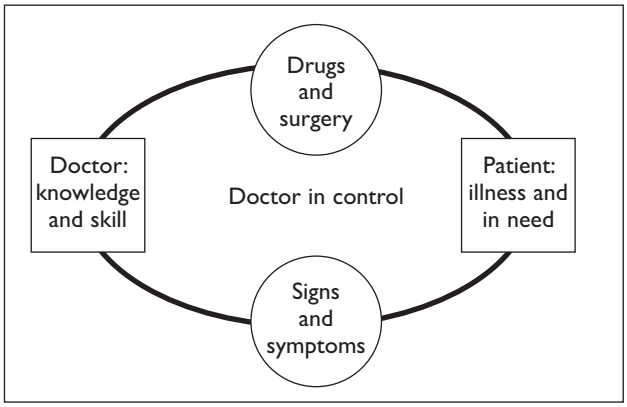
- **Concern for the patient as a being of body, mind and spirit seen in historical, social and political contexts**. The person as a being of body, mind and spirit is a classic view which we invoked but did not at this point elaborate in any detail. Nor did we specify any definitions of mind or spirit except to indicate that by mind we certainly included feelings and will as well as intellect. We also saw the wider context of the patient as of fundamental importance.
- **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 allowed.
- **Power sharing between doctor and patient**. By this we meant 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 makes co-operative problem-solving possible. It was clear in our first discussions that such shared power was 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 – whether physical, emotional or spiritual – as well as conventional medicine.
- **The doctor as self-gardening**. By this we meant the principle of personal growth and self-care physically, emotionally and spiritually. The practitioner of holistic medicine needs to be holistic in their own personal development, behaviour, and lifestyle, 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.

Having developed this model, we sought strategies for applying the principles in the clinic, brainstorming and discussing long lists of possible strategies for each aspect. Finally, each participant developed their own personal plans and contracts for putting the model (or some part of it) into practice over the following six weeks. These application plans were idiosyncratic, at least in the first instance: individual participants could choose the strategies most relevant to themselves and their own practice, so the inquiry would build a range of diverse ideas and practices. At the third cycle of inquiry, where it was agreed that our individual applications were too divergent, we decided to focus on two dimensions: power-sharing and spirit.

Working with the model

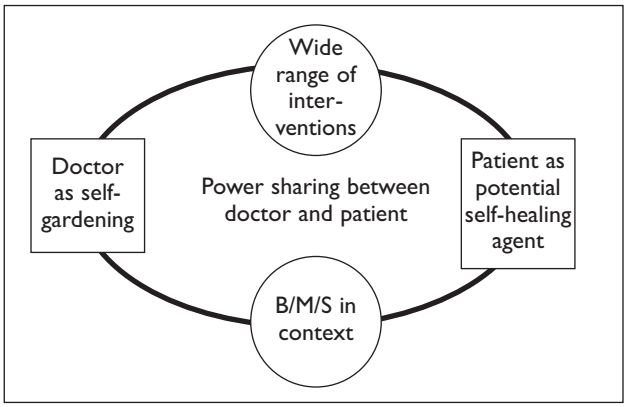
At each meeting participants shared their experience of applying the model in practice, and together we reflected on its robustness and applicability. We developed and expanded each of the five dimensions and at the same time saw the danger of falsifying the whole concept of holism by anatomising the idea and not looking at it whole.

An orthodox relationship between doctor and patient shows the doctor as expert and in control.



A holistic medical approach shows the relationship as one of mutual sharing of information and power: the patient having direct experience of the nature of their condition, the doctor experience of a range of potential interventions.

The contrast between the two ways of portraying the model 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 their learning, understanding and way of relating to patients.

The five dimensions of holistic practice

In addition to the overall model, participants explored ways of applying the different dimensions of the model in detail. These experiments are reviewed at length in the original *Whole Person Medicine Report* (Heron & Reason, 1985). There is only space here for a glimpse of the range of experience.

Wide range of interventions

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, with respect to the context of personal history, social relationships, and economic, political, and cultural factors.

The second dimension along which practitioner interventions can range widely is the continuum from doctor-centred to patient-centred interventions.

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, counselling and psychotherapy, exercise, yoga.

Power-sharing

Issues about power are present in every consultation. There is no neutral position on these issues since we are already operating with certain assumptions and attitudes to our power. However, it is only rarely that these issues are made explicit: doctors often hold the implicit assumption that they are the one who rightfully are (or should be) 'in control'. And all too often the patient's loss of personal power inherent in their illness is compounded by a sense of helplessness when facing the overbearing authority of their doctors.

Participants devised and tried out several ways to equalise power within the doctor–patient relationship. These centred on strategies for levelling up and de-mystifying, and for inviting patients' feedback. Specific experiments in power-sharing included: change of seats roleplay, inviting the patient to make their own diagnosis and recommendations; changing the environment to make it less formal and doctor-centred; sharing of personal information; skill sharing; dictating referral letters with the patient present. Explorations of this dimension of the model exposed significant issues for participants: many patients were confused when the expectations were not met; doctors' colleagues thought they had gone soft and woolly; some senior consultants were outraged at the sharing of professional information.

There were intense discussions of the meaning of power and the paradoxes involving the power-sharing. In the end, the group was drawn to the idea of patient autonomy, and the maxim that 'patients should always go out more autonomous than they came in'.

Spirit

Once we had decided that consideration of a whole person would entail a consideration of a spiritual aspect, we were left with the question, in this irreligious, godless and scientific age what do we mean by 'spirit'?

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 to prepare for a consultation; how to meet and greet the patient; how a consultation ends; how to clear our mind and centre ourselves in preparation for a consultation, maybe having been deeply involved or emotionally affected by the previous one?

The methods used by the members of the group were naturally varied but seemed to have some likeness to prayer or meditation: ways of clearing the mind of the past and the ego while still being entirely present and centred, and open to what the patient has to bring.

We saw that many everyday greetings and farewells implicitly call on a higher power for help or supervision or care, and so are forms of invocation – after all 'goodbye' is a contraction of 'God be with you'. By studying such an everyday occurrence as a doctor/patient consultation we saw that both prayer and invocation often occurred, which led us to reflect that perhaps spirit is always present in medicine, though often unobserved and uncultivated. The participants' work was to make this presence more evident and present, for example by blessing the surgery before consultations, and by choosing invocatory words more intentionally – from the simple 'take care' to more explicit phrases like 'blessings' and 'may you be whole in spirit'

Patient as self-healing

The self-healing powers of the body are self-evident. However, 'the patient's potential self-healing agency' implies much more than this. This dimension of the

model of holistic practise suggests that human beings have far greater powers of intentional self-healing than is usually recognised by either doctors or patients. We also say a major part of holistic practice is to enable this potential human capacity to be actualised. Self-healing is often a matter of getting obstacles out of the way: poor nutrition; 'stress'; an unaddressed life predicament; but also bigger picture stuff like beliefs, ignorance, poverty, loneliness However, we did not as an inquiry group devote much specific attention to this aspect of holistic practise, touching relatively lightly on the doctor as educator and as client-centred facilitator, and the place of patient self-help groups.

Doctors as self-gardening

A view which emerged in our first meetings 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 unacknowledged 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.'

> Patients should always go out more autonomous than they came in

This view that professionalism is in part both a defence and a projection is not peculiar to medicine, but symptomatic of our culture as a whole, with its lack of any model of emotional and spiritual education. In addition, doctors expose themselves on a daily basis to human need and suffering, which in themselves are psychologically burdensome. Precisely because the medical profession has such high status as the senior helpers in our culture, its members are caught in an invidious catch-22 predicament: they are not supposed to have any problems, and therefore they cannot admit to themselves or others the very real issues 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'.

From the beginning of the inquiry, some, but not all, participants considered that this dimension was really the hub of the model, on which all other four parts depended. What is clearly important is the experience reported by several members, that it was attending to their own self-gardening which gave them confidence and competence to apply other parts of the model, and to stand against orthodox expectations of partners and patients in practising in new ways.

Self-gardening processes used on the project included: physical self-care including exercise; mental and emotional self-care including through humanistic therapies, aesthetic practice such as poetry reading; spiritual self-care through prayer and meditation; social/political care like spending more time with family.

Legacy of the holistic medical inquiry

This inquiry was in many ways a pioneering project. It offered careful reflection on innovative forms of practice (many of which have become far more prevalent in the mainstream 40 years later) at a time when the debates about holistic and complementary practice were generally ill-informed. It was also the first major application of the co-operative inquiry model both in medicine and more generally. While the primary impact was on the practice of those practitioners who too part, it can be said to have had a wider and continuing influence. The project contributed to the founding of the British Holistic Medical Association; to the debate within the BMA and more widely on the role of complementary medicine; to the further inquiries that were part of the innovative urban primary care work of the Marylebone Centre Trust (Reason, 1991, 1999; Reason *et al*, 1992); to innovative practice within general practice more generally. It has been personally fascinating to re-visit the documentation of this project and to present it for a contemporary readership.

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