ARTS, HEALTH & WELL-BEING

FROM THE WINDSOR I CONFERENCE TO A NUFFIELD FORUM FOR THE MEDICAL HUMANITIES

A REPORT FOR THE PERIOD APRIL 1998 - JUNE 2001
INCLUDING PROCEEDINGS OF THE WINDSOR II CONFERENCE
IN SEPTEMBER 1999

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Opposite: 'Falling Leaves' by Sian Tucker, at the Chelsea and Westminster Hospital

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FOREWORD

In 1997 the Nuffield Trust embarked on a programme of work to raise the importance of the humanities in medicine and emphasise the place of the arts in health and wellbeing. The first landmark was the Windsor Declaration of 1998 for the Arts, Health and Wellbeing. Since then the Trust has supported a number of other initiatives as part of its programme. There was a second conference at Windsor, *Making It Happen;* it provided support for the Council for Arts and Humanities in Health and Medicine at the University of Durham; it made a contribution to the King's Fund initiative on the forum for the Arts and Health; and it encouraged the creation of the Association for the Medical Humanities. The Trust also convened a Forum under the chairmanship of Sir William Reid to establish and maintain an overview of developments in the arts, in community development and health, in the arts as therapies, and the place of humanities in medical education.

This text is a further contribution, incorporating a review of recent literature relevant to the Arts, Health and Wellbeing. It consists of the proceedings of the second Windsor meeting and material to help strengthen ongoing work in the UK for education and research programmes for the medical humanities.

The challenge remains, however, to gather evidence regarding the effectiveness of the humanities' involvement in medical education, research and practice as well as evaluation of arts-based interventions in the community. This is a priority and those who are committed to the human side of medicine need the resources to establish evidence and inform discussion in the United Kingdom and beyond concerning both the human side of medicine and the value of cultural interventions in the health of communities as a means of reducing health-seeking behaviours and to improving the general indices of health status.

John Wyn Owen CB
Secretary
Nuffield Trust
December 2002

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In preparing this report, we are indebted to The Nuffield Trust for sponsoring the Windsor I and Windsor II conferences on 12-13 March 1998 and 6-7 September 1999, and since then for helping to explore possibilities for a National Institute of Medical Humanities (NIoMH) and / or a Medical Humanities Network, and for endorsing and supporting the work of a Central Co-ordinating Council to help strengthen roles of the Arts and Humanities in Health and Medicine and of the new Centre for the Arts and Humanities in Health and Medicine, (CAHHM), of the University of Durham. This work could also not have been undertaken without the very willing support and active involvement of all the participants at the Windsor I and Windsor II conferences and we are extremely grateful to them and to our other colleagues and friends who have all helped to shape the ideas, plans and programmes of work that have emerged. We are also extremely grateful to Mrs Pamela Thorne, research psychologist, for transcribing the audiotapes of keynote presentations and the discussions of proceedings of the Windsor II conference and for her help with the technical editing, and to Dr. Ernst Philipp, former General Practitioner, WHO futurist to the WHO Collaborating Centre for Environmental Health Promotion and Ecology, University of Bristol, 1989-96, and from 1997-2000, consultant adviser to the Centre for Health in Employment and the Environment, (CHEE), Bristol Royal Infirmary, for his help in developing the concepts, strategic frameworks and programmes of work that enabled us, with WHO colleagues in 2000, to establish the AESOHP programme [A European Sense of Healthy Place & Purpose] (Philipp, R. 2001). It is based on work presented here.

We believe this report is an accurate account of the background, deliberations of the Windsor II conference and progress since the Windsor I and II conferences. We do however accept responsibility for any errors or omissions that may have occurred in compiling it. If they are brought to our attention we will address them in on-going and future work. Inquiries about this present report should be sent to the author (RP).

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INTRODUCTION

The purpose of this book is to review the recent literature relating to the arts, health and well being, describe the background leading up to the second conference on the arts and humanities in health and medicine organised by The Nuffield Trust, report on the proceedings of this second conference, and explore what has evolved since it took place, up to June 2001, to help strengthen on-going work in the UK for educational developments and research programmes for the medical humanities.

The literature base of this subject is broad and vast. For the purposes of this book, papers relevant to the principal themes of subjects discussed at the Windsor 1 and Windsor II conferences have been selected, primarily from the UK medical literature, to illustrate what has been published previously for these themes. The following journals for the years 1996-June 2001, have been manually retrieved and examined fully in a library-based study: the British Medical Journal; British Journal of General Practice; the Journal of Medical Ethics; the Journal of the Royal College of General Practitioners; the Journal of the Royal Society of Medicine; Occupational Medicine; Occupational and Environmental Medicine; Medical Humanities; Public Health; Public Health Medicine; and The Lancet.

To avoid unnecessary duplication, much of the literature referenced in the report of the first Windsor conference has not been cited again in this book. The first report (Philipp et al, 1999a), summarised the background, papers, proceedings and outcomes of this conference. It was convened to learn about and assess current activities, perceptions, beliefs and models of effective practice in medical undergraduate education in the UK and the USA and about the place of the arts in therapy both in the community and in health care environments. The conference brought together people from different backgrounds and practitioners from many of the health professions, the arts, philosophy and theology to explore the three themes of the conference. Foundations were laid there to promote the arts into a pivotal role across the spectrum of Britain's health care and public health systems, to complement the scientific and technological models of diagnosis and treatment that have driven medical policies and practice for much of the 19th and 20th centuries. Following this first conference The Nuffield Trust set up a national steering group and helped to establish the Centre for the Arts and Humanities in Health and Medicine (CAHHM), in the University of Durham, as a central collaboration centre (The Nuffield Trust, 2000).

- The Objectives of the Windsor I conference are listed on page [insert page number] of this present report.
- The Declaration of Windsor for the Roles of Humanities in Medicine (i.e. pages 111-114 of the Windsor I conference report) can be found in Appendix 1.
- The 12-Point Action Plan that was drawn up at the first conference (i.e. pages 115-117 of the Windsor I conference report) can be found in Appendix II.

SECTION I. **LITERATURE REVIEW**

OVERVIEW

The UK Government green paper that preceded its recent report, *'Our Healthier Nation'* (Department of Health, 1999), explicitly defined health as: *'a resource for enjoying life to the full'* (Stuart-Brown, 1999). Moreover, humanity's response to major world problems *'is one crucial test of its wisdom'* (McMichael et al, 1999). Accordingly, as the present massive transition in world population and health continues (Raleigh, 1999), should greater attention be given to factors that help foster *'ease'* as well as the traditional principal medical focus on *'disease'* ? Addressing this question, the former Chief Medical Officer has suggested that the Department of Health should become a *'Department of Health and Happiness'* (Ward, 1999). In these contexts, it is increasingly being asked if attention to the arts and humanities in medicine could provide fresh insights and suggest additional 'preventive checks' to help mankind? As Napoleon once mused: *"Nothing is more difficult and therefore more precious than to he able to decide"* (Editorial, 1999d). It is hoped this report will provide some answers.

The long standing tradition of links between the arts and medicine was explored at the Nuffield Trust Windsor I conference on the humanities in medicine (q.v. Publication 1 below). It was noted there that in antiquity, the Greek god, Apollo, presided over both the arts and the humanities (q.v. report of the Windsor I conference, page 101). Early in the 20th century, Osier described medicine as *"a science of uncertainty and an art of probability"* (Pencheon, 1999). However, it has also been reported that *'medicine is an art based on science and is slowly moving away from art and towards science'* (Cooke, 1987), and that *'it is one of the proudest claims of certain academic doctors that medicine is no longer an art but a rational science'* (Horrobin, 1987). Some people would therefore ascribe to a view that *'if you can't measure it, it's not worth doing'*, and that *'what gets measured gets done'*. Nevertheless the health care needs of populations, medical education and expectations of doctors by the General Medical Council are changing. It has, for example, been reported that, *'if problem based learning is truly a vehicle for integrating knowledge across subject boundaries in order to understand a clinical scenario, there should be a wider view of the art and science of medicine than the one that currently prevails in the evidence base'* (Maudsley, 1999).

'Medicine' is defined in the Oxford Dictionary as: the *'art of restoring and preserving health'*. Although defined as an art, its practice requires interdependent application of both: *'the art of the science and the science of the art'*. The medical humanities focus on this interdependence. It is not new. For example, in 1869, it was reported that:

'Every science touches art at some points - every art has its scientific side; the worst man of science is he who is never an artist, and the worst artist is he who is never a man of science. In early times, medicine was an art, which took its place at the side of poetry and painting; today they try to make

a science of it, placing it beside mathematics, astronomy and physics:' Armand Trousseau, Lectures on Clinical Medicine (vol.2), The New Sydenham Society (Wyman, 2000).

This interdependence of art and science is just as relevant today. In it, 'art' is the "skill as a result of knowledge and practice" and its application, and *'science'* is "a body of study ... concerned either with a connected body of demonstrated truths or with observed facts systematically classified and... brought under general laws, and which includes trustworthy methods for the discovery of new truths within its domain" (Onions, 1973).

Voltaire, however, more wryly, put it differently when he commented that: *"the art of medicine consists in amusing the patient while Nature cures the disease"* (Knight, 1999).

Nevertheless, as Johann Wolfgang von Goethe, describing his formative years at the law faculty at the University of Strasbourg, 1770-1, wrote:

"Medicine engages the whole person because it is engaged with the whole person" (Bamforth, 2000).

The physician's role in this interdependence was described in: *'Hippocrates Revisited': 'The art of medicine consists of the skilful application of scientific knowledge to a particular person for the maintenance of health or the amelioration of disease. For the individual physician, the meeting place of the science of medicine and the art of medicine is the patient ... But scientific knowledge is more readily taught, whereas the application of knowledge at the bedside* is *largely the function of the sagacity inherent in or personally developed by the individual physician'* (Weed and Weed, 1999).

Self-esteem of individuals can too *'be influenced by the way doctors treat their patients. If they respect and value them as equals, patients find it easier to value themselves and their self esteem rises'* (Stuart-Brown, 1999).

These interactions are widely known. Yet, it is believed that *'wider recognition of the worth of the arts in health care is required'* (Martin, 1999). This present report has, therefore, been prepared as one of three interlocking and, where appropriate, cross-referenced publications to date of The Nuffield Trust for the arts and humanities in medicine. These reports are intended as *'information tools'* for interested persons and as a baseline framework for work of the new Nuffield Forum for the Medical Humanities (NFMH). The need for a NFMH was identified at the first Windsor conference for the arts and humanities in medicine (q.v. publication 1, below, page 51).

The three interlocking Nuffield Trust publications to date for the arts and humanities in medicine are:

1. **Humanities in Medicine: Beyond the Millennium. (1999). Eds. Philipp, R., Baum, M., Mawson, A., and Caiman, K. Nuffield Trust Series No. 10; pp.164.**

This fully referenced report addresses the background, proceedings, conclusions and recommendations of the first conference for the arts and humanities in medicine convened by The Nuffield Trust at Cumberland Lodge, Windsor Great Park, England, on 12-13 March 1998. Three Working Groups were convened for this conference: The Humanities in Medical Undergraduate Education; Humanities in Community Development and Health, and; The Arts in Therapy and Health Care Settings. As the report noted about this Nuffield Trust

initiative (page 7), *'it is the first of a series of intended outcomes'*. In the report, examples of projects for the arts and humanities for health, medical practice and medical education were given, the concept of *'healthy living* centres' was examined in detail, and a selected bibliography of additional background references was listed (q.v. pages 151-156), in addition to references cited in the text (q.v. pages 120-127). Three objectives were identified by its Steering Group before the conference (q.v. page 11 of the Windsor I conference). They were:

- to take stock and assess current activities, perceptions, beliefs and models of effective practice in medical undergraduate education, community development and arts as therapy;
- to consider, develop and promote practical applications of the humanities in medical undergraduate education, health and community development, and in caring for people and promoting better health;
- to develop an action plan and indicators of progress to be disseminated at the Windsor II conference in 1999.

The Declaration of Windsor and the 12-Point Action Plan that were drawn up and endorsed by conference participants, are appended to this present report (q.v. Appendices 1 and II).

2. Arts, Health and Well-being: from the Windsor I conference to a Nuffield Forum for the Humanities in Medicine. (2001). Eds. Philipp, R., Bauin, M., Macnaughton, J, and Caiman, K. Nuffield Trust Report

This present report.

3. A User's Guide to the Practice and Benefits of Arts in Health Care and Healthy Living. (2001). Ed. Philipp, R. Forthcoming from The Nuffield Trust.

This handbook is based on recommendations of the Windsor I conference for practical guidance to be prepared (q.v. publication 1, above). It comprises three fully referenced sections with contact addresses where appropriate: (i) developing a research framework; (ii) guidance for health care purchasers and health promotion specialists, and; (iii) a review of the interdependent psychodynamics of health, creativity and aesthetics. The book has been written to help give answers to six questions which the reader is invited to keep in mind when using it:

- Why do the arts and humanities matter to anyone?
- Do the arts affect me directly?
- Why should I identify and explore my own creativity?
- Where can I see practical examples of work going on for the arts and health and get help in choosing and preparing artists to work in health care settings?
- Is the aesthetic quality of our environment important to my health and if so how?
- Could applications of the arts to mental health issues help to reduce the UK statistics for suicide, mental illness, sickness absence, job instability and unemployment?

Cross references are given in these three reports to relevant sections in the other reports. Each report can however be read independently.

The Windsor I conference explored the concepts and background to advocacy for the arts and humanities in medicine and began to develop a framework for helping to strengthen the evidence base for benefits to the public health. The Windsor II conference examined progress in these areas and identified the next steps to be taken. These initiatives taken for roles of the arts and humanities in medicine were endorsed by:

- the President of the General Medical Council;
- the Chairman of Council, British Medical Association;
- the Chairman of the Committee of Vice Chancellors and Principals of UK Universities;
- Dame Margaret Turner-Warwick, former President of the Royal College of Physicians of London;
- Sir William Reid, former Health Service Commissioner for England;
- Baroness Hayman and Baroness Jay, former Under-Secretaries of State for Health;
- the Right Honourable Mr. Chris Smith, MP, then Secretary of State for Culture, Media and Sport;
- the Right Honourable Mr. Alan Howarth, MP, then Government Minister for the Arts;
- Mr. Andrew Motion, the present Poet Laureate.

In 1999, in extending its work with the arts and humanities in medicine, The Nuffield Trust also established a new fellowship for young researchers *"to enter a different realm for a month - the theatre or civil aviation, for example - and to draft a lecture on what different organisations can learn from each other ... The placement can he anywhere in the world"* (Minerva, 1999).

Ten linked points now provide a background framework and rationale to an interdependence for the above four interlocking reports, published to date by The Nuffield Trust for the arts and humanities in medicine. It is hoped they will give readers a better appreciation of what underlies this work:

1. As Epictetus noted in the 4th century BC, *"men are disturbed not by things but by the views they take of them"*. The Ancient Greeks also spoke of *'ataraxia'* - freedom from disturbance of mind or passion (Onions, 1973). As noted in the Windsor I report, page 94: *"the way we look outwards at our world influences our perception of it, our values of what is truly important in it, and what we wish to do with our lives in the world we live in"*.
2. External events and pressures impinge on each individual and in an insecure, unstable world people can feel helpless in protecting and helping themselves.
3. Addressing the emotional resilience of individuals can help mankind to reduce the sense of helplessness many people have.
4. Experience, for example in Eastern Europe, has shown that in times of repression in society people exercise their imagination and creativity by increasingly resorting to

artistic expression. Art provides opportunities for expression of feeling and interpretation of experience.

5 . Exploring and nurturing an individual's inner human resources for imagination and creativity can enrich the enjoyment, wonder, pleasure, self-esteem and emotional well-being that individuals can experience from life and thereby help to improve one's mental health.

6. An arts-science gradient is recognised which spans the artistic, intuitive, inspirational and subjective personal viewpoints, to the measurable, deductive, logical and scientific perspective (q.v. Windsor I report, page 88).

7. As health professionals, we should explore our obligations, duty of care and collective conscience to identify strategies, plans and practical programmes that can be audited for their worth and that will help individuals to achieve emotional well-being.

8. Strengthening roles of the arts and humanities in medicine is one way of helping individuals and communities to better achieve emotional well-being. At the same time it can help to foster conceptual frameworks of the arts and humanities that should help humanitarian efforts to diminish the likelihood of inter-personal conflicts arising from problems such as the sometimes opposing concepts of *individual freedom* and *collective responsibility.*

9. As discussed in The Nuffield Trust report of the Windsor I conference (pages 95-96): *"If we do not broaden our approach to research and education needs for sustainable development by linking the findings of scientific and artistic studies, then as T.S. Eliot noted in his poem, 'Chorus from the Rock':*

   Where is the life we have lost in living?
   Where is the wisdom we have lost in knowledge?
   Where is the knowledge we have lost in information?"

10. Mental health is one of the four priority areas in the UK government public health white paper, *Saving Lives: Our Healthier Nation* (Department of Health, 1999). Ways of using the arts and humanities to help achieve mental health therefore deserve our attention.

THE GENERAL FRAMEWORK

In the General Background to The Nuffield Trust Report of the Windsor I Conference (pages 12-17), attention was drawn to the Department of Health's long term strategy for public health. It emphasises the need to promote healthier living in the community, and the need for the medical profession to become more aware of the possibilities and of the importance of the humanities in medicine in helping to achieve the World Health Organisation (WHO) goal of Health for All. Although it might be reasoned that *"health is a state of being less recognised and considered when one is well rather than ill",* it should be recalled from the report of the Windsor I conference (page 13), that:

"doctors who are particularly appreciated by their patients include those who discover and deal with patients' concerns and expectations about their problems, those whose manner communicates warmth, interest and concern, and those who volunteer a lot of information and explain matters in terms that are understood" (Editorial, 1983).

Equally, it should be noted that although *"Trousseau said: 'II n'y a pas des maladies, seulement des malades', most of us, medical and lay, have little difficulty in understanding what is meant by the term* 'disease' " (Cooke, 1987). It is defined in the Oxford Dictionary as an *"unhealthy condition of the body or mind'.* Its relevance to health of the body and mind can also be thought of as a: *'lack of ease'.*

The Foreword to this report and these points are the basis for progressing this work of The Nuffield Trust with the medical humanities. As stated by the WHO Regional Director for Europe in the 1998 World Health Declaration: 'the *enjoyment of health is one of the fundamental rights of every human being. Health is a precondition for well-being and the quality of life. It is a benchmark for measuring progress towards reduction of poverty, the promotion of social cohesion and the elimination of discrimination. Good health is fundamental to economic growth. Intersectoral investment for health not only unlocks new resources for health but also has wider benefits, contributing in the long term to overall economic and social development. Investment in outcome-oriented health care improves health and identifies resources that can be released to meet the growing demands on the health sector'* (Asvall, 2000).

Three basic values form the WHO ethical foundation for the European Region programme, HEALTH 21 - Health for All in the 21st Century:

- health as a fundamental human right;
- equity in health and solidarity in action between and within all countries and their inhabitants; and
- participation and accountability of individuals, groups, institutions and communities for continued health development (Asvall, 2000).

Moreover, "as *the world becomes increasingly interconnected economically, politically, physically, culturally, and electronically, the discourse about population-environment-health relationships and about sustainability is shifting from local to global contexts"* (McMichael and Powles, 1999). In, for example, considering the British Commonwealth, it has also been recognised that *"in the past the security of states was high on the international agenda, but we are moving towards the*

security of peoples and that includes maintaining their identities, origins, beliefs, customs and practices" (Williams, 1995).

In recognition of this 'global' process, in May 1998, the WHO adopted a resolution in support of the new global Health for All policy (WHA, 1998). It was considered the first step in the renewal of the Health for All movement and represents a further call for social justice (van Herten and van de Water, 1999). Ten new health targets were adopted. In considering *'Determinants of health'*, Global Health Target 6, *'Measures to promote help'*, states that:

"By 2020, all countries will have introduced, and be actively managing and monitoring, strategies that strengthen health enhancing lifestyles and weaken health damaging ones through a combination of regulatory, economic, educational, organisational, and community based programmes".

This target is especially pertinent to aims and objectives for The Nuffield Trust medical humanities project and the need for new institutions to work for the 'new' public health. *'Globalisation'* has itself, been defined as *'the accelerated flow of labour, capital, goods, and services between countries because of improvements in transport and communication and deregulation policies adopted in many countries'* (Leung, 2000). This definition implies but does not acknowledge the resultant opportunities for sharing information and for improved understanding, collaborative education and joint development. These social opportunities are important as the principal aim of the World Bank is *'to reduce poverty and improve living standards by promoting sustainable growth and investment in people'* (Abbasi, 1999).

The problems of global health and local responses that are needed were considered at a United Kingdom (UK) national conference on 31 January 2000, hosted jointly by The Nuffield Trust and the Royal College of Physicians of London. Participants examined the complex relationship between globalisation and health. Globalisation was seen as a political, technological and cultural as well as an economic phenomenon, in which geographic and national barriers lose their importance as trade and investment, communication and cultures cross these boundaries. It was noted there that: *'the current regulatory system provided by the World Health Organisation, the World Trade Organisation and other international institutions developed in response to a world of nation states, and cannot match the power of globalisation. This does not mean that there is nothing to be done; local action, community to community support based on a raised awareness of the moral issues raised by globalisation and global health are important as well as national and international action ... The Nuffield Trust hopes to establish a secretariat for the UK Partnership for Global Health to proceed ... It is also intended to work with the International Commission on Macro Economics and Health recently established by Dr. Gro Harlem Brundtland, the Director of the World Health Organisation'* (Parsons and Lister, 2000). As Professor Morton Warner, University of Glamorgan, Wales, one of the speakers, commented at the conference: *"Global glue will help prevent global gloom".* Investment in people (the glue) helps personal development and encourages social cohesion.

Responses to the new challenges, for example for humanitarian protection, are needed (Bruderlein and Leaning, 1999). The idea of peace-building from below has also emerged and in which 'sustainable conflict prevention' is thought to be best achieved by reinforcing local and indigenous resources and capacities (Woodhouse, 1999).

There is though a cautionary note. As a WHO slogan notes: "Think globally, act locally"; Albert Einstein also commented: *"Any intelligent fool can make things bigger, more complex, and more violent. It takes a touch of genius - and a lot of courage - to move in the opposite direction"* (Editorial, 1999e). As Richard Smith, editor of the British Medical Journal has however noted, *"parochialism is rarely a virtue"* (Smith, 1999). Nevertheless, with the arts and humanities in mind, and in the words of the poet, George Eliot (1819-1880):

"What do we live for, if it is not to make life less difficult for each other?" (Exley, 1999).

In these uncertain times, in our attempts to make life less difficult it has been reported that *'complex emergencies demand a thorough* analysis *and a context specific response; humanitarian efforts alone are often insufficient and may be dangerously misrepresented as an effective response'* (Salama et al, 1999). Nevertheless, it is believed that as the deliberations on the questions of medicine, moral choice, and international law continue: *"in the sphere of international humanitarian law and human rights there is not only room for the moral voice of physicians - but an outright imperative that it should be heard"* (Leaning, 1999). Within the UK, it has also been noted that more training is needed for the problems of human rights abuse and the Chairman of the British Medical Association Students Committee has said that *'there should be more teaching about ethics and human rights'* (Jones, 1999). The Director of the charity, 'Medical Care for Victims of Torture' has also noted from her work that individuals need help with their grief and memory before *'creative progress'* is possible (Bamber, 2000).

Links in all this for the medical humanities can be fostered. For example, within the UK the WHO global health strategy is illustrated by the interest of public health physicians *"to provide an annual forum to discuss developments in the area of public mental health [including emotional well-being]"* (Connelly, 1998), and by plans, implemented in the year 2000, to revitalise the National Health Service (NHS). The work of six NHS task forces ('modernisation action teams') fed into a steering group chaired by the health secretary, Alan Milburn. A Cabinet subcommittee on modernisation of the NHS was chaired by the Prime Minister, Tony Blair. Each action team addressed one of five areas for improvement:

- Partnership with social care systems;
- Performance and productivity;
- Professions and the wider NHS workforce;
- Patient care - two teams will look at separate aspects of care - empowerment and speed of access to services;
- Prevention and inequalities (Jones, 2000).

For this modernisation process, it has been reported that: *'the prime minister, determined to convert the NHS from a liability to an election winner, is not only overseeing the reform process personally but intends to bang heads together in his dialogue with the professions'* (Salvage and Smith, 2000). This strategy builds on key themes in the Ottawa Charter which underpin much *'new public health thinking':*

- the need to build policies which support health in a range of policy sectors;
- creating supportive environments (physical, social and psychological);
- strengthening community action;
- developing personal skills;
- reorienting health services towards the public health model espoused in the Alma Ata declaration of 1997 (WHO, 1986).

These points are particularly relevant for The Nuffield Trust's approach to the medical humanities. For example, The Nuffield Trust approach to all its work *'is centred on analysis with a view to action, and thinking based on evidence'* (The Nuffield Trust, 2000).

In the Windsor I conference report (page 9) it was noted that:

"The underlying aim of the strategy is to elevate the arts (and other humanities) into a pivotal role across the spectrum of Britain's healthcare and public health systems, to complement the scientific and technological models of diagnosis and treatment that have driven medical policies and practice for much of the 19th Century. Among the anticipated benefits are:

- *More compassionate, intuitive doctors and other health practitioners;*
- *Patient empowerment through creative expression;*
- *Reduced dependence on psychotropic medication such as tranquillisers and anti-depressants;*
- *Growing confidence and self-reliance of individuals and communities;*
- *Providing an approach and support to help combat social exclusion."*

Such aims reflect multi-disciplinary efforts for health promotion. One widely accepted definition of health promotion is:

"Health promotion is the science and art of helping people change their lifestyle to move towards a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health. Lifestyle changes can be facilitated through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact on producing lasting changes" (Lindsay, 2000). It is also considered to be: *'the study and application of any combination of environmental, educational, organisational, social, economic or political interventions that evoke behavioural changes conducive to health'* (Guidotti, 1995). In this context, what constitutes *'good health'* was discussed in the report of the Windsor I conference (q.v. pages 12-13, and 95).

The report of the Windsor I conference also explored the concept of a *'Healthy* Living *Centre'* and examples of their work (q.v. pages 61-67). Since then, the Department of Health has stressed their potential to:

- mobilise community activity in improving health and reducing inequalities;
- bring together health promotion in its widest sense across a broad range of interests which do not necessarily have a tradition of working together; and

- improve access to mainstream services for those who for whatever reason do not currently use them, or to provide a better alternative to mainstream primary care (Department of Health, 1999b).

The UK government has set aside £300 million from the National Lottery to establish a network of healthy living centres (Salisbury, 1999), and the Health Education Authority has produced *'An Evaluation Resource for Healthy Living Centres'* to use with the projects (Meyrick and Sinkler, 1999). They are taking various forms and can exist as partnerships and networks rather than as new buildings. For example, the Bromley by Bow centre, London, links health, education, arts and the environment; in Bristol, Knowle West Health Park was planned to include a new health centre, family centre, dance studio, community cafe, jogging track and community gardens. Assessing the impact of such models of care on health is however noted to be difficult because of the long time lag between intervention and outcome, and as the changes in local culture sought by healthy living centres may take generations to achieve. It has also been anticipated that it will be difficult to determine whether any improvements are related to the healthy living philosophy, or to better buildings, greater resources, and influx of new staff (Salisbury, 1999).

Technological developments are therefore, it seems, insufficient to achieve health. The NHS is too, as an Austrian view purports: *'a wonderful laboratory in health care reform and experimentation in healthcare delivery'* (Koeck, 1998). It has however been suggested that technology has come *'to depend increasingly on human thought - or what Teilhard de Chardin called the evolution of the noosphere. This he saw as the thin sphere of creative and self-conscious human thought within the biosphere. Teilhard de Chardin identified the arrival of the noosphere as a transition in the evolutionary process just as far-reaching as the evolution of life out of a non-living planet. The philosopher Karl Popper, using a different model, referred to the total product of noogenesis as World 3, a non-physical but very real world of objective knowledge created by human thought"* (Geering, 1999).

There is too, a note of caution for the uniformity that can come through technological improvement. For example, it has been reported that standardisation can lead to *'the loss of variety and creative innovation; some of our progress in improving the public health has been based on developments by enthusiasts who went far beyond the strict guidelines of their jobs. If every departure from the stated list of activities and standards has to be evaluated against evidence, prevailing opinions and endless committees, there is a risk that few will introduce new ideas, and fewer still will have time to test them"* (Editorial, Health & Hygiene, 1998).

The role of creative thought in respect of health promotion was explored in the report of the Windsor I conference (pages 82-83); - human aesthetic values for environmental health in our biosphere were explored on pages 93-96.

At the Windsor I conference, Sir David Weatherall explored the bio-reductionist approach to medicine and the art of the practice of the science of medicine. Using the words of the cardiologist, Thomas Lewis, he noted that: *"the clinician at the bedside needs self-confidence which breeds faith and hope; a scientist requires diffidence to breed inquiry"* (q.v. Report of the Windsor I conference, pages 20-23). Yet, it has been reasoned that the human aspect of health care should remain an important feature in patient interaction (Koh et al, 2000). Koh

et al reasoned that *'several forces act to diminish empathy and compassion in the practice of health care. They identified ... the fascination with technology, gadgets, and instruments; the inherent depersonalising influences of our highly institutionalised social structures; the replacement of care by individuals with care by the 'team'; a scientific medical education that focuses on man-the-object-of-study; and, finally, a medical education, fraught with rigidities, that does little to help the student develop his humanity'.* They also commented that: *'Added to this negative setting is the lexicon conversion by health planners or health economists, or some group that most likely has never seen a patient in agony, of the preventive or therapeutic relationship into an interaction between a 'provider' and a 'consumer', the former concerned about cost effectiveness and the latter perplexed by the technology of the vast institution that provides tertiary care'.* They added a quote by William Bean: *"Indeed, merely thinking of a physician ministering to the sick as someone providing consumables to a consumer illustrates the depersonalisation which endangers our relations ... cost effectiveness is not the same as care effectiveness".*

In May 2000, Richard Smith, editor of the British Medical Journal, reported that as with evidence based medicine which *"came from applying epidemiological ideas to clinical practice",* so, *"innovation often comes from combining ideas from different disciplines"* (Editorial, 2000b). This present report is therefore intended to:

- outline ideas;
- support innovation; and
- suggest ways of strengthening the arts and humanities in medicine.

It presents progress with the objectives since the Windsor I conference in March 1998, up to the establishment of the Nuffield Forum for the Medical Humanities (NCMH) in January 2000 and since then, to February 2001, in developing its work plans.

The underlying belief in this work is that without the arts and humanities, the health and well-being of mankind is impoverished, and that they enrich the following personal and group values:

- moral
- emotional
- psychological
- spiritual
- aesthetic
- educational
- social
- cultural
- societal.

As such, health professionals have a professional responsibility to explore and, where there is evidence, utilise the arts and humanities for the benefit of human health.

WHAT ARE THE MEDICAL HUMANITIES?

It has been reported that *'surprisingly few people seem to worry about the technical competence of doctors. What they worry about is their doctor's ability to understand the patient as a person and provide the right guidance'* (Boland, 1995). At least one doctor has also reported that *'humanity is a longed for and often elusive quality in medicine'* (Gibson, 1997).

A humane doctor, it has been noted, is *'one who is wise, compassionate, and liberally educated, and who recognises that there is more to life than medicine - both for doctors and their patients'* (Charlton, 1993). It has however been suggested that *'humanity cannot be put on the medical curriculum'*, and that instead *'humanity and its comprising qualities are promoted by a broad education in the widest sense of the word'* (Gibson, 1997). Indeed, Sir David Weatherall has noted that *'no medical school can teach a young person how to be understanding and caring. This can come only from experience of life'* (Weatherall, 1994). Nevertheless, in exploring his views further at the Windsor I conference, he reported that the humanities and arts are *'vitally important in the medical curriculum and that they should be made available, ideally as a break in the middle, or a voluntary special study module'* (q.v. Windsor I report, pages 20-23).

The Windsor I report also explored the concepts of ethics and moral values for the effective and equitable delivery of health care services (q.v. page 86). These concepts are well-described. For example, in 1987, Sir Douglas Black, Emeritus Professor of Medicine, University of Manchester, and Past President of the Royal College of Physicians of London and the British Medical Association, reported that:

'The conduct of doctors in the exercise of their profession has been a matter of overt concern to the lawgiver since the days of Hammurabi in ancient Babylon, and to our own profession since the time of Hippocrates in classical Greece. The term itself was made familiar in the English language by Thomas Percival, a Manchester physician, who changed the title of his book, published in 1803, from 'Medical Jurisprudence' to 'Medical Ethics'; and as was then the fashion, he defined the term in a subtitle, 'A Code of institutes and precepts, adapted to the professional conduct of physicians and surgeons. In an admirable general statement on the nature of medical ethics, Canon G.R. Dunstan defined these as 'the obligations of a moral nature which govern the practice of medicine'. Members of the medical profession 'are expected both by fellow-doctors and by the society in which their patients are found, to adhere to them' (Black, 1987).

'Like other people, doctors owe an allegiance to patterns of behaviour of the type expressed in the 'golden rule' - 'do unto others as you would have them do unto you'; or in Kant's formulation, act in accordance with what you would accept as a universal law' (Black, 1987). Doctors, he believed, *'whether or not they formulate it clearly, tend to have a general perception of social responsibility, but are much less tolerant of the concrete acts of those authorities which press closely upon them'*. He added that *'a high standard of formal ethical knowledge can certainly make some contribution to the quality of a doctor's practice; but by itself it falls far short of ensuring it, supplemented as* it *must be by adequate knowledge, a strong sense of professional duty, and a basic kindness of heart'*. He then added the word, 'experience', to this list (Black, 1987).

From such starting points for medical ethics, it was noted at the Windsor I conference that the *'key principles of equity, human rights, social justice and concern for the individual are at the heart of the effective and equitable delivery of health care services. They form a value base to*

further a strategy for improving the health of people. They point to a need to consider holistic aspects that cover physical, social, psychological and spiritual aspects of life, putting the patient and the community first; ecological aspects, in that they put the health of human beings within the context of the world as a whole, and relate human activity to animal and plant life and the wider environment; inter-sectoral working, in that they acknowledge that a wide range of agencies and individuals need actively to pursue the potential for health; and equity, in that existing variations and inequalities in health must be tackled' (Caiman, 1997a). Application of these principles requires not just an external morality (regulation of moral conduct through external controls), but also an internal morality (a new ethic in which professionals live up to the trust placed in them by others). Both require norms and values. Without internal morality there is a special danger for trust. Complex regulations can disempower those forced to observe them. If they accept they cannot be trusted there is then a risk they will become less trustworthy and obey the letter of the law only (Paul, 2000). Arguments for professional self-regulation rely therefore, on the notion that trustworthiness is enhanced by self respect accompanying ownership of professional standards (Irvine, 1997).

What then are professional and personal values? Professor McGettrick, Dean, Faculty of Education, University of Glasgow, has defined a *"value"* as 'a *set of principles which are consistent and inform and direct our thoughts, actions and activities. Thus, a value has essentially an intellectual base, but this base informs and has its expression in action and in life'* (McGettrick, 1995).

From these concepts of conduct, kindness, responsibility, ethics and moral values, the Windsor I conference (page 92), defined *humanity* as:

"the study of human nature and the practice of compassionate concern for the advancement of mankind's welfare".

This definition agrees with the first fundamental principle of the International Red Cross (IRC) and the Red Crescent Movement - "*humanity".* The IRC website, www.ifrc.org, reports that, for this first principle: *'The International Red Cross and the Red Crescent Movement, born of the desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, co-operation, and lasting peace among all peoples'.* Humanitarian organisations such as the International Committee of the Red Cross and Medecins Sans Frontieres frequently face situations which challenge their guiding ethics and principles (Perrin, 1999; Nolan, 1999). They do too, frequently deal with *'social lesions',* defined as *'a sustained sense of tension between population groups one of which regards itself as superior to the other, which, in turn, feels inferior' (Acheson, Sir Donald, personal communication,* 1999).

'The *humanities'* as the Windsor I conference noted (page 92), is defined in The New Encyclopaedia Britannica, 15th edition, 1993, as:

"those branches of knowledge that concern themselves with man and his culture or with analytical and critical methods of inquiry derived from an appreciation of human values and of the unique ability of the human spirit to express itself".

Participants of the Windsor I conference considered that the arts and humanities can be better harnessed to stimulate and use the five bodily senses more (sight, sound, smell, touch and taste) to interpret personal experience better and to express understanding each of us has thereby gained to derive and give in life, emotional pleasure and personal meaning.

Widespread interest in the humanities seems to be re-awakening. The historical background is therefore important. It helps to give 'context' to the present Nuffield Trust initiative. During the Middle Ages for example, *'the Renaissance was much more than the rediscovery oj the classical texts oj ancient Greece and Rome .... The study oj these texts, written as they were by pagan, pre-Christian authors, led to such a new appreciation oj the creative capabilities oj humankind in its unredeemed state that it has been called a revolution oj consciousness. The leading thinkers oj the Renaissance began to look with new eyes on the human condition ... Attention was no longer jocused on other-worldliness; as a result, the natural and the material world came to be revalued. Humans came to be seen less as jallen creatures living in a jallen world and more as autonomous, rational beings, capable of choice, oj doing good oj their own free will, and oj creativity ... The men oj the Renaissance began to turn away from the eternal and the absolute (as commonly conceived) and to concern themselves with the world oj nature and oj internal human experience. The Greek and Latin classics they studied became known as the humanities, jor in Cicero's day 'humanitas' meant the education oj humankind. So the leading jigures oj the Renaissance commended the study oj the classics as the means oj nurturing our human potential. Because they placed such emphasis on the value and dignity oj the human condition, their philosophy came to be known as humanism. The humanists eagerly sought the rebirth oj the jree and creative human spirit which they believed to have flowered in the ancient world and to have been lost in the Middle Ages. Thus the Renaissance brought to birth our modern awareness of historical change, our passion jor jreedom, our respect jor human reason, and our eagerness to investigate the natural world and to extend our knowledge'* (Geering, 1999).

'*… Within the continuum of planetary life there have evolved many inter-connected systems, each of them in symbiotic relationship with its environment. In the case of the human species, we have evolved not only in a symbiotic relationship with the physical environment of the earth but with another kind of environment, known as human culture. By this is meant everything we humans have constructed with our hands, performed by our actions and thought with our minds. The basis of all human culture is language ... 'Language is the medium in which we live and move and have our being. In it we act, we structure the world and order every aspect oj our social lie. Only Language stands between us and the Void. It shapes everything'* (Geering, 1999).

'Language enabled our human forebears to reach a heightened form of consciousness; they became to depend less and less on biological drives and animal instincts, and organised their lives with an increasing awareness of their emotional, intellectual and spiritual needs. Consciousness began to evolve into the critical self-consciousness we are capable of today. So as our species gradually became human, we ceased to live an exclusively animal existence and developed, in addition, a cultural existence. It is by means oj language that we have developed human culture and it is by being immersed in culture that each new generation becomes human ... Within the changing conditions and evolving life on this planet, and out of the various developing cultures that have shaped us, we humans can and do create meaning for ourselves' (Geering, 1999).

The basis of the Windsor I report was renewed interest in the medical aspects of the humanities. In 1999, Evans and Greaves reported that: *'the perspective of the practitioner is crucial in framing explanations for the problems which medicine exists to address - patients' experience of illness, disability and suffering. The medical humanities explore how the humanities, traditionally concerned with recording and exploring human experience, engage with specific experiences of patients, doctors, health, illness and suffering. An integrated conception of the medical humanities carries this engagement through to the perennially important question: What is medicine for? It affirms medicine's unique character as a form of human self exploration, recognising that in medicine our material and our experiential natures are irreducibly fused; our bodily tissues and our personal values unite in constituting those experiences of illness and suffering which send people to their doctors. Medicine's objects - its patients - are also self reflecting subjects who, together with the doctor, actively form and transform the clinical encounter, the central arena of medicine'* (Evans and Greaves, 1999).

The integrated concept of the medical humanities has been taken further with the recent emergence of *'integrated medicine'* with *'its focus being on health and healing rather than disease and treatment. It views patients as whole people with minds and spirits as well as bodies and includes these dimensions into diagnosis and treatment. It also involves patients and doctors paying attention to lifestyle factors such as diet, exercise, quality of rest and sleep, and the nature of relationships'* (Rees and Weil, 2001). In this work the concept of *'creative medical caring'* has emerged with its encouragement in clinical care to *'gather knowledge from other places - placebo effects, hypnotherapy, psychoneuroimmunology, psychology, psychosocial studies, spiritual practices, art and complementary medicine, not as ends in themselves but as portals to common grounds in creative change'* (Reilly, 2001).

However, in considering how the medical humanities might further evolve, as Machiavelli, writing about 15th century Italy, commented:

'There is nothing more difficult to arrange, more dangerous to carry through, than to initiate a new order of things ... Men are incredulous, never really trusting new things unless they have been tested by experience'.

Yet, medical students are asking for progress in this area of medical education. One has reported that: *"We must focus on the bigger picture - producing student doctors who are aware of the value of having an appreciation of the art involved in medicine as well as the science, and of the importance of being a human being as well as a doctor"* (Bryden, 2001). It should be noted therefore that now, in the year 2001, there is a documented, peer-supported background to this present Nuffield Trust initiative. It has, in addition to other publications of the Nuffield Trust, arisen from:

1. Publications on health-related aspects of the arts and humanities at least since the 1980's (q.v. Windsor I Conference Report, 'List of References' - pages 120-127, and 'A Selected Bibliography Of Additional Background References', pages 151-156),

2. Conferences at least back to 1993, (q.v. Windsor I Report, pages 14-16 and 100) and including:

   - the Wellcome Foundation, seminar on 'Arts and Health', 1993, London, UK;

- the Royal New Zealand and Australian Colleges of General Practitioners Combined Conference, 'The Science and Art of Medicine', 1994, Wellington, New Zealand;
- the Royal Society of Medicine, Section of the History of Medicine, Symposium, 'Art in Hospitals, Past, Present and Future', 1995, London;
- the University of Auckland, New Zealand, International, Interdisciplinary Conference, 'Narrative and Metaphor Across the Disciplines', July 1996;
- the Wellington Clinical School, University of Otago, New Zealand, Interdisciplinary Conference, 'Health in the Writer's Hand', July 1996;
- the Roehampton Institute, London, Interdisciplinary, International Conference, 'The Arts in Health Care: Learning From Experience', September 1997, London;
- the two Nuffield Trust Conferences, Humanities in Medicine: beyond the Millennium, Cumberland Lodge, Windsor Great Park, UK, 1998 and 1999;
- the World Symposium on Culture, Health and the Arts, Manchester Metropolitan University, UK, 1999;
- conferences organised during 2000, by the Centre for the Arts and Humanities in Health and Medicine, University of Durham, the Medical Humanities Unit, University College Hospital, London, and South East Arts, Sussex.

Also q.v. the following other Sections of this present report: 'Practical Applications of the Medical Humanities', [see below], 'Indicators of Progress', [page 66] and 'BMJ Publishing Group Launches New Journal, Medical Humanities [page 67].

Arts courses in the medical curricula have been introduced to help reduce the 'inhumanity' of modern technological medicine. They explore patients' questions of the meaning of life and thereby explore ways of reducing pent-up emotions and tensions, help develop our self-perceptions, examine communication skills, and encourage an understanding of what illness and disease mean to the individual patient (Caiman and Downie, 1996).

SOME PRACTICAL APPLICATIONS OF THE ARTS AND HUMANITIES IN MEDICINE

(A) FEARS AND WORRIES OF PATIENTS IN HOSPITAL

Although first reported in 1949, the importance of reminding physicians (and all health care professionals and their students) of the fears and worries that can afflict patients in hospital is emphasised in the *Oxford Textbook of Medicine* (Cooke, 1987). These concerns are the:

- feeling of strangeness and helplessness;
- worry about relatives and dependants;
- worry about job, examinations etc;
- financial worries;
- concern about the illness itself;
- fear about the diagnosis;

- fear of pain;
- fear of the operation;
- fear of physical handicap or deformity;
- sense of guilt;
- fear of getting well; and
- fear of death.

Personal experiences of physicians who have also been patients continue to be reported in the medical literature. They indicate that the needs for compassion should be more widely understood and always practised. In these respects, intuition for what a patient is experiencing, trying to express, or suppressing, is recognised as an important skill and tool (Philipp, Philipp, and Thorne, 1999).

In paediatrics, new initiatives for patient entertainment and to reduce anxiety are being introduced. For example, clowns have worked on children's wards since 1986 and in a dozen countries, including Canada, the USA, France, and Brazil (Oppenheim et al, 1997). Clowns reportedly help children to:

- find their place within the department;
- master space in the hospital;
- travel along their own path;
- cope with sounds and silence;
- preserve intimacy;
- move between medical theories and their own fantasies;
- cope with their bodies;
- cope with emotions;
- transform the department into a scene where imagination has free realm;
- reassure other care givers (Oppenheim et al, 1997).

It has also been reported that: *'a clown care unit (CCU) is not a ward where sick circus performers can set fire to each other's trousers in safety and comfort, hut a new venture to entertain in-patients at Chicago Children's Hospital. 'Legacy', the University of Chicago hospitals' newsletter, reports that clown care has been bought for the children's hospital by a technology services company for $ 105,000 and is proving popular with the kids. No doubt some enthusiastic intern is already conducting a randomised trial comparing the health benefits of red noses, buckets of water, and unfeasibly large shoes with more standard entertainment'* (Minerva, 1999b). *Le Rire Medecin,* a Paris-based organisation now employs professional clowns to work on paediatric wards in French hospitals. It has *'developed a code of ethics, which has built confidence between the performers and the medical teams'* (Martin, 1999).

(B) THE GENERAL MEDICAL COUNCIL'S VIEWS ON GOOD MEDICAL PRACTICE

Medical practice has two components. It has been reported that: *'the first is generic to all doctors and is expressed in the General Medical Council's (GMC) guidance document 'Good Medical Practice' (GMC, 1998). This document proposes a wide definition of competence, including relationships with patients, teamwork, participation in continuing professional development, and a commitment to maintaining performance alongside the traditional competencies in diagnosis, management, and practical skills that make up good clinical care ...*

The second component of actual practice comprises the clinical problems which face the doctor. The generic attributes should be assessed in relation to common and important problems with which the doctor will be faced'' (Southgate and Pringle, 1999). The ability to 'communicate' is a key feature of these components. It is against this background, in the interests of revalidation of doctors, that the GMC *'rightly recognises that the public and the government want effective processes that will guarantee that doctors are not only technically competent but also courteous, responsive, and good communicators'* (Smith, 2000).

A recent BMJ editorial, reported that: 'As *the General Medical Council has suggested in 'Tomorrow's Doctors' (GMC, 1993), engagement with the humanities might offer several benefits, including fostering clinician's abilities to communicate with patients, to penetrate more deeply into the patient's wider narrative, and to seek more diverse ways of promoting well being and reduce the impact of illness or disability. For chronic illness in particular (where biomedicine offers only a partial response) clinical medicine seems likely to serve its patients best by incorporating into their treatment an appreciation of individual patients' experience. This might help to avoid over-prescribing (or occasionally under-prescribing) and over-dependence. Again, a narrowly causal view of how people become ill in the first place is inadequate to understanding the role of psychosocial factors in aetiology and how they fuse with physical factors. Hence a more 'narrative' understanding of illness might be more important diagnostically as well'* (Evans and Greaves, 1999).

Evans and Greaves (1999) also reason that: *'although the promise of these benefits is plausible, they need to be shown convincingly, and this remains to be done. But producing the evidence also needs a richer conception of what kinds of evidence are pertinent to clinical assessment, requiring qualitative studies to refine as well as to apply this conception. In short the medical humanities stand in need of investigation and elaboration both conceptually and empirically. This is a real challenge, but one that must be undertaken'*.

Nevertheless, although a background of study in the arts and humanities and the opportunity to study these subjects in medical courses should influence the way in which future doctors practice, it should not become a substitute for knowing their medicine and delivering good medical care (Macnaughton, 1998).

(C) LOCAL MECHANISMS TO DELIVER CLINICAL GOVERNANCE

In March 2000, the Chief Medical Officer reported that *'the local mechanisms which will deliver clinical governance will move us towards a real partnership between patients and staff - this will require questions and answers, hearing and listening, patience, commitment, dedication, self-belief and courage'*. He urged us to accept that *'the human condition is imperfect; let us examine, acknowledge and welcome the public expectations ... And then let us commit to create an open, participative and evaluative culture which will allow, encourage and require the scrutiny necessary in order that we can deliver the continuous quality improvement and clinical excellence that our patients deserve and expect'* (Donaldson, 2000).

(D) REASSURANCE

A dilemma for health professionals is often: *"how to get it right without getting it wrong"* (Essex, 2000; Baron, 2000). For example, the relationship between general practitioner and

patient, whether an individual or a family, is unique and multi-layered. *"Around the professional aspects of doctors' duties and responsibilities and patients' rights and expectations (and their own responsibilities) are interwoven the personal human qualities of acquaintance, amicability, fondness, and shared experiences"* (Editorial, 1999a). General practitioners, it has been reported, *"who visit their patients in hospital bestow incalculable benefits on them"* (Saperia, 2000). Reassurance is a crucial clinical task. Methods of imparting reassurance successfully are, however, poorly understood. A qualitative study of semi-structured interviews recently identified that patients make sense of the doctor's words within the context of their own views and experience. Acknowledgement of patients' views of their condition was important for reassurance (Donovan and Blake, 2000).

(E) MAKING SENSE OF ILLNESS

In surveys of the use of complementary medicine, about 80% of patients are satisfied with the treatment they receive. Interestingly, this is not always dependent on an improvement in their presenting complaint. *Tor example, in one UK survey of cancer patients, changes attributed to complementary medicine included being emotionally stronger, less anxious, and more hopeful about the future even if the cancer remained unchanged'* (Zollman and Vickers, 1999). This finding may be explained by noting that *'patients often want to incorporate their experience of illness into their understanding of themselves and their world. They ask questions like 'Why has this happened to me?' and 'What in my life has caused my problem?' Complementary practitioners may have explanations that make sense to patients - such as describing illness as a result of environmental factors or as a physical expression of emotional patterns. Conventional medicine may have problems with such explanations if they have no scientific justification, but sociological research shows that patients consider them beneficial when they reinforce their own beliefs and expectations'* (Zollman and Vickers, 1999).

'The specific effects of particular therapies obviously account for a proportion of patient satisfaction, but surveys and qualitative research show that many patients also value some of the general attributes of complementary medicine. These may include the relationship with the practitioner, the ways in which illness is explained, and the environment in which they receive treatment. When these augment the therapeutic outcome of treatment, they contribute to ... 'the placebo effect' .... The relative therapeutic importance of specific and non-specific attributes obviously depends on individual patients and practitioners, but some complementary practitioners may be better than their conventional colleagues at using and maximising the placebo effect'. Moreover, *'practitioners of modern Western medicine have become expert in recognising, identifying and treating disease. When there is no organic disease present but simply ill defined symptoms or a general 'lack of health' they may have much less to offer. As a result, patients presenting with illnesses such as chronic fatigue, functional back pain, or irritable bowel syndrome may feel that their doctor does not take their symptoms seriously or does not really believe that they are ill. Complementary practitioners do not need a conventional diagnosis to initiate treatment; in fact, many think that their treatments are most effective in patients without organic pathology'* (Zollman and Vickers, 1999).

Is it therefore possible that what is known as 'the placebo effect' is instead, the result of a specific intervention, the humanities?

(F) COMMUNICATION IN GENERAL PRACTICE CONSULTATIONS

A recent qualitative study identified that in general practice consultations: *'doctors may overestimate the extent to which patients are primarily concerned with medical treatment rather than with gaining information and support'* , and that: 'unless *patients are overtly distressed doctors may have trouble in recognising those who are seeking support'*. It was noted from the findings that: *'in consultations patients seem only partially present, with only limited autonomy - that is, to make requests but not to suggest solutions. Outside consultations patients are more fully present; as socially and contextually situated, thinking, feeling people, with their own ideas on their medical condition and opinions and possible criticisms of medical treatments'*. It was noted that two voices are present: *'The voice of medicine, in which the consultation is conducted, and the voice of the lifeworlds (reports of contextually grounded experience of events and problems expressed in everyday language), which* is *largely left outside the consultation. This suggests that in the consultation the patient is most commonly construed as a purely 'biomedical' entity - that is, a person with disconnected bodily symptoms, wanting a label for what is wrong and a prescription to put it right. Even under this guise patients still sometimes fail to report their full biomedical agenda'* (Barry et al, 2000).

If such findings are commonplace, they suggest that the present-day practise of medicine may not be meeting the needs of patients. This possibility is supported by evidence from complementary medicine practice (q.v. example (0 above). Do they therefore reflect widespread dissatisfaction? The voice of medicine, it has been argued: 'is *characterised by medical terminology, objective descriptions of physical symptoms, and the classification of these within a reductionist biomedical model. The voice of patients, on the other hand, is characterised by non-technical discourse about the subjective experience of illness within the context of social relationships and the everyday world. Typically, doctors have more power than patients to construct the nature of the interaction between them. As a consequence, many feel that their voice is overridden, silenced, or stripped of personal meaning and social context. To improve communications between doctors and patients we need also to understand the nature of the decision making that is taking place in the consultation'* (Charles, et al, 2000).

'Understanding the reasons why communication problems occur can help researchers develop interventions designed specifically to address potentially different types of communication issues' (Charles et al, 2000). The arts and medical humanities are such interventions.

(G) THE BIOPSYCHOSOCIAL APPROACH TO GENERAL PRACTICE

It has been reported that if science is to be the basis of clinical work in general practice, a new definition of the specialty is required that emphasises the need for general practitioners to be able to take a biomedical, psychological, and social approach to patients and their problems. In this approach: *'general practitioners themselves can create methodologically sound evidence within most of the different parts of the core contents of the discipline. Evidence is not limited to the biomedical aspects and certainly not to randomised controlled studies. An evidence based scientific approach is feasible in most cases when addressing concepts like continuity of care, communication skills, coping, empowerment, enabling, health beliefs, health promotion ('salutogenesis'), somatisation of feelings, and personality traits. The general practitioner must acquire knowledge from the fields of medical*

sociology and anthropology to enable him or her to diagnose how patients' conditions are shaped by their culture, family, and others in their networks and relations with society at large, including their working environments. This knowledge should be explicit, scientifically based, and theoretically sound and should be understood to a degree where it can be turned into appropriate clinical skills in diagnosis, cure, care, and palliation. This is not easy and requires hard work' (Olesen et al, 2000).

This integrated biopsychosocial approach illustrates the application of medical humanities to one medical specialty.

(H) INFORMATION NEEDS OF CANCER PATIENTS

Cancer patients' attitudes to cancer and their strategies for coping with their illness can constrain their wish for information and their efforts to obtain it. In a qualitative study of in-depth interviews, three over-arching attitudes to their management of cancer were identified as limiting patients' desire for and subsequent efforts to obtain further information: faith in doctors' medical expertise precluded the need for patients to seek further information themselves; hope was essential for coping so that they could carry on with life as normal and maintain a positive outlook and could be maintained by avoiding potentially negative information; and charity to fellow patients, especially those seen as more needy than themselves, included the recognition that scarce resources (including information and explanations) had to be shared and meant that limited information was accepted as inevitable (Leydonetal, 2000).

Such findings are used in the teaching of palliative medicine, hospice and terminal care.

(I) STOPPING TREATMENT IN INTENSIVE CARE UNITS

It is: *'incumbent on intensive care practitioners to become as skilled in the management of death as they are in managing other complications of critical illness. The management of death requires consideration of the interests of all the people affected - not only the patient and his or her family but also of the medical and paramedical staff caring for the patient and of the community at large. The interest of these diverse groups and individuals may be in conflict, and reconciliation may be difficult or impossible ... Delay in stopping apparently futile treatment is often required where the arrival of a close relative is awaited or the family needs time to adjust to or accept an inevitable, though often sudden, death. In an affluent society, this seems a reasonable compromise between the various interests involved. At some point, however, this delay becomes unreasonable ... Staff caring for the patient may have difficulty reconciling the apparent misuse of scarce resources or the compromise of the patient's dignity. This will increasingly be an issue the longer treatment continues and is compounded by the apparent inconsistency of continuing some treatments but not others. Though it is usually feasible for practice in the intensive care unit to reflect compassion within a legal and ethical framework, this becomes increasingly difficult when non-standard management regimens preclude access to an intensive care bed for patients with a chance of survival'* (Fisher and Raper, 2000).

These such ethical dilemmas, for example involving ethnic or religious expectations, require renewed communication and heightened multidisciplinary networking skills for resolution of both the intra and inter-personal conflicts that arise. The medical humanities are increasingly

drawn into questions such as: Are such skills inherent in health professionals or can they be learned? If they can be learned what are the most effective ways of imparting knowledge, ensuring it is enacted and that the quality of attitudinal and behavioural outcomes are sustained?

0) HEALTH BENEFITS OF SOCIAL AND PRODUCTIVE ACTIVITIES

Little is known about predictors of survival among elderly people. Longstanding depression seems to be a predictor for mortality (Pulska et al, 1999). The importance of social networks and social support is increasingly recognised, yet little research has been undertaken on their determinants (Stoddart et al, 2000). In chronic care, *'the goal is not cure, hut maintenance of pleasurable and independent living'* (Holman and Lorig, 2000). In the USA, a prospective cohort study with annual mortality follow up recently identified that social and productive activities are as effective as fitness activities in lowering the risk of death. Enhanced social activities may also help to increase the quality and length of life. Activities studied included church attendance, visits to cinema, restaurants and sporting events, day or overnight trips, playing cards, games or bingo, participation in social groups, gardening, preparing meals, shopping, unpaid and paid community or other work. Clinicians, it was concluded, can therefore consider these as *'powerful, new intervention tools'*[1] in addition to exercise (Glass et al, 1999). At least in Britain, motivation does though deserve study - today for example, 70% of British adults take exercise less than once a month (Carnall, 2000).

Guidance has been given by at least one author who noted that as we grow older, *'we must not see ourselves, nor allow anyone else to see us, as the tenants of time, waiting impassively for our lease to expire'* (Bright, 1997). It has been noted that the author: *'teaches us to appreciate the totality of a person who happens to have aged'* and with the 'wish *to continue our personal growth as we grow in years'* (Philipp, 1998).

(K) THE ASSOCIATION FOR THE LITERARY ARTS IN PERSONAL DEVELOPMENT (LAPIDUS)

The organisation, LAPIDUS, evolved from interdisciplinary action for the arts and health. It now has its own impetus and links with the Nuffield Forum for the Medical Humanities. LAPIDUS started with a letter from within the University of Bristol to the British Medical Journal, published on 1 January 1994, that asked: *'Could or does reading or writing poetry benefit health? In a project with the World Health Organisation and as part of our interest in mental health and the environment, we welcome comments'* (Philipp et al, 1994). It was a tentative start to explore if there could be anything 'scientific' and 'measurable' for the role of literature and creative writing, and poetry in particular, in medicine. Since then, to date, (June, 2001), responses have been sent to some 600 persons who replied spontaneously with personal comment about health benefits perceived by them and their interest in networking with other similar persons. At the request of the news media, more than 100 interviews were given between 1994-2000 on the subject. (More information about this project is given in the report of the Windsor I conference (pages 98-100). In August 1994, the widespread interest in this project led to its links with a new Poetry Society campaign, 'A National Health of Poetry'. LAPIDUS evolved from this link. On 14th October, 1996, a LAPIDUS meeting was held at The Royal Institute of Public Health and Hygiene, (RIPHH), London. The RIPHH

is an independent award granting organisation promoting the advancement of public health. Its executive staff have since met with Poetry Society staff to help determine:

- possible collaborative ways forward for users and researchers that might ensure sustainable educational development;
- appropriate standards setting;
- criteria for 'best possible' professional practice;
- ways of disseminating information; and
- better empowering of public actions.

Arising from this framework and in on-going work with the BBC, Mr. Andrew Motion, Poet Laureate, and the Right Honourable Alan Howarth, then Government Minister for the Arts, recently expressed their interest in roles that LAPIDUS members could have in helping to shape projects with the new NFMH, and in monitoring outcomes. In the year 2000, the Arts Council of England generously agreed to support LAPIDUS for the following two years (Philipp, 2000). This has now been extended for a further three years.

Known areas of current research in this subject include:

- direct prescribing cost savings for anxioloytic and anti-depressive medication from interventions with poetry and creative writing workshops;
- uses of poetry with school age victims of bullying to help improve their emotional resilience and coping skills;
- the effects of poetry on the psycho-neuro-immuno-endocrine axis and perceived stress levels;
- health benefits of the Poets-in-Residence schemes;
- uses for poems in doctors' waiting rooms.

(L) USES OF WRITING AND NARRATIVE IN MEDICAL PRACTICE

It was recently reasoned that in medicine a language divorced from thought has developed because 'medical literature has been infected with language which impedes understanding and corrupts our thinking, by the equating of data with knowledge, by the need to add inches to the cv and attract more grants', and that 'medical papers serve the needs of the authors, not the needs of the readers' (Fox, 2000). In his final editorial for G.P Writer, the Journal of the General Practitioner Writers Association, the outgoing editor commented too, that *It is sad that our profession, so deeply rooted in humanity, should be branded as writing in a 'language divorced from thought'. General Practice, the branch of medicine most dependent on the art of communication, should be leading the way to greater clarity of written as well as spoken English'* (Hull, 2000). Perhaps, in part as a response to such concerns, the British Medical Journal Publishing Group has published a book that explores dialogue and discourse in clinical practice (Greenhalgh, T., and Hurwitz, B. *Narrative Based Medicine;* pub. BMJ Books, 1998; pp.304). It explores our understanding and appreciation of the role of story-telling and narrative analysis in the practice of medicine

The role of literature in medical education is being increasingly explored (McLellan, 1996; Caiman, 1997b; McLellan and Hudson Jones, 1997).

Ways in which literature might be used to improve communication skills and the quality of professional education were explored in the report of the Windsor I conference (pages 18-19, 32-33, 39-43, and 160).

Readability is usually considered to be purely subjective. However, an objective way of assessing it was identified for the GP Writer Association from the Society of Authors (Selcon, 1999). The formula is derived as follows: Choose a representative passage from the work to be assessed. From this passage:

1. Count the number of words. Call this number A.
2. Count the number of syllables. Call this number B.
3. Count the number of sentences. Call this number C. (For this purpose any series of words broken by anything other than a comma (i.e. by semicolon, colon, dash or full stop) counts as a sentence.
4. Divide B by A and multiply the result by 84.6. This generates another number X. Divide A by C and multiply by 11.015 generating a further number Y. Add X to Y to give yet another number Z.
5. Subtract Z from 206.

This last step gives a numerical readout of the Readability Factor (RF). Ideally this should be in the region of 100. A score of 50 or less means the author should try harder to avoid long words and long sentences!

Apart from this method, the function of the 'Discussion' section in academic medical writing, its purpose and the differences between 'speculation', 'rhetoric', and 'science' have been considered. It has been suggested that to assist authors in writing discussions, detailed, evidence based guidelines are needed (Skelton and Edwards, 2000).

The use of narrative to explore a patient's problems holistically and to uncover diagnostic and therapeutic options has also been explored (Greenhalgh and Hurwitz, 1999; Elwyn and Gwyn, 1999), as has the narrative approach to mental health in general practice (Launer, 1999), and the use of narrative in medical ethics (Hudson Jones, 1999).

The role of narrative in psychotherapy and the narrative stream in medical ethics have too, been recently reviewed (Greenhalgh and Hurwitz, 1998). Reflective writing courses for health care practitioners have also emerged. In them, the term *'reflectivepractice' ...'has gained a great deal more usefulness by being harnessed to the explorative and expressive power of creative writing, and the supportive and educative force of effective facilitated small-group work'* (Bolton, 1999). Nevertheless, more research is needed. For example, the need for substantiation of the reported effects of writing as therapy on immune mediated illness (Greenhalgh, 1999).

(M) BULLYING IN SCHOOLS

Bullying in schools is a widespread social problem. At the 9th Annual Public Health Forum in March, 2001, it was for example reported that, in the UK, 27% of primary and 10% of secondary school pupils are being bullied, despite 88% of schools now having anti-bullying policies (Judith Emanuel, University of Manchester, unpublished report). It has significant

implications for health professionals. There is greater awareness of the mental health problems of young people, estimated to be as high as 20% in some parts of Britain, where teenage rates of suicide give rise to alarm, and the mental health effects of bullying are beginning to emerge (Chesson, 1999). It is still prevalent in schools (Salmon, 1998; Leff, 1999). Victims of frequent bullying have been reported to experience a range of psychological, psychosomatic, and behavioural symptoms including anxiety and insecurity, low self esteem and low self worth, considerable mental health problems, sleeping difficulties, bed wetting, feelings of sadness, and frequent headaches and abdominal pain. They are also more likely to be unhappy and depressed and absent from school (Forero et al, 1999).

Preliminary work in Welsh schools has found that creative writing and poetry workshops can be used to help rebuild morale and self esteem and improve emotional resilience to the effects of bullying (Hartill, G., personal communication). It may therefore be no coincidence that when the BBC conducted a poll in conjunction with National Poetry Day 1995, of the 12,000 votes cast, Rudyard Kipling's poem, 'If, received twice as many votes as the runner up (Rhys Jones, 1996). Kipling's poem starts with the lines:

'If you can keep your head when all about you
Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowances for their doubting too;'

It ends with:

'If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
And - which is more - you'll be a Man, my son!'

The potential of poetry to help improve emotional resilience associated with bullying therefore deserves formal study.

(N) 'LOVE' AS A BASIS OF HUMAN UNDERSTANDING AND MOTIVATION FOR WORK

'According to the Trades Union Congress, stress at work costs employers around £5bn a year, affects over half a million workers annually and adds up to nearly six million working days lost'. In a biennial survey published in 1998 of nearly 6,000 health and safety representatives, 75% cited stress as the major workplace hazard. The main causes were identified as workloads and staffing levels, new management techniques, long hours, shiftwork and bullying (Rouy, 1999).

The Health and Safety Executive has suggested that harmful levels of stress are more likely to occur where:

- people are confused by conflicting demands on them;
- people feel trapped or unable to exert any control over the demands made on them;
- pressures pile on top of each other or are prolonged (Rouy, 1999).

What then are the key factors that might help people to enjoy their work more? As one step in seeking additional information for solutions to the problems of stress in the workplace , the question: 'What is love?' has been examined (Philipp and Philipp, 2000). It is part of an

apparent resurgence of medical interest in the topic. For example, in his recent book an obstetrician has reported that *'at a time when people are focusing on violence and the roots of violence,* I *am convinced that we can go a step further in our understanding ... by turning the question on its head and looking instead at how the capacity to love develops'* (Odent, 2000). Examples of other recent interest include a new book, 'Love Stories', recommended for anyone with even a passing interest in humanity (Lewis, 2000), and the premise that love is critical for human survival (Kawachi, 2000).

The recent report (Philipp and Philipp, 2000) has been followed by recently completed fieldwork for a pilot study of what Occupational Health Physicians, and qualified and student Occupational Health Nurses think their patients mean when they spontaneously report that they love' their job. The 43 participants identified 34 factors, grouped under four headings:

- relationships at work;
- personality of the worker;
- the work itself;
- and life outside work.

The study findings are now being used to further explore, with Directors of Personnel and Human Resources, the key motivators and demotivators for enjoyable working that employers can influence and that employees themselves perceive as being important in the workplace.

In respect of the art and humanity of medicine, in the words of the poet, Ogden Nash:

'Love is the patient architect that builds Misunderstanding into understanding' (Exley, 1999).

(O) THE ASSOCIATION OF HEALTH WITH AESTHETIC QUALITY AND ENVIRONMENTAL VALUES

The underlying hypothesis in this work is that: *'our mental well-being is influenced by the aesthetic quality of our external environment and that improved understanding of this association can influence our sensitivity to environmental values and help us to identify what we seek and can attain from these aesthetic qualities'* (Philipp, R., Windsor I report).

The report of the Windsor I conference explored this hypothesis (pages 93-96), and reported there that *'the psychological impact of environmental factors on personal well-being is well-known'*. In response to points in the WHO European Charter on Environment and Health about the role of aesthetic factors in health, it was noted that from within Eastern Europe, a new discipline, *'aesthetic* medicine' has been proposed. Indeed, the sciences have been used traditionally to study environmental values and their association with well-being, and as a basis for setting standards and guidelines of environmental quality. It is also recognised that the different sensory inputs (sight, hearing, taste, smell, and touch) stimulate the building of images in the mind and the associations, connections and interpretations that give meaning, understanding and purpose to living (Philipp, 1997b; WHO, 1998). Aesthetic effects and their associated amenity values can therefore influence well-being and health gains (Williams et al, 2000). Accordingly, 'as *well as what the sciences contribute, the arts are sometimes used to express what we seek and consider worthwhile. Creative expression of this pleasure can also provide research material to help identify, categorise and prioritise human needs for different aesthetic qualities in the external environment'* (Philipp et al, 1999).

An arts-science gradient is now being applied to the design of studies to explore the role of aesthetic factors in the environment and their effects on personal well-being. This arts-science gradient spans the artistic, intuitive, inspirational and subjective personal viewpoints, and the measurable, objective, deductive, logical and scientific perspective (Philipp, 1998b). Examples of initial studies have included interpretations of paintings by children of the nuclear age (Philipp, 1983); of children's paintings of their family doctor (Philipp et al, 1984; Philipp et al, 1986; Philipp, 1987); the verbal and written views of schoolchildren on the question: 'what is love?' (Philipp and Philipp, 2000); subjective poetic expression of environmentally-evoked sensations (Philipp, 1992; Philipp, 1997b); paintings and drawings of breast cancer care (Macfarlane, 1995); the arts in health care environments (Senior and Croall, 1993); the influence of a view from the hospital window on post-operative recovery times from surgery (Ulrich, 1984); the anxiety-reducing effect of exposing patients to images of nature before cardiac catheterisation (Martin, 1999); and uses of children's art from schools participating in the WHO initiated European Network of Health Promoting Schools, which communicated their ideas and feelings about the environment and health themes to the Third Ministerial Conference on Environment and Health, 16-18 June 1999, organised by the WHO Regional Office for Europe. Fifty-four countries were represented at this event (Price, 1999).

In the hospital environment, a Swedish study in which post-operative heart surgery patients were randomly assigned a landscape, an abstract, or no picture to look at, showed that a representational landscape with trees and water gave the best results. Those patients registered less anxiety, required less analgesia, and spent about one day less in hospital than control groups. A rectilinear abstract painting however, made patients feel sicker (Martin, 1999).

In the USA, a study has also identified the advantages of exposing patients to images of nature before cardiac catheterisation. Patients who were shown a picture of a valley and stream with an audiotape of water running, showed much less stress than those who were shown only the picture, played only the audiotape, or received neither (Martin, 1999).

At the 2nd International Conference on Health and Design, Stockholm, June 18-21, 2000, based on such research, it was reported that the proposed International Academy for Health and Design would help to stimulate "evidence-based design" which was poised to emulate evidence-based medicine as a central tenet for health care in the 21st century (Martin, 2000).

BUILDING FROM THE REPORT OF THE WINDSOR I CONFERENCE TOWARDS THE WINDSOR II CONFERENCE

Participants at The Nuffield Trust Windsor I conference for the arts and humanities in medicine believed that the issues explored there should be further studied. As noted in the Introduction to this present report, the Declaration of Windsor and the 12-Point Action Plan that were drawn up by Windsor I participants, (q.v. Appendices I and II to this present report) provided a rational basis for the next steps. In considering additional background leading to the Proceedings of the Windsor II conference, and that which followed on from the Declaration of Windsor and the 12-Point Action Plan, four key areas (A-D, below) can be identified:

(A) HEALTH AND DEVELOPMENT

Dr. Gro Harlem Brundtland, Director General, World Health Organisation, at the first Steering Committee meeting for the then forthcoming International Conference on Health Research and Development, held in Bangkok, Thailand, 10-13 October 2000, emphasised that:

- *"health is both a condition and an outcome of development"* and that
- *"health and development issues are intrinsically linked and as such, need to he addressed together".*

She emphasised that the advancement of the twin goals of better health and more equitable development requires a proactive approach to health research. She also reaffirmed WHO's commitment to the promotion of research, as being the organisation's decision-making process: *"Research is the international public good and as such, its promotion is the core function of WHO".* She added that *"to a large extent the research priorities we set for ourselves today determine the health agenda, health practices and technologies of tomorrow. In addressing current challenges, we must base our policies and action on current scientific knowledge and the lessons drawn from the past. But research must also help us anticipate future challenges and propose workable solutions. Sustainable development and sound health policies also require foresight and long-term planning"* (Internet: http://www.conference2000.ch).

As part of its contribution to this need for sustainable development, The Nuffield Trust has been working with the WHO Regional Office for Europe and the King's Fund to establish a European Health Communication Network (Apfel, 1999).

(B) HUMANITIES AND PROFESSIONALISM

Social development depends on collaboration, co-operation and co-ordination, but especially on shared goals. It is therefore recognised that *'education for future health and social care practitioners requires shifts in mind-sets and attitudes to working with complexity, change and difference'* (Williams and Wilson, 1998). To this list, 'overcoming diffidence' could also be added. Thus, in effect, sustainable development requires sustained effort. In this respect, health professionals (it has also been suggested) should change the way they work to be: *'on tap, not on top'* (Aston, 1998).

Good communication between team members is crucial for the best results, and successful teams are built on mutual respect (Tattersall and Thomas, 1999). Yet, we live in a world of barriers - religious, ideological, administrative, economic, physical and emotional (Loefler, 2000a). Patients however, *'presume all doctors to be trained to a high level in communication skills. With more and more emphasis on the technical aspects of medicine, the reality is that students and practitioners often become de-skilled in areas such as empathy and self-understanding, qualities they may have had before conditioning and battle-fatigue took over'* (Sloan, 2000). Nevertheless, the skilled practitioner *'seems to have a capacity for self-reflection that pervades all aspects of practice including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values'* (Epstein, 1999). This has been termed mindful practice, the characteristics of which are:

- active observation of yourself, the patient, and the problem
- peripheral vision
- attentive processing
- critical curiosity
- courage to see the world as it is rather than as you would have it
- willingness to examine and set aside categories and prejudices
- adoption of a beginner's mind
- humility to tolerate awareness of your areas of incompetence
- connection between the 'knower and the known'
- compassion based on insight
- presence (Atik, 2000).

The sentiment underlying such principles has been summarised in the words of Helen Keller:

"1 long to accomplish a great and noble task, but it is my chief duty to accomplish humble tasks as though they were great and noble. The world is moved along, not only by the might shoves of its heroes, but also by the aggregate of the tiny pushes of each honest worker" (Editorial, 2000a).

Nevertheless, *'relevance', 'coherence'* and *'connection'* are concepts also needed to give 'context' to what any individual might actually 'do'. For example, Michel de Montaigne (1533-1592) wrote:

"Like him who paints the sea, rocks and heavens, and draws the model of a ship as he sits safe at his table, but send him to sea and knows not how or where to steer, so doctors often make such a description of our maladies as the town crier does of a lost dog or donkey, of such a colour, such ears, etc., but bring the very animal before him and he knows it not for all that" (Editorial, 1999b). A recent handbook on educational supervision produced by the UK South West Region Postgraduate Medical Dean's Department, put it more prosaically:

"The danger is (to paraphrase T S Eliot) of trainees having the experience but missing the meaning" (Eaton et al, 1997).

In medicine, the concept of a *'sustained partnership model'* has emerged in which a patient centred relationship is ensured that does not devalue special skills of the clinician (Toop, 1998). General practitioners for example, *'must achieve a working diagnostic and therapeutic knowledge across the reach of biomedical science and must be able to forge effective and continuing relationships*

with an enormous range of individual patients. They need to understand the processes by which illness is socially constructed within the patient's life, and they must mediate between the patient's subjective experience of illness and the scientific explanation' (Heath et al, 2000).

As Sir Douglas Black has noted, *'the various health professionals have a duty to work together as a team, in the interests of their patients; if they fight their own corner', they are diminishing their professional status'* (Black, 1987).

The issues of partnership are also wider than relationships of the health professions and between doctors and patients. For example, in the past, health professionals have been reluctant to become involved with voluntary organisations (Black, 1998a). They were viewed as a threat to jobs or levels of pay (Black, 1988b). A lack of understanding of their potential contribution may still exist and it has been suggested that some initiative is required to ascertain answers to the questions of how, and to what extent, the enormous potential of the voluntary sector could be realised (Crombie and Coid, 2000).

(C) CONTINUING MEDICAL EDUCATION, PROFESSIONAL DEVELOPMENT AND THE HUMANITIES

The national quality strategy for the new NHS highlights lifelong learning as a way of improving health care. Intriguingly, it notes that although learning is something achieved by individuals, *'learning organisations'* can configure themselves to maximise, mobilise and retain this learning potential. It adds that learning occurs at different levels - single loop learning is about incremental improvements to existing practice; double learning occurs when organisations rethink basic goals, norms, and paradigms; and meta-learning reflects an organisation's attempts to learn about (and improve) its ability to learn. Learning organisations are purported to be those which maximise learning capacity by developing skills in double loop learning and meta-learning. Whereas individuals in them may come and go, the organisation, even in the turbulent world of health care, usually endures. Robust organisations can still accumulate competence and capacity despite the turnover of staff; individual learning can be retained and deployed in the organisation. How well any organisation can do this depends on factors such as internal communication and the assimilation of individual knowledge into new work structures, routines, and norms. Learning organisations see a central role for enhancing personal capabilities and then mobilising these within the organisation (Davies and Nutley, 2000). These concepts of the national quality strategy are pertinent to the place of the medical humanities within continuing professional development.

Internationally, there is a move from continuing medical education (or clinical update) to continuing professional development, including medical, managerial, social and personal skills (Peck et al, 2000). There is however, no sharp division between continuing medical education and continuing professional development. Nevertheless, the term continuing professional development acknowledges not only the wide ranging competencies needed to practice high quality medicine but also the multidisciplinary context of patient care (Peck et al, 2000).

Continuing medical education is part of the process of lifelong learning that all doctors undertake from medical school until retirement and has traditionally been viewed by the

medical profession in terms of updating their knowledge. However, all career grade doctors need skills that extend beyond updating their knowledge in order to practice effectively in the modern NHS. Such skills include management, education and training, information technology, audit, communication, and team building. These broader skills are embraced by continuing professional development, which, in 1999, was endorsed in medicine by the Academy of Royal Colleges. Thus, the colleges have now accepted responsibility for both continuing medical education and professional development of hospital doctors (with parallel arrangements for general practitioners) (Boulay, 2000). In this process, it has been noted that:

'professional development schemes need to be flexible so that doctors can participate and be recognised for what they do in the context of their professional practice'

and that:

'the vast majority of doctors are good learners and have always just got on with their own continuing medical education and professional development - that is what being a professional means' (Boulay, 2000). For example, when making career decisions, we have been invited to adopt a personal perspective that allows each of us to *'adjust history to suit yourself and still feel good about it'* and that it helps to *'conceptualise yourself in the best light possible, retrospectively'* (Gray, 2000). Moreover, it has been suggested that *'continuing professional development will not be an externally imposed discipline, but a spontaneous response from within'* (Horner, 2000).

The worth of such philosophy for personal development involving the humanities was noted at the Windsor I conference which reported that *"the way we look outwards at our world influences our perception of it, our values of what is truly important in it, and what we do with our lives in the world we live in"* (q.v. Conference Report, p.94). It was also noted there that this thinking is not new. As Epictetus noted in the 4th century BC, *"men are disturbed not by things but by the views they take of them"* (Conference report, p.94).

Yet, it has also been noted:

'the process ofprofessional development needs to be managed. The changing political climate and need to be more accountable mean that doctors now have to demonstrate that they are developing professionally and that their activities are educational and cost effective and improve their practice' (Boulay, 2000).

In the process of professional management, it is a truism for all professions and crafts that outcome is related to experience, teaching and training. Yet, as noted for example with surgery, specialisation is a necessity imposed by limitations in capability, be they knowledge or skill (Loefler, 2000b). In medicine too, *'the days when the consultant physician could know everything in medicine have long gone. The exponential increase in knowledge and the extraordinary advances in technology have seen the emergence of specialists, sub-specialists, and superspecialists'* (Turnberg, 2000). Nevertheless, the core values of medicine cross all disciplines in medicine. They can be seen as one way in which to help synthesise and unify the discipline and to cross specialist boundaries. These core values, identified by the British Medical Association for the 21st century, include:

"the ancient virtues of

- *competence*
- *integrity*
- *confidentiality*
- *compassion*
- *and commitment*

practised with an enquiring and impartial mind" (BMA, 1994).

These such qualities are exemplified in for example, palliative care which is described as *'a person centred approach concerned with physical, psychosocial, and spiritual care in progressive disease'* (Higginson, 1999).

As the debate about continuing personal and professional development needs, personal responsibility and integrity evolves, the words of Alexander Pope (Murrin, 2000) can usefully be recollected:

"A man should never he ashamed to own he has been in the wrong, which is but saying, in other words, that he is wiser today than he was yesterday".

(D) PROFESSIONALISM AND THE MEDICAL HUMANITIES

It has been noted that 'it will require intelligence and hard work to translate the principles of revalidation into a process that stimulates the continuing professional development of doctors but does not become an empty chore that diverts clinicians' time and energy from caring for patients' (Buckley, 1999). *'When the public is not in a good position to judge the quality of a service, the training, qualifications, and codes of ethics and behaviour of a self regulated profession have traditionally provided the desired protection. However, these structural characteristics of a profession are no longer enough to reassure a less deferential and better informed public ... Societies now expect evidence of the effectiveness of services and of the continuing competence of individual practitioners. The introduction of clinical governance within organisations and revalidation for individuals has been the first step to meeting this expectation in health care in the UK'* (Buckley, 1999). Criteria for 'professionalism' are therefore important.

The Windsor I conference noted that: 'professionalism is essential to help the arts (and all the humanities) in health and health care to move ahead' (p. 81), and that the term, professionalism implies:

- acquiring and maintaining a recognised level of competence in specific skills;
- adhering to an ethical code of conduct;
- having a sense of dedication and purpose;
- being prepared to take responsibility;
- retaining a certain amount of autonomy;
- being prepared to accept accountability for one's actions;
- willingness to collaborate and co-operate with others (Philipp et al, 1997).

Professionals, it was also noted there (p.81), have

- a public register of practitioners;
- available codes of practice;
- effective disciplinary procedures and sanctions;
- an established complaints mechanism.

It was considered that to progress the development of arts and humanities in health and health care, there are several interdependent, inter-professional needs for education, information, research, policy and service delivery projects. Improved team-working is needed (q.v. Table I below). Towards this objective, a working draft of shared ethical principles for everybody working in health care has been prepared by the Tavistock Group. Its intention is to recognise the separate codes of ethics developed for individual disciplines, but to help establish a shared code that might bring all stakeholders in health care into a more consistent moral framework (Smith et al, 1999).

In the words of Francis Bacon:

"This *communicating of a man's Selfe to his frend works two contrarie effects; for it redoubleth* Joys, *and cutteth Griefs in halves"* (Galatea Trust, 2000).
Whom then should become involved in professional networking for the medical humanities? Those professions identified from discussions of the Windsor I and II conferences are shown in Table I:

TABLE I: PROFESSIONAL NETWORKING FOR THE MEDICAL HUMANITIES

Identified for Working Group III, Windsor I Conference (q.v. Windsor I Report, page 82)	**Additions identified for the Windsor II conference**
architects	anthropologists
artists	art historians
artists-in-residence	behavioural scientists
arts administrators	classicists
art therapists	ethicists
counsellors	historians
doctors	journalists
health care planners	literature specialists
nurses	modern language experts
occupational therapists	philosophers
psychologists	social geographers
psychotherapists	social scientists
counsellors	theologians

The NHS supports improved networking. For example, "there is encouragement of 'horizontal' networks - NHS organisations working in partnerships with others towards solving problems, not reinforcing old barriers" (Dixon and Preker, 1999). The encouragement of health action zones, primary care groups (and healthy living centres)

has been likened to the 'vibrant horizontal networks' that are an emerging feature in successful European companies (Dixon and Preker, 1999). The WHO Regional Office for Europe has also noted that in many Member States public health infrastructures and functions will require strengthening and modernisation to support its policy for 'Health for All in the 21st Century': *'The education and training of public health professionals need to prepare them not only for their technical work, but also to act as enablers, mediators and advocates for health and population-based actions in all sectors. Educational programmes for professional groups, such as architects, engineers, economists, journalists and sociologists, need to provide the necessary knowledge, motivation and skills to support multi-sectoral action for health'* (Asvall, 2000).

The report of the Windsor I conference explored how the medical humanities can support such networking, particularly in its consideration of 'social capital', 'social entrepreneuring' and 'community action networks' (q.v. Windsor I report pages 56-59), and 'healthy living centres' (pages 61-78).

This networking is essential for the policy, education and research needs implied by mottoes such as *"cum scientia caritas"* - science with humanity and feeling, the motto of the Royal College of General Practitioners, UK, and the Royal New Zealand College of General Practitioners (also q.v. Windsor I Report, p. 102). Such networking has an ethical basis. For example, it has been reported that *'all health care workers share a common healing ethos, arising from the intimate nature of the doctor-patient relationship, the need to provide information and consent, the moral imperatives of confidentiality and truthfulness, and the collegial relationships within the medical profession'* (Campbell et al, 1997).

Key questions are emerging. For example, for doctors and nurses working together:

- Can the professions forge good working relationships in a context where an opportunity for one becomes a threat to the other?
- Are new guidelines emerging that facilitate team working?
- Are the barriers at the point of practice set up by nurses who are reluctant to take responsibility and doctors who are reluctant to share it?
- Are the barriers in another place, in the lack of adaptation of structures and processes in the regulatory bodies, perhaps, or in the policy framework of the new NHS? (Davies et al, 1999).

At least one nurse has reported that: *'Nurses have been indoctrinated with the belief that doctors are capable of exercising only a cold, scientific medical model. They treat the disease not the patient. Nursing literature is full of anecdotal accounts of the distant approach that doctors have towards patients and carers. Nurses, on the other hand, claim to practise in a holistic manner, caring, not purely about individuals' physical well-being, but also their emotional and spiritual needs. Rapid changes in technology and new treatments have necessitated changes in nursing practice. Many of these have been welcomed. Nurses have extended their clinical competencies, and as a result have challenged traditional roles of other healthcare professionals, particularly doctors. This would seem to be in line with the government's modernisation agenda for the NHS to improve access, shorten the wait in the system, and decrease lengths of stay. Indeed nurses may congratulate themselves in that the profession has spent the past two decades building up its unique*

body of knowledge, complex theories based on sociology and psychology, creating a pseudo science out of assessing patients, and writing care plans as part of the nursing process. But in this somewhat evangelical search for professional status nursing has slipped into the same trap that befell other prof essions and has created a professional mystique all of its own, with its own complex language and behaviours ... Let there be a warning to nurses, managers, and educationalists. Professionalisation in itself will not guarantee improved patient care. Our only hope is to re-educate nurses to care again ...' (Fletcher, 2000).

Underlying such issues are the questions of:

- Is there more to working together than making sure that the work of the one profession dovetails with that of the other?
- Is there really any content in the "co" words, so popular in government policy documents - co-ordination, collaboration, and co-operation? (Davies, 2000).

Interestingly, a recent *'Medline search on the MESH term 'interprofessional collaboration', including the terms 'doctor' and 'nurse', produced more than 1000 articles. Almost all were rhetorical or editorial, with some offering explanatory hypotheses or sociological theories. There were few empirical studies of the nature of the interactions, conflicts, and collaborations between nurses and doctors'* (Zwarenstein, and Reeves, 2000). Nevertheless, *'By its very nature the healthcare labour force is an interdependent one. The different occupational groups did not develop in isolation from each other but as part of a complex and interdependent system capable of carrying out the many activities that make up a modern health service ... Much effort has been put into team building and improving communication skills, but attempts at working together continue to be constrained by differences in styles of learning, in career patterns, in models of working, and in regulatory mechanisms ...As the 'core' skills and responsibilities of the different groups change, the organisation of the NHS labour force will be increasingly out of line with the traditional map of the healthcare professions. The resulting tensions will not be amenable to solutions devised by individual directorates or trusts or by different professional bodies working alone'* (Doyal and Cameron, 2000; Dowling et al, 1996).

The issues surrounding inter-professional networking also need to be extended to other aspects of communication (GMC, 1998). For example, effective chronic illness interventions generally rely on multidisciplinary teams so as to ensure that critical elements of care that doctors may not have the training or time to do well are competently performed (Wagner, 2000). At least one charity, Caring Matters, [caringmatters@dial.pipe.com], has too, been founded to empower and inform people facing the challenges and complexities of long term care and to help them become aware of their rights and responsibilities (Windsor, 2000).

In respect of *'caring societies',* thinking has therefore continued to evolve since the days of Sir William Osier who, in 1891, reported:

"In the gradual division of labor, by which civilization has emerged from barbarism, the doctor and nurse have been evolved" (Wagner, 2000).

The words of Machiavelli on clinical management are also apt:

"He who neglects what can be done for what ought to be done, sooner effects his ruin than his preservation" (Stone, 2000).

In doctor-patient relationships now, for example when managing chronic disease, ten communication techniques have been identified:

1. Attend to the patient (signalled by cues such as making eye contact, sitting rather than standing when conversing with the patient, moving closer to the patient, and leaning slightly forward to attend to the discussion);
2. Elicit the patient's underlying concerns about the condition;
3. Construct reassuring messages that alleviate fears (reducing fears as a distraction enables the patient to focus on what you are saying);
4. Address any immediate concerns that the family expresses (enabling patients to refocus their attention toward the information being provided);
5. Engage the patient in interactive conversation through the use of open-ended questions, simple language, and analogies to teach important concepts (dialogue that is interactive produces richer information;
6. Tailor the treatment regimen by eliciting and addressing potential problems in the timing, dose, or side-effects of the drugs recommended;
7. Use appropriate non-verbal encouragement (such as a pat on the shoulder, nodding in agreement) and verbal praise when the patient reports using correct disease management strategies;
8. Elicit the patient's immediate objective related to controlling the disease and reach agreement with the family on a short term goal (that is, a short term objective which both provider and patient will strive to reach that is important to the patient);
9. Review the long term plan for the patient's treatment so the patient knows exactly what to expect over time, knows the situations under which the physician will modify treatment, and knows the criteria for judging the success of the treatment plan;
10. Help the patient plan in advance for decision making about the chronic condition (such as using diary information or guidelines for handling potential problems and exploring contingencies in managing the disease (Clark and Gong, 2000).

In 1998, working towards a second Windsor conference for the arts and humanities in health and medicine, the possible establishment of an Institute of Medical Humanities was first discussed and in the context of professional development (q.v. report of the Windsor I conference, page 51). The concept can also be seen in the context of sustainable development and five sequential indicators of progress with the Nuffield Trust initiative for the arts and humanities in medicine:

- the Declaration of Windsor (from the Windsor I conference)
- the Action Plan (from the Windsor I conference)
- the Resolution (from the Windsor I conference)
- the Communique (from the Windsor II conference)
- progress with developing an on-going structure and purpose for the work (i.e. this present report).

SECTION II. **THE SECOND NUFFIELD TRUST CONFERENCE ON THE ARTS AND HUMANITIES IN HEALTH AND MEDICINE,** 6-7 September 1999

The programme and names of participants at the Windsor II conference can be found in Appendix IV

THE STRUCTURE OF THE WINDSOR II CONFERENCE

The Steering Group for the Windsor II conference recognised that:

- sustained effort is essential to ensure success of the Nuffield Trust arts and humanities initiative and that such effort should be in the interests of *'sustainable'* development;
- the Declaration of Windsor and the 12-Point Action Plan , prepared at the Windsor I conference, (q.v. Appendices I and II of the present report) provided the rational base from which to plan forward;
- without a continued central initiative, sustained, collaborative national and international progress for the arts and humanities in health and health care is unlikely.

The Steering Group identified that in the Opening Session of the conference:

1. participants would be welcomed and their role explained;
2. the purpose of the Windsor II conference would be explained in the context of the Windsor I conference and the possibilities for future development;
3. reference would be made to developments since the Windsor I conference, especially those that flowed from it;
4. it would be explained how the tasks identified for the three Windsor I Working Groups had been managed since the first conference.

Three Working Groups were established to explore and report at the Windsor II conference on:

- research;
- a proposed 'Virtual Institute';
- new ways of working.

Each Group Chairman was charged with producing in co-operation with the group rapporteur:

(a) a coherent vision for their particular area;
(b) a practical plan for achieving it;
(c) a 10-minute oral report for the final plenary session;
(d) in co-operation with the rapporteur, a summary of the group's discussions and outcomes for incorporation into a 'Windsor II report';
(e) help to co-ordinate a publication arising from deliberations and outcomes of the conference.

Each Group Rapporteur was charged with preparing:

(a) the 10-minute oral report for the conference on the vision of their particular topic area and the plan of action;
(b) a summary of the Group's discussions and outcomes.

Sir William Reid, former Health Service Ombudsman, was invited to deliver a comment at the end of the final plenary session on the vision identified by conference participants and the plan of action for each area, and to supply a unifying theme linking work undertaken during the Windsor II conference with the Declaration of Windsor. He had prepared this Declaration previously for The Nuffield Trust from conclusions of the Windsor I conference, with a 12-point Action Plan (They are reproduced in Appendices I and II of this present report).

THE PROCEEDINGS OF THE WINDSOR II CONFERENCE

(A) BACKGROUND WORKING PAPERS PROVIDED FOR EACH PARTICIPANT

As a basis for the Working Group Discussions, each delegate was given a copy of the following 'working papers':

1. Philipp, R. 'A User's Guide To The Practice And Benefits Of Arts In Health Care And Healthy Living', based on the recommendations of the Windsor I conference, Working Group 3: 131 pages (q.v. Windsor I conference report, pages 103-107);
2. Baum, M. 'Some Thoughts On The Teaching Of Arts And Humanities Within The Medical Under-Graduate Curriculum': 16 pages;
3. Harris, P. 'A Short Story Of A Life And Illness': 5 pages;
4. 'Protocol Between The Ministry Of Culture And Communication And The Ministry Of Health And Social Security', (France): 36 pages;
5. Hodgson, K. and Mather, K. 'Arts And Humanities In Medicine - An Undergraduate Perspective - Current Curriculum - Personal Experiences': 11 pages;
6. El-Kadi, G. 'An English Undergraduate's Experience At An American Institute Of Medical Humanities': 39 pages;
7. Arnott, R. 'Tomorrow's Doctors And The History Of Medicine': 30 pages;
8. Benatar, D. 'Philosophical Ethics': 8 pages;
9. Bolton, G. 'A Different Way Of Being: Reflective Practice At The Turn Of The Millennium': 13 pages;

10. Lloyd, D. 'Participatory Arts - Helping To Create Local Environments For Health?': 10 pages;
11. Creber, M. 'Bromley By Bow Living Centre: Art In Health': 15 pages;
12. White, M. 'Where's The Map? Finding A Place For Arts In The Community': 18 pages;
13. Rigler, M. 'Arts And Health In Dudley': 17 pages;
14. Anon. 'Dance And Health': 9 pages;
15. Anon. 'Eric's Chapter': 20 pages;
16. Anon. 'Looking Well: Photos': 5 pages.

(B) INTRODUCTION: SETTING THE SCENE

Sir Kenneth Caiman, Warden and Vice Chancellor of Durham University.

In his address, Sir Kenneth Caiman noted that:

'In 1996 when we first called a group together to explore ways forward for the arts and humanities in health and medicine, I believed that this whole area was 'an idea whose time had come'. Since then, and following the Windsor I conference in March 98, a lot has happened: we have seen several conferences, local, national and international, and numerous people have written about interesting and enlightening things they are doing.

There is now an increase in possible funding for this kind of area - Regional Arts groups, sponsorships, particularly business sponsors for the Arts, the creation of NESTA, a national organisation for bringing together the arts and sciences which will begin operating soon, and there will be new Opportunity and Millennium Funds. The numbers are increasing, which shows recognition by the decision makers and politicians that this is quite an important area.

Looking back through the report of the Proceedings of the Windsor I conference, *Humanities in Medicine: Beyond the Millennium,* we set out at that conference to:

- take stock and ask ourselves what was going on in undergraduate education, community development and the arts as therapy;
- see how we could practically apply that; and to
- develop an action plan.

The Windsor I conference finished with its first outcome, a Declaration of Windsor which set the tone for the way forward and gave some idea as to where we should go. We adopted several points in areas where work needs to be done:

- use existing resources and talents to better purpose;
- develop and expand existing skills, expertise and knowledge;
- prepare a taxonomy of achievements and collaborations;
- emphasise the need for health professionals to deal with people sympathetically and without condescension;
- encourage the growth of projects involving various sectors around the country.

The second outcome was a 12 point Action Plan. It is salutary to look through what we said we would do 18 months ago:

Medical education:

- medical students will be given the opportunity to study humanities during undergraduate education;
- all university medical schools should incorporate humanities and in particular moral philosophy, literature etc;
- studying a mix of Arts and Science subjects at A level should be no bar to securing a place at Medical School;
- create a national database of practice and research in the medical humanities.

Arts and therapy:

- provide a Users Guide. The draft is now available and has been distributed to Windsor II conference participants (q.v. Background Working Paper, No.l, above). It is a huge compendium of information, which has been a very important product of Windsor I.
- publish other documents, catalogue various on-going initiatives, spread awareness of current activity and develop tester courses at undergraduate level for healthcare practitioners.

Arts and community development:

- promote the notion of arts as a means of self expression, a catalyst for strengthening and energising communities.
- integrate the arts into Health Action Zones and Healthy Living Centres, an important part of the political agenda.

All around the country, and particularly where I am now based in the North East of England, a very significant amount of work is going on to develop the arts and humanities for health and medicine.

These are some of the things that we said we would do. In terms of development in professional education we have come quite a bit of the way although we could do more and go further; setting up a Centre for the Arts and Humanities in Health and Medicine in the University of Durham is quite an important part of that.

Arts and therapy is also a remarkable area with an enormous amount of work going on. There are considerable links too with sports and movement. At Durham, for example, we have a degree validation programme for the Royal Academy of Dance, and I have a contact with the Foundation of the Community of Dance. A lot of this is covered in the Users Guide (op.cit.).

The third area, Arts in Community is perhaps the most striking, with an increasingly wide range of activities all over the country and a lot of interest internationally. With all the skills available here, the UK could well become a leading force in the development of this area. At a very practical level, the Reverend Andrew Mawson's development of the Community Action Network (CAN), providing access to information and help on a whole range of things, is another example of how the community is able to offer support in an interesting and unusual way.

There are three issues which need to be taken further and these are the subjects of this conference:

- How do we bring the activities together and plan for future development in the UK: how should proposals for a Virtual Institute evolve?
- Evaluation - thinking how we can develop programmes for evaluation is a central part of this conference.
- The questions and issues are changing fast. We need to see how we can do things differently, find new ways of working and re-think the agenda in a different kind of way.

We can learn enormously from other areas, not just the university sector or the community arts sector, but in other places where exciting things are being done. This is an idea whose time has very definitely come, and over the next 24 hours we have the opportunity to find ways in which we can move this forward over the next 18 months-2 years.

I am delighted to be here, and that the Nuffield Trust is continuing to support this venture, and I look forward to the conclusions tomorrow'

(C) KEY POINTS FROM THE INTRODUCTORY SPEECHES

RESEARCH AND EVALUATION

Dr Robin Philipp

To paraphrase what the tortoise said: *'To take a step forward we have to stick our necks out'!*

'The purpose of coming together again is to look at how we can drive our thinking forwards for the arts and humanities in health and medicine with an integrated model; we need to tie Windsor I into Windsor II by looking again at the concepts and the background to the Windsor I conference, how the advocacy issues for the arts and humanities in health and medicine emerged from this, and how, since then, frameworks have been shaped for different groups of health professionals to develop their interests and to begin to explore evidence for the public health gains. On-going collaboration across the disciplines is essential for sustainable development of the arts and humanities in health and medicine. Moreover, in today's society, as we have noted previously, *'to address questions raised by the needs of sustainable development, future environmental quality debate will ... have to be broadened and encompass increasingly important public health concepts such as 'personal well-being' and 'loss of environmental opportunity' as well as the more traditional concerns'* (Philipp, 1996). Standards will too, need, in time, to be set for the educational and policy programmes that are evolving from the research and development work that is going on.

In the background to the present needs for improved research and evaluation, at a meeting convened by the Wellcome Foundation in 1993 for the arts and health, there were two principal groups of people in the auditorium. On the one hand the artists there were saying 'this is what we do, we know it helps people, there is some evidence to show this', and on the other hand the health care purchasers in the room were saying 'we hear what you say and it's very exciting but it's the quality of that evidence we need to examine'.

Since the Windsor I conference, information tools to use with research and educational development projects have started to emerge, not only for our own use but for others to pick

up on, and so that people can start to do things at a local level with the back up of the quality research evidence which we hope will soon start to accrue. For example, a framework to help design studies to evaluate the effectiveness of the arts in health care has been published (Philipp, 1997).

To illustrate what can be done at the local level, there is a small town 12,000 miles away in New Zealand called Bulls. The community there decided to use its name, Bulls, to help enhance the image of the town. They named the Visitor Information Centre, 'lnform-a-Bull'. The idea caught on. If you want to buy antiques there you now go to 'Afford-a-Bulls'. The Health Centre has become 'Cure-a-Bull' and the Pharmacy is 'Indispens-a-Bull'. A policeman is a 'Consta-Bull'. This brought people together and helped them to engender a new community spirit. This town, Bulls, is incidentally, twinned in the UK with Cowes! Another small township nearby, Martin, was, I am told, reconsidering its own situation at the same time. It was explained to me that there had been considerable unease there because they had experienced four suicides of young male residents during some recent eighteen months. As part of the concern, I understand residents asked themselves if there could be anything about Martin as a place which might be giving people a self-deprecatory personal image and if so, if anything could be done about this?' They apparently decided to call themselves the 'garden city of New Zealand' and set about getting everyone to take an interest in the landscaping, house gardens, architecture, development and mythology of the gardens. I am told that there was an apparent association there of this initiative with the community well-being and spirit which has emerged, and that to date, there has been a much improved general morale and no further suicides.

Although this may not have been 'cause and effect', there could be a message in it for us. For example, every two hours someone here in the UK commits suicide. What might we be able to do about problems like this, and given the example I have just cited, in terms of building an evidence base for roles of the arts and humanities in health and medicine, how should we examine the quality of research evidence, such as it is at present? How might we too advance this evidence base in terms of getting better quality information from well-designed qualitative and quantitative research studies to support the sorts of initiatives we are all involved in? We need to show clearly if there are health benefits and what they are.

Participants at this Windsor II conference have been given the first draft of 'A User's Guide to the Practice and Benefits of Arts in Health Care and Healthy Living'. It has been prepared from a recommendation of the Windsor I conference. It is, at this stage a consultation document for our further consideration. Following the Windsor I conference it emerged that a lot of different projects and programmes were being started, but with little co-ordination or guidance as to how they might be best developed and extended. The User's Guide was written with these points in mind. It is in three parts:

- Part I: suggestions for developing a research framework to explore further the evidence base for health benefits;
- Part II: guidance for health care purchasers and providers;
- Part III: theory underlying the interdependent psychodynamics of health, creativity and aesthetics.

In now trying to draw closer together the needs for research and evaluation and find ways of moving forward with educational development, policies, practical programmes and audit of the activities, one dilemma has been the apparent dichotomy between the two separate arms of the *'artistic'* and the *'scientific'* approaches. The professionalism of each approach comes at questions of the arts and humanities in health and medicine from different mindsets. Each is however informative and expressive with its own evidence base, and like the two sides of an ancient Roman bridge, both are needed. With this metaphor, what this conference is seeking to identify is the keystone that holds both sides together and that will take us forward. We are attempting too, to look at both *'the art of science'* and *'the science of art',* to see what each can contribute synergistically In the Working Group for research and evaluation for this conference we need to draw up a framework which incorporates these points.

In sustainable development for the arts and humanities in health and medicine, we should remind ourselves that education, research, information, policy and progress are interdependent. Therefore, from the debate about concepts and an advocacy background that led to the Windsor I conference, we need to move on now to develop collaborative frameworks and an evaluative vision. This will help us to establish the most appropriate model, or models, for truly sustainable development in this area of medicine. The *'quality'* of what we now go on to do and how the work is presented for wider scrutiny is what will, longer term, help us to make a difference for the good of the public health. Therefore, as a recent editorial reported, *'perhaps we need to have a little economic modelling to demonstrate the personal and societal benefits of putting more effort into delivering a health service rather than a sick service'* (Editorial, 2001a).

A pilot economic model we used in work for the Windsor I conference to explore potential health gains and saved direct health care costs from arts and humanities interventions has attracted widespread public and news media interest since the press conference following Windsor I. As sophisticated models for such purposes are not yet available, this pilot model and its derivation deserve closer examination:

An evaluation of possible direct health care cost savings from self-help 'poetry and healing' projects:

Introduction

The British pioneer clinical epidemiologist, Archie Cochrane, defined the concepts related to testing health care interventions. He reported that *'efficacy'* is the extent to which an intervention does more good than harm when provided under usual circumstances of healthcare practice ('Does it work in practice?'), and that *'efficiency'* measures the effect of an intervention in relation to the resources it consumes ('Is it worth it?'). Efficiency trials he noted, are more often called cost effectiveness or cost benefit trials (Haynes, 1999).

'The constant introduction of new health technologies, coupled with limited healthcare resources, has engendered a growing interest in economic evaluation as a way of guiding decision makers towards interventions that are likely to offer maximum health gain. In particular, cost effectiveness analyses - which compare interventions in terms of the extra or

incremental cost per unit of health outcome obtained - have become increasingly familiar in many medical and health service journals' (Briggs and Gray, 1999). It has too, been reasoned that sustainability can be better operationalised using measures of economic 'stock' (capital, including natural capital and human resources) than using measures of 'flow' (income) (McMichael and Powles, 1999). Nevertheless, the nature of cost of illness studies has been the cause of debate among economists. It is considered that current research efforts "would be better focused on undertaking economic evaluations, such as cost effectiveness evaluations, which involve assessing both costs and outcomes" (Byford et al, 2000). Starting points are therefore need for comparative costs of different treatments and new approaches are being identified. For example: 'extreme scenario analysis involves setting each variable to simultaneously take the most optimistic (pessimistic) value from the point of view of the intervention under evaluation in order to generate a best (worst) case scenario' (Briggs and Gray, 1999).

Within these health economics frameworks, mental health problems involve considerable direct health care costs. For example, in the UK, the Department of Health has estimated that the cost in England, in 1999, amounted to £32.1 billion (Department of Health, 1999). In the United States, suicide is currently the eighth leading cause of death and is, with homicide, the third leading cause of potential years of life lost (van Wijngaarden et al, 2000). Within Canada, each suicide in New Brunswick costs nearly $C850,000 (£UK354,000) presumably for treatment of the unsuccessful, necropsies, funerals, police investigations, and lost productivity. Suicides there account for about 2% of deaths in the province and in 1996 cost nearly $C80m in total, excluding the cost of mental health services and lost productivity in bereaved family and friends (Editorial, 1999e).

The preventable elements of suicide are too, largely determined by social pressures (Carnall, 2000). It has for example, been reported that 'most *young people involved in repeated parasuicide come from appalling backgrounds of physical and sexual abuse. Small wonder they feel worthless, unloved and unwanted ... if the value of human life depends on being loved, wanted, perfect and free from pain, it should be recognised that, for these tormented youngsters, suicide is a rational decision'* (Freemantle, 1999).

Within the spectrum of mental health problems, anxiety is a major issue. A landmark World Health Organisation epidemiological survey conducted recently in five European centres estimated that 11.5% of patients attending primary care suffer from well defined anxiety disorders, while a further 4.1% were found to have threshold generalised anxiety (Anderson, 1999). Only about one third of definite cases were recognised, and of these even less (about 60%) received any intervention. Among consecutive primary care attenders, 4.6% consulted specifically for anxiety symptoms (Weiller et al, 1998). In the United States researchers have estimated that anxiety disorders accounted for $US46.6bn (35%) of the total economic costs of mental disorders in 1990 (Rice and Miller, 1998).

For these such reasons, in 1984, European Target for Health No. 12 reported that: 'By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide'.

Estimates of the direct health care costs from prescribing for depression in the UK

The UK Government Report, The Health of the Nation (1992), reported that the lifetime risk for depressive disorders amongst persons over 16 years of age is greater than 20%. Therefore, as the population of the UK is approximately 56,000,000 persons, 11,200,000 people during their lifetime will experience depression. If the average UK lifespan for both males and females is taken as 74 years, then during every 12 months period in the UK, 151,351 people will experience depression.

It is known also from costings for 1992, of the direct health care costs of antidepressive treatment, that £81 million are spent per annum in the UK (Editorial, 1993). This is equivalent to £535/treated person/year (derived as £81 million / the 151,351 persons who experience depression during every 12 month period in the UK). The assumption however, with this cost estimate is that each of the 151,351 persons who experience depression each year are also treated pharmacologically for it. It may therefore be an over-estimate. Nevertheless, information does not at present seem to be available for the proportion of people identified by The Health of the Nation (1992) who require pharmacological treatment for their depression.

Another estimate for the direct health care drug costs for antidepressants can be derived from calculating the cost of prescribing one antidepressive medication for one person for 12 months and from pricings in the British National Formulary. The approximation for 1992 is £300/person/year. For the year, 2001, this estimate is £375 (UBHT Pharmacy, personal communication).

How might poetry help reduce these direct health care costs?

In 1996, we reported a small qualitative study in which we looked at responses from members of the public as to whether or not reading or writing poetry might benefit people's health (Philipp and Robertson, 1996). We had first posed the question in a letter published in 1994, (Philipp et al, 1994). During the first two months following its publication, there was considerable news media coverage of this letter. We received 196 unsolicited letters and telephone calls from members of the general public, reporting their positive experiences with poetry (Philipp and Robertson, 1996). Amongst the respondents, 6.6% (13/196) reported that they had been able to wean themselves off benzodiazepine tranquillisers or anti-depressants as a consequence of discovering poetry for themselves. They had apparently found a relaxing or self-affirming effect from either writing out their thoughts, feelings and emotions as poems about something on their mind, or by reading published poems and identifying with their themes, moods and rhythms. Given therefore that the lifetime prevalence of depression in the UK is around 20% of the whole population, we could postulate that poetry might benefit some of these people. But by how much? Could it perhaps be, as the findings of this small qualitative study suggest, as many as 6.6% of all people with depression?

Based on this reasoning, we could speculate that a similar proportion (6.6%) of the general population who each year experience depression might benefit from writing or reading poetry; i.e. 10,039 people (derived as 13 / 196 (6.6%) of the 151,351 persons with depression each year in the UK).

If then, at 1992 costings, the pharmacological costs of treating one person for 12 months really are £535 per annum as estimated above and, as a conservative but reasonable estimate, we assume the average duration of this pharmacological treatment for any individual is only four months during any 12 month period, £178.33 (£535 / 3) is being spent / person / year in the UK on direct treatment costs for depression. We have, above, estimated that 10,039 people each year might benefit from a poetry intervention. Accordingly, we can speculate that the annual direct care savings in the UK from widespread use of poetry as an intervention rather than drug treatment could be, at 1992 costings, £1,790,255 (derived as £178.33 x 10,039 people). If however, the estimate derived above from British National Formulary prices for 1992 is used, the annual direct care savings estimate would be £1,003,900 (derived as £300 / 3 x 10,039 people). At 2001 prices, it would be £1,254,875 (£375/3 x 10,039 people) - a 25% increase.

Another population base that can be used to derive estimates of direct savings in drug treatment costs is the UK-wide Survivors Poetry network. Its some 3,000 members believe they have survived the mental health care system through finding poetry for themselves. If only 10% of these people find they can then manage without pharmacological treatment, then 300 people are "saved" from direct health care costs. These costs were in 1992, from the above data, £535 - £300 / person / year = total saved health care costs of £160,500 - £90,000 per annum. At 2001 prices, these savings become 25% greater: £192,600 - £108,000.

There are several assumptions implicit in such estimates and they are based on very limited data. They could therefore be inaccurate. Nevertheless, cost-benefit studies for arts and humanities interventions in medicine do not seem to have been previously undertaken. They are needed. This example suggests that arts interventions can result in considerable direct health care cost savings. It is worthwhile, in reaching this conclusion, to recollect that if a widely practicable treatment or preventive measure *'could be shown to reduce the absolute risk of death and disability by just a few per cent, then, because this might affect the treatment of hundreds of thousands of patients, it could protect thousands from death or disability* (Dickinson et al, 2000).'

A VIRTUAL INSTITUTE FOR THE ARTS AND HEALTH

Sir Kenneth Caiman (standing in for Professor Michael Baum)

'It is important that everyone understands what we will be talking about in this working group. We will spend some time over what a 'virtual institute' might actually be called, but the underlying concept is that within the UK we have the significant resources of universities, medical schools and community arts groups. The question is how best can we bring this together, both from a research point of view and an education and training perspective, *as something that will begin to change things.*

Important questions this group will have to think about are:

- If there was to be such a virtual institute, what would it do?
- What would its range and scope be?
- How will it work? How will it be organised and how will it link with existing groups?
- How can we bring together and focus the great deal of work already going on in this area?

One model could well be a central advisory 'something' with a series of collaborating centres around it, but we will look at different models. It is relatively easy to think about what it might do, but more difficult thinking about how it might operate. There are also likely to be significant sensitivities amongst participants of this conference about who would do it and how it might be organised. Also, how would it be funded and what would it be called? The draft 'Users' Guide to the Arts in Health Care and Healthy Living' given to participants, gives an interesting possible agenda for such a centre, with the Nuffield Trust as a central part (p21).

How do we develop it? Areas that would be of interest certainly at the University of Durham are: professional education; publication of documents; developing the evidence base; courses of various sorts to raise awareness; interaction with Healthy Living Centres and Health Action Zones. Any central part would not necessarily do all of that, and other collaborating centres may be the appropriate place to raise particular issues.

We have ahead of us an interesting but difficult discussion. We are fortunate at this conference in having people from other countries - for example the USA - who might give us some insight on how this has been developed elsewhere.

In terms of taking things forward from this conference, and into *the future,* a central issue will be the evidence base and how it is developed. This virtual institute could be the vehicle, or mechanism for allowing the considerable skills, many of which are represented at this conference, to be brought together.

If we can get our act together and the funding to do it properly, we could set a beacon for other places and show that the UK is going ahead quite rapidly on this. It will be an exciting 24 hours but not an easy one. I am delighted to be chairing it.'

NEW WAYS OF WORKING

Reverend Andrew Mawson

'To illustrate new ways of working, I would like to relate two experiences I had this summer:

My 19 year old son's friend has been spending time at our house and as 19 year olds do they wonder about the future of their lives, talking endlessly until the early hours of the morning. I went downstairs at 3 am and found them working on a list of entrepreneurial ideas - they want eventually to work but don't want to start on anything less than £100,000 p.a. I began to think back to the 1970s and my own hippy days and thought how the world has changed.

The second experience was spending time with a relative who has worked in the health service as a psychiatric nurse for some 20 years and is now running a Healthy Living Programme. He told me of the massive frustration of working in the health service; for example, why is it the government has taken a vertical silo where everything worked in vertical straight lines and turned it 90 degrees into what is called partnership which is a horizontal silo where everything works in horizontal straight lines?. Every part seems to work in the same endless torque. My relative asked for £5000 last March to help a project get started; six months later paperwork is still going through a committee in Manchester, they cannot trust him with £5000. What he believes we need is not another silo but a network where people move all over the place on the basis of what they want to deliver and what they want to do.

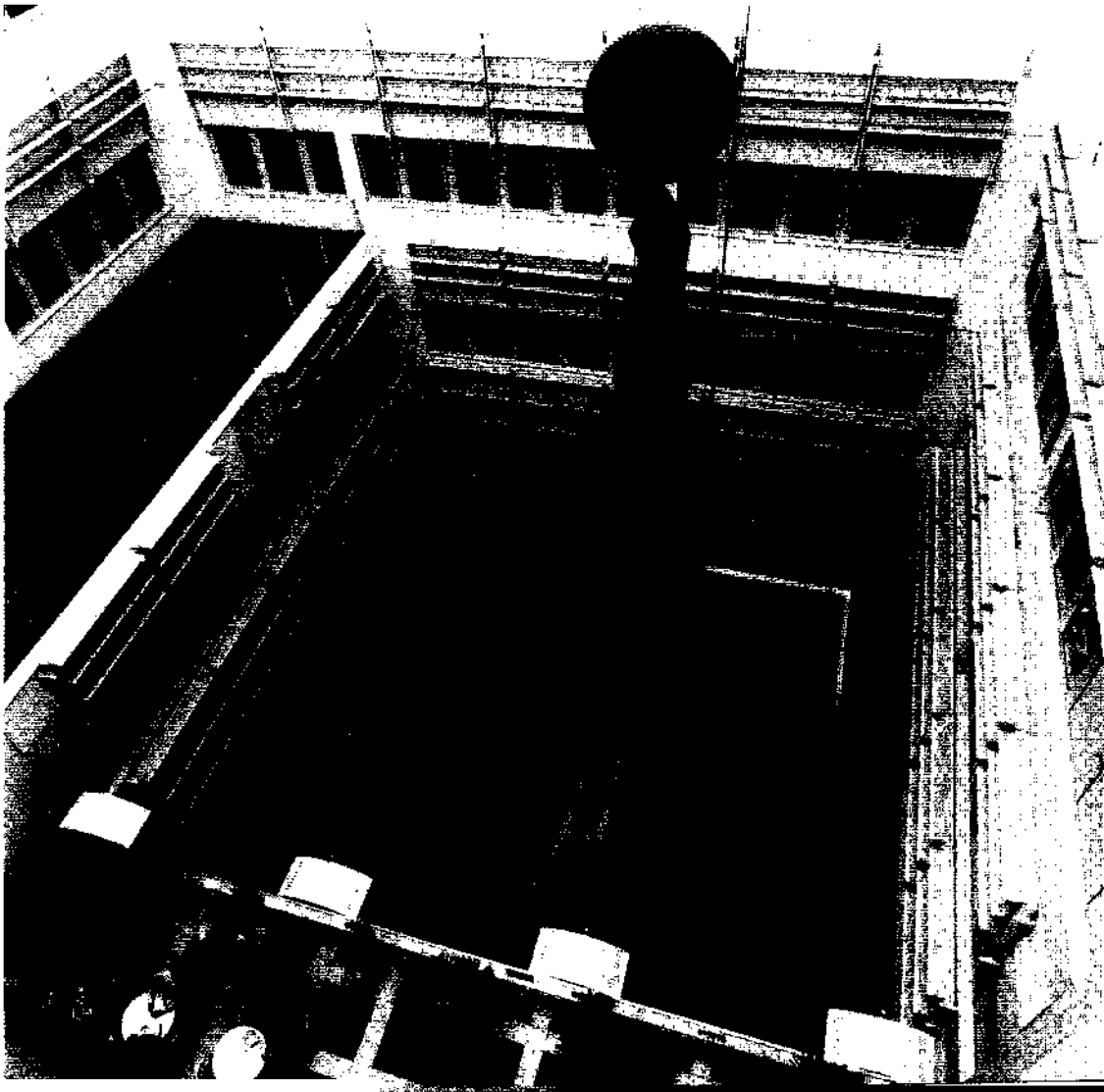
We live in a world which is changing at a serious pace. Charles Leadbetter's book *'Living on thin air'* (Viking, 2000: ISBN 0140277935) gives an excellent description of why the world is changing as it is. It explains the implications of new technology and why, at the speed all this is moving, new levels of flexibility are needed. New structures and organisations will have to trust people who have worked some 20 years in their service with £5000. They are going to have to get serious about a whole range of new values if they are to survive, as indeed quite a lot of businesses are having to do. Charles Handy in his latest book The New *Alchemists',* (Hutchinson, 1999: ISBN 0091802156) features 29 people, from the business and social sectors, who have taken what he calls base metal and tried to turn it into gold. All sorts of different people are there, quite a lot of whom failed at school and left at 16; one or two suffer from dyslexia. One guy started with a drum kit he bought for £40 and sold for £60 and now he has a £60 million business.

The local authority in Hartlepool have apparently decided not to employ people unless they get degrees. If this trend continues, half of the people who build massive businesses, including Sir Richard Branson, would not be able to get a job. As we move into this new culture and environment a lot of the ideology, and some of the liberal values that our generation have grown up with, are going to have to be abandoned in favour of some new thinking, new values and new ways of working. I think that's what I saw when I went downstairs in the early morning in my own house.

At the Bromley by Bow Centre in the east end of London, over the last 15 years we've tried to pioneer healthy living centres and have connected GPs with arts, with parks, and with housing. We're now pioneering an idea about a water city. It is all based on an organic model of backing people before structures. Germaine Greer came and spent some time with us and at the end she commented that what was going on was neither top down nor bottom up, but actually inside out; we find centres of energised people and back them with real money so that they can expand and multiply and form relationships with each other. We trust in them and they just get on with it.

Instinct tells me that you can't put new things into old environments. You need to create new environments. At CAN (Community Action Network) we have started to create the beginnings of a virtual market place. If you can spot people who are doing arts and other projects and being entrepreneurial, you can begin to connect them together. For example, anyone wanting to start a Healthy Living Centre can be put directly in touch with someone who has actually built one, and so you start to create a person-to-person environment where decisions can be made today and acted on tomorrow, not six months later. We now have the first 200 members and by the end of the year 2000 we will have 2000 people all trying together to build this new environment.

A range of people are trying to build a more enterprising culture. We are in conversation with 15 different places around the country about opening Community Action Centres which will seek to bring together the dynamic bits of business, the public sector and the social sector. We've opened the beginnings of one in London in Haymarket. We are there and some good businesses are there, for example the former Saatchi and Saatchi who are looking at the whole social marketing question. We now have a partnership with Coca-cola who are beginning to get very close to the idea of bringing some of their serious marketing budgets onto this agenda. We also have the Youth Net site there, set up by Martin Rivers, as a whole load of technology and information for young people which now has a thousand users each day.



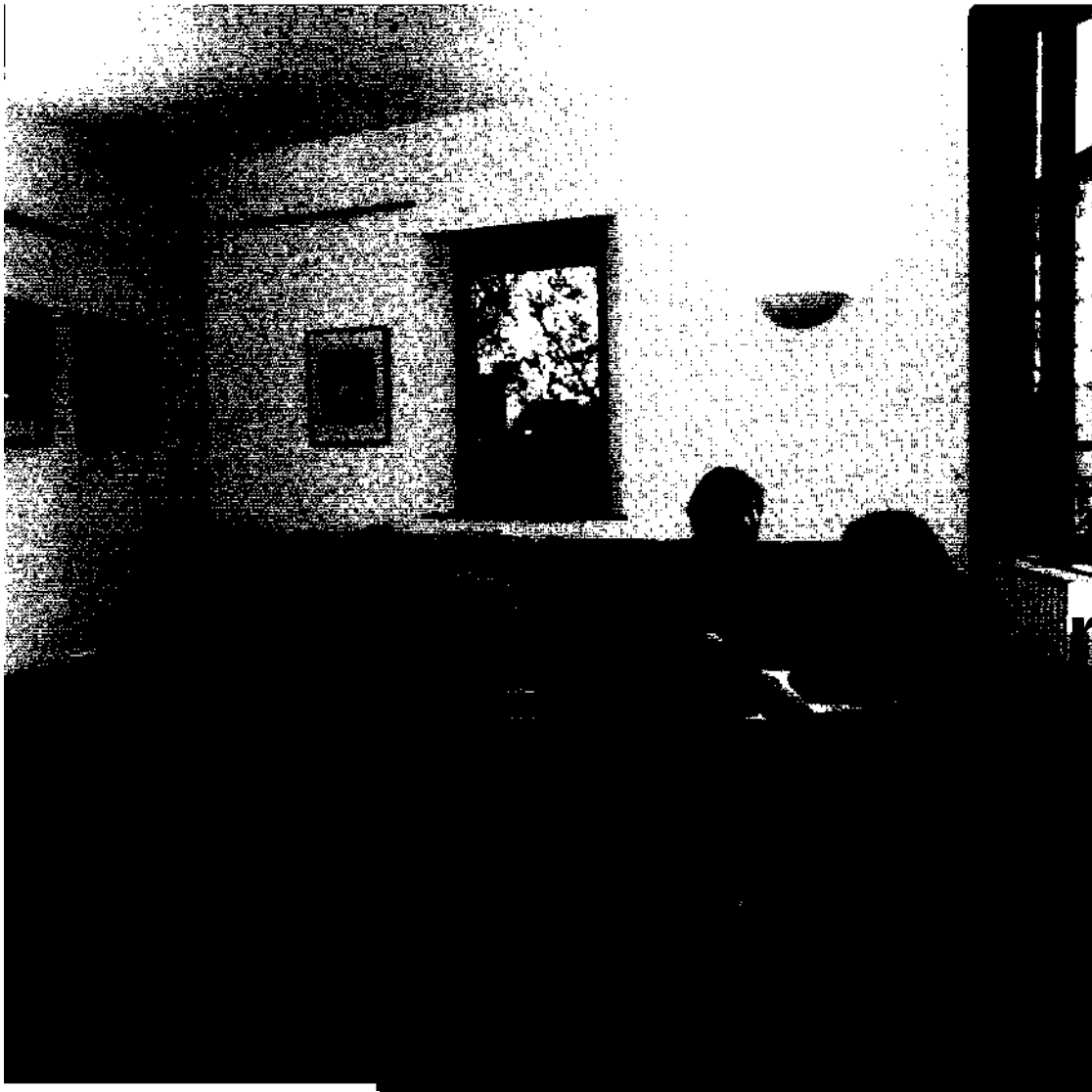
'The Acrobat' by Allen Jones, at the Chelsea and Westminster Hospital

The Intensive Therapy Unit at the Chelsea and Westminster Hospital

Opposite: Sheehagh McKinlay, stained glass artist, at work in her studio at Bromley-by-Bow Healthy Living *Centre*

Colour, patterns and movement lighten this place — the Main Reception, including the Dolphin Clock, at the Bristol Royal Infirmary for Children

In a prayer room reflections have many meanings — the Chapel at the Bristol Royal Infirmary for Children



A room for staff at Bromley-by-Bow Healthy Living Centre

Sculpture and community: father and daughter enjoy the Bromley-by-Bow Healthy Living *Centre*

We've just opened one in Cumbria, with a Vicar who already runs a multi-story car park with the unemployed, a house for the homeless, two churches and three cafes. We've just bought a building together in the middle of Whitehaven and hope to open this as an art gallery, a place that brings the three sectors together. We are also in conversation with the Health Authority there about becoming a Healthy Living Centre. In Hartlepool we found a church run by a civic entrepreneur who is director of leisure - a beautiful building, again with an art gallery. The local authority have taken it over and it is going to become a Community Action Centre.

Can we create a whole new environment? This is what we are trying to say to this Government - can we build a way in which those involved in health and art and enterprise can actually begin to connect together? I hope that what we do here is find a creative way to connect all of this. I am very sure that the future is about a business environment. It is about delivery and it is about communities in business, not communities in community. If that is true it will involve risk taking, new values, people trusting each other. I thought of writing a paper on this policy and calling it 'Close your eyes and think of England'.'

(D) FEEDBACK FROM RAPPORTEURS OF THE GROUP SESSIONS

Two preliminary points were made by the chairman of this session:

- It is very important to recognise the enormous amount of effort going on right across the country in this area.
- The advantage of spending two days at Cumberland Lodge, Windsor Great Park, is not to set that aside as unimportant, but rather to take time out to look at what sort of strategic framework and medium to long term plan of campaign is needed to ensure that this becomes embedded in the way that medicine and healthcare is delivered to the people of the UK - to ensure more universal application of those activities.

Group I. The Virtual Institute of the Medical Humanities

At the Windsor I conference it was proposed that a national body should be established to promote the place of the arts and humanities in improving health. Working Group 2 from the Windsor I Conference was asked to develop a plan for the establishment of such a body. This report summarises the conclusions of the working group and outlines its recommendations.

The Aim of a National Body

The working group proposes that the aim of a national body should be to work for an improvement in the quality of life for the community, patients and professional groups by fostering synergy between the arts, humanities, healthcare and health across the United Kingdom.

The Justification for a National Body

At present important work is being undertaken by a variety of community groups, organisations and individuals that is consistent with these aims. A national body would be able to support these initiatives by providing a mechanism for co-ordinating this work so as to make the best use of the resources available and help in the dissemination of good practice.

The working group also believes that the establishment of this national body can be justified because there are areas in which this synergy can have nationally important practical outcomes for the community, patients and professionals.

We are all members of the community whether we are healthy individuals, suffer from ill health, seek help from the medical professions thus becoming patients, or have professional skills to offer the community. Therefore, we all have an interest in fostering health within the community. The arts and humanities can contribute to this in the following ways by:

1. fostering alliances for health;
2. empowering the community to improve health;
3. improving the expectations and potential for a healthy life within the community;
4. broadening the understanding of health and its determinants;
5. fostering an understanding of the importance of the aesthetic quality of the environment in health;
6. acting as a medium for the promotion of health.

When individuals become patients, the arts and humanities can work together with healthcare providers to understand the experience of illness and its treatment by:

1. providing therapeutic interventions for some conditions;
2. investigating the effectiveness of these therapeutic interventions;
3. fostering an understanding of the experience of illness and its treatment in patients and professionals making interventions more sensitive to patients;
4. fostering an understanding of health in patients and healthcare professionals.

Professionals both from the sphere of healthcare and the practice of the arts and humanities can benefit by:

1. fostering personal and professional development;
2. developing transferable skills;
3. challenging the goals of professional groups;
4. challenging established professional attitudes;
5. contributing to the understanding of the clinical judgements made by healthcare professionals;
6. fostering an understanding of the importance of the aesthetic quality of the environment in which health care is delivered.

The Structure of the National Body

The working group proposes that the national body should have a federal structure consisting of partner centres with one of these acting as a national co-ordinating centre. In order to be considered as a partner centre it should be situated within an educational or research institution and have expertise in either the development, delivery or evaluation of initiatives in the arts and humanities in relation to health and healthcare. It was unanimously agreed that the co-ordinating centre should be situated within Durham University.

Associate Membership

It was also proposed that associate membership be established open to individuals who have an interest in the arts and humanities in health and healthcare. A small annual subscription would be charged and members would receive a newsletter.

Relationships *with Other Interested Organisations*

It was also proposed that the national body would seek to establish co-operative and complementary relationships with other bodies working in this field e.g. The Kings Fund.

The Functions of the National Body

All partner centres within the National Body would have the following functions. However, the co-ordinating centre would take the lead role in some of these and would have other specific functions. It is envisaged that over time individual partner centres may become responsible for specific areas depending on the expertise developed within centres.

Functions of Partner Centres

1. Education
2. Research
3. Development of evaluation tools
4. Sharing expertise across academic and non-academic boundaries
5. Links and co-ordination with other national bodies
6. International dimensions
7. Career development - developing individuals with skills in the arts and humanities in relation to health and healthcare in sufficient numbers
8. Dissemination and publication
9. Advocacy of the arts and humanities in relation to health and healthcare
10. Development of funding

Functions for which the Co-ordinating Centre takes the key role

1. Links and co-ordination with other national bodies
2. Advocacy of the arts and humanities in relation to health and healthcare nationally
3. Development of funding - nationally

Functions specific to the Co-ordinating Centre

1. Maintenance of the National Database
2. National secretariat
3. Associate Membership
4. National Body Website
5. Production of Newsletters

The Name of the National Body

This caused considerable discussion within the working group with the pros and cons of various names being aired. The working party finally proposed The Council for Arts and Humanities in Health and Medicine. However, further proposals were made in the plenary meeting and it was decided to defer adoption of the name.

Recommendations

1. A federal national body be established with a co-ordinating centre in Durham
2. A subscription based associate membership of the National Body be established
3. A steering committee of 10-12 individuals (see appendix A below) chaired by Professor Michael Baum is established to oversee the development of the National Body. The committee to meet at the Nuffield Trust in London
4. The steering committee to seek funding opportunities.

Proposed Membership of the National Body Steering Committee to establish a National Institute of Medical Humanities

Working Group 2 proposed the following membership of the National Steering Committee to meet at the Nuffield Trust in London:

Chair:

Prof. Michael Baum
Professor of Surgery, Department of Surgery, Royal Free & University College Medical School, London.

Members:

Robert Arnott
Lecturer in Ancient History and Archaeology/History of Medicine, University of Birmingham

Gillie Bolton
Research Fellow, Institute of General Practice and Primary Care, Sheffield University

Prof. Robin Downie
Professor of Moral Philosophy, University of Glasgow

Dr. Martyn Evans
Director, Centre for Philosophy & Health Care, University of Wales, Swansea
(now at the Centre for the Arts and Humanities in Health and Medicine, University of Durham)

Dr. Jane MacNaughton
Lecturer in General Practice, University of Glasgow
(now at the Centre for the Arts and Humanities in Health and Medicine, University of Durham)

Rev. Andrew Mawson
Community Action Centre, Haymarket

Dr. Richard Meakin
Sen. Lecturer in General Practice, Medical Humanities Unit, Dept. Primary Care & Population Sciences, Royal Free & University College Medical School, London

Dr. Robin Philipp
Consultant Occupational and Public Health Physician, Centre for Health in Employment and the Environment, Department of Occupational Medicine, Bristol Royal Infirmary

Sir William Reid
Health Service Commissioner (retired), Edinburgh

Mike White
Assistant Director, Arts, Gateshead Council
(now at the Centre for the Arts and Humanities in Health and Medicine, University of Durham)

John Wyn Owen
Secretary, The Nuffield Trust, London

Group II. Research and evaluation

This group explored formative and summative evaluation, and interventions of artists-in-residence, art therapists and arts facilitators. Differences between input, process, activity, output and outcome indicators and choices of different ones, and the need to 'unlock' funding were discussed. Points that arose in the debate included:

- measures of 'how art in different health and environmental settings makes you feel';
- 'what is the bio-medical basis for what is happening';
- 'arts as prevention in health and arts as intervention in illness';
- whether art in health care settings is intended for the public, patients, visitors or staff;
- criteria for effective mental health promotion;
- different medical and social models of evaluation and qualitative and quantitative research methods;
- the role of the placebo (Hawthorne) effect;
- if research is the same as evaluation;
- how art compares with the effectiveness of other interventions when assessing improved ability to express oneself or improved appreciation of the quality of one's environment;
- cost-benefit analysis and differences between accountability, audit and clinical governance;
- the importance of feedback to participants;
- how art is used to make connections and contact or friendship with people, and its role in emotional literacy;
- ways people can better understand the theory of how art can/could 'change' people's lives;
- the 'impact' of art;
- the need for a more egalitarian approach to tackle inequalities in health;
- the importance of valuing 'social capital';
- what the social process is that leads to improvements in self-esteem;
- the needs to help understand the processes for inputs from social and cultural theorists and for correlation studies by social scientists;
- cause and effect relationships of arts and health;
- the need for a research vision and what the strategic research agenda might comprise;
- needs to better understand health activities outside and inside the health care system and to form a coalition and co-ordinate the educational and research roles of the Economic and Social Research Council, the Arts Council, Science Council and the Medical Research Council, and how the Nuffield Trust initiative might help enable this;
- how central initiatives of the Nuffield Trust, King's Fund, Arts Council, Health Education Authority, NHS Executive and General Medical Council might become more cohesive, and collaborate/co-operate more closely, for example, with the arts and humanities in medical education;
- the need to tie together strategic UK government priorities for health (which include mental health), undergraduate medical education needs, evaluations of undergraduate student projects and initiatives in the arts and humanities, and ways of helping to improve the emotional resilience of health care staff;
- the need to explore, in a similar way to a recent Health Education Authority study, what initiatives the UK undergraduate medical students have already undertaken with their projects and Special Study Modules and what initiatives they now seek for the arts and humanities in medicine;
- ways that the wishes of undergraduate medical students for improved arts and humanities skills to help them assist patients to better manage their difficulties can be ensured, with for example, more opportunities for projects or Special Study Modules;

(also q.v. Section I: Some Practical Applications of the Humanities: (a) 'Fears and worries of patients in hospitals, page 16);

- how the practical tools and information yield from evaluations of the arts and humanities can be utilised by undergraduate medical students and practising doctors to help them become better practitioners;
- if a health role for 'arts representatives' could be identified from the model of the pharmaceutical representative.

The group reported that these points should be explored now because social scientists recognise that research over the last 20 years has, in a lot of places, been focused on correlations not causation. A paradigm shift is now being seen and social scientists think it is a very opportune moment to take on board the published experience to date.

A recent HEA study (Health Education Authority, 1999) which looked at the arts and community, analysed the effectiveness of projects according to social rather than biomedical indicators. New indicators will be increasingly important in the evaluation of our field over the next 5-10 years.

Over the past 25 years Arts Projects within healthcare environments have conformed to a 'natural history' model. Various health benefits are said to result from Arts and Health initiatives. Yet, if you look at those projects carefully, the nature of change cannot necessarily be solely attributed to the intervention itself. No real detailed analysis has taken place, so we need to establish some sort of classification, a theoretical framework both to accommodate those applied research projects and to stimulate debate about pure research initiatives which might begin to say why arts and health initiatives work in the way they do.

We would like to tie into *Policy Futures*, the Nuffield Trust's own publication which has been looking at long term prospects for the next 20 years and how expenditure in the NHS on biological treatments may potentially go sky high as increased patient expectations lead to increased costs.

We need to find a way of dealing with patients expectations in different ways, beginning to shift responsibility for health care from individual practitioners to partnerships which involve patients. In this process, the present Nuffield Trust work for the arts and humanities in medicine has stimulated cross-sector negotiation, and the beginnings of a coalition have emerged.

Continued professional development for medical practitioners and for arts practitioners is going to be the key to work in this field over the next 10 years.

Although we believe that as a group within the last 24 hours we have arrived at a coherent picture of the present, it was too short a time to determine a detailed strategic research plan and we submit the following proposals.

Proposals

We would like to ask the Nuffield Trust to convene a group of appropriately qualified individuals to draft a two-page document setting out a strategic research initiative which could be presented to a collation including, but not limited to, the Education and Science Research Council; the Arts Council; and the Medical Research Council with a view to asking

those agencies to fund both pure and applied research projects over the next 5-10 years. We would like them to look at the big question of why Arts interventions make people feel better more effectively than some other activities.

We would like to see an institute of the sort proposed investigate five key areas:

- Arts in the community;
- Arts in primary healthcare;
- Arts in hospitals - facilitated programmes and projects, both participative and as show cases;
- Arts as therapy;
- Arts and the built environment of hospitals - including the need for the design of hospitals and other healthcare buildings to shift within the next 30 years to accommodate ramifications of future policies.

We believe continuing professional development is the key to all these five areas.

In response to comments and questions from the floor, the following points were added:

- The sub group formed to develop an evaluation strategy that should be multidisciplinary, and include patients/users.
- It is important to ensure that the research group does not duplicate the work of other groups; initial funding will be needed to allow meetings to take place.
- The use of evaluation tools developed for other projects should be explored.
- Other partners such as the Forestry Commission in respect of health issues associated with aesthetic quality of the environment, have expressed interest in this area and could be approached as potential research partners.
- Health economic evidence needs to be built into a qualitative approach from the beginning, to maximise the chances for change in resources.
- Discussion by newsletter could possibly build on something already in existence, for example, the journal 'Artery' produced at the Metropolitan University, Manchester.

Chairman's comment

The two sets of proposals so far are related in that the Council will provide the capability for us to move forward with a strategic research perspective, and possibly develop a set of steps including new journals. The internet is also a powerful communication tool and a way of avoiding duplication in communication.

Group III: New ways of working

This group touched on a lot of issues already raised so there is a certain amount of common ground.

The theme 'New ways of working' is about creating environments which provide trust and support and allow safe experimentation, enabling people to establish their own rituals and patterns for staying healthy, wherever they are in their life cycle.

It is important to listen to different perspectives, to stimulate creativity alongside technical and analytical skills and bring those two together.

We need to encourage co-operation, honesty and experimentation but people also want to hang onto things - the sense of status quo, existing ways of doing things, meetings, structures, and specialist roles where people know what they're doing.

We need to create an environment which provides congenial space for communities to exchange information. Walking around the neighbourhood is a simple, low-tech thing to do but it connects people. We can simply take time to engage with the community. On the other hand projects such as Kaleidoscope are trying to introduce new technology which is obviously the 'leading edge' but they are having real problems convincing people. New technology involves introducing broader issues including cost containment and accountability for finance.

New ways of working means trying to work out how we move safely from existing structures and systems into the new world we envisage. For example, we need to see an investment in what has been described as 'social art'. Is it possible to introduce artists into a real situation, to take on a management role?

There is a suggestion that in some situations people are getting poor services and poor quality of care, for example in mental illness, and existing systems are not engaging to move the agenda on and make a difference. There is a need for creativity but it needs to be aligned with ability. To spend a care budget differently, in a creative way, entails bringing together a lot of different components; some people approach this by engaging in a discussion process to tease ideas out of people, others believe you must charge forward and make things happen. Inevitably some people's backs will be put up and there will be casualties.

Points and comments from floor:

- There was a concern over whether the present health service has a realistic vision of its future.

- Present thinking about equity isn't working; a lot of serious discussion is needed about what fairness means in this new environment and how to build on success.

- An organisation like a possible Institute of Medical Humanities as a virtual network, with a centre and associate members, will make new ways of working possible. Individual centres round the country with an interest in arts in health and medicine, can work quite differently and one role of the network will be to influence external organisations to work together in new ways.

- A key principle is to back people before structures.

(E) PLENARY SESSION

Sir William Reid summed up the discussions and conclusions of this conference and linked the proposed plans of action to the Declaration of Windsor and 12-point action plan drawn up after Windsor I. His summary, incorporating final points from conference participants, has been published as the official communique of the Windsor II conference. It was released at a press conference on 10 October 1999. This communique is given below:

ARTS AND HUMANITIES IN HEALTH - 1999 WINDSOR COMMUNIQUE
Sir William Reid

In 1998 the Nuffield Trust convened a conference at Cumberland Lodge, Windsor to discuss the Humanities in Medicine beyond the Millennium. On that occasion the Declaration of Windsor was formulated. After adopting six principles about the role of the humanities in medicine and the links between arts, health and well-being, the Declaration set out a 12 point Action Plan.

On 6th-7th September 1999 the Nuffield Trust held a second conference at Cumberland Lodge to take stock of what had been achieved and what future action was required to move forward the Action Plan in a positive and coherent way.
The conference reached a number of decisions and welcomed progress that had been made in:

1. producing the proceedings of the 1998 Windsor conference in book form;
2. preparing, thanks to Dr Robin Philipp's co-ordinating work, 'A Users' *Guide to the Practice and Benefits of Arts in Health Care and Healthy Living';*
3. publishing the Health Education Authority's bulletin on Arts for Health;
4. summarising initiatives led by the Reverend Andrew Mawson through the Community Action Network.

The conference received an encouraging diversity of reports and summaries of actions taken. These included an English medical undergraduate's story of her year's experience at an American Institute of Medical Humanities, a report on the therapeutic potential of creative writing, and an account of Bromley by Bow Healthy Living Centre.

The Nuffield Trust's conference is not unique. There are other initiatives being taken in this general area of interest, but catalysts for change are needed now to make health care, the professionals who deliver it, and the people who receive it responsive to the needs and constraints of the next century. The conference recognised the need to ensure that knowledge of what has been achieved in so many different parts of the UK, Europe, the USA and Australasia is made available and accessible to all who are interested in necessary innovation and change. As an engine of change the conference warmly welcomed the proposal to set up at the University of Durham a new collaboration centre which is described below. One of the benefits such an institution would bring would be access to information, the possession of which would make it unnecessary to re-invent the wheel when innovation was being planned locally, e.g. in setting up a Healthy Living Centre, or in devising a course in art, dance or music for health. The conference heard what it would do and how it would work.

Its provisional title would be **THE COUNCIL FOR THE ARTS AND HUMANITIES IN HEALTH AND MEDICINE,** acronym CAHHM. It would consist of a co-ordinating centre in

Durham with a number of partner centres based in institutions throughout the country which have a record of achievement in education and/or research in the arts, humanities and health care. It would have aims to achieve for communities, for patients and for professionals, primarily but not exclusively involved in delivering health care. It would have a broadly based steering group, to ensure that action was taken to develop it, and seek appropriate funding for its work. The work being undertaken to found CAHHM is being supported by the Nuffield Trust.

But why now?

- Arts projects over the last 25 years have conformed to a natural history model leading to the accumulation of many new specimens. However, this phase has, in general, lacked theoretical underpinnings. The Report of the Windsor I conference, published by the Nuffield Trust in September 1999, explores the background, concepts and issues needing to be addressed. There is now an urgent need to develop both pure and applied research.

- The recent evaluation by the HEA of community-focused projects and initiatives which use the arts to impact on health and well-being, *Art for Health,* is a valuable stepping stone to a new research agenda. The projects were evaluated not in terms of reported direct improvements to physical health, but in terms of the factors that precipitate or facilitate such improvements.

- Whilst social and other health scientists have demonstrated various positive correlations in this area, the underlying causal mechanisms remain to be explored. The link between art and health is now recognised to be a social process requiring new and fundamental research.

- The Nuffield Trust programme on Policy Futures for UK Health encourages a more long-term approach to research and policy. People's increasing expectations of the NHS cannot be met by an ever-expanding and unlimited budget. A shift to greater concern with prevention rather than treatment will add point to a greater concern with the arts and the social content of health.

- The time is ripe to set out a strategic research agenda building on past work with a view to approaching the Arts Council, the Economic and Social Research Council, the MRC, the King's Fund and the Arts and Humanities Research Board for joint funding of projects.

Bearing in mind the importance of health and safety, the Conference was keen to encourage improvement in the healthcare of professionals who are stressed by the environments in which they work and by the increasing but understandable demands made by the population, who want to know how to be looked after in illness but - no less important - how to maintain a healthy lifestyle. The participants considered that central Government - in particular the departments of Health and of Culture, Media and Sport - should now unequivocally and clearly indicate support and encouragement for closer links between their responsibilities in the interests of good health. The conference considered that many existing cultural and sporting facilities should make a greater contribution to healthy living. They strongly

advocated that planning should be undertaken on a 5 to 10 year span and that inequality of provision should be remedied by delegating responsibility to local people, trusting them to get on with planning and delivering improved facilities, without being subjected to over-detailed, over-invasive and over-lengthy administrative procedures. They recognised the great advances that have been made in adopting business best-practice, and they also emphasised that savings can be achieved in drug bills by educating people in healthier living and in self-help and self-education, and through new methods of integrating pharmacies into society. The conference noted the importance of health service buildings, their variable visual quality, and the quality of the general environment as areas for further action by a multiplicity of interests - patients, artists, architects, engineers, environmentalists.

The conference recognised the need for a culture shift in the delivery of health care, where people matter more than structures. If there is to be a new vision of the Health Service, action is called for now. Some continuity of personnel is needed to maintain standards and delivery of service. But there is also a need to break the mould. The Conference saw in the Durham initiative a means of enriching and updating undergraduate education in medicine and of enhancing postgraduate personal and professional development. These developments should not be confined to the medical profession. They should act as leaven also for nursing and all the professions supplementary to medicine. They should be shared with managers and administrators. All those who contribute to health care must come together with a common vision and a shared understanding that partnership in all parts of the Health Service is vital. They need greater insight into the part the arts and the humanities can play in improving understanding and empathy with patients and with those who seek to remain healthy. If all the players can unite, they will achieve a service fit for the 21st Century.

CLOSING THANKS

Mr. John Wyn-Owen and Sir Kenneth Caiman, thanked all the participants for their involvement and contributions. They explained that a report of the proceedings would be prepared from the background working papers, taped presentations and discussion, conclusions reached and the communique. This report would be linked to the published Nuffield Trust report of the Windsor I conference for the humanities in medicine and to actions arising from this Windsor II conference.

'I think this is an idea whose time has definitely come' Sir Kenneth told fellow participants. 'There is huge potential out there, in skills, knowledge and expertise - and we must tap into it. Both in the UK and internationally there is a great deal of interest in this field and in taking forward the work already achieved'.

Drawing this year's event to a close, John Wyn Owen said that the organisation was 'extraordinarily lucky' to have Sir Kenneth playing a strategic role in pursuing the project. 'Our role [at the Nuffield Trust] is to provide a degree of space and independence in which people can explore ideas and bring together groups and individuals who do not normally come together.

I think we have made good progress. We have the basis of a good programme of work, which will have a major impact on healthcare and the health of the people of the UK'.

SECTION III. NETWORKING TO TAKE THE MEDICAL HUMANITIES INITIATIVE FORWARD

UPDATE ON PROGRESS IN THE ESTABLISHMENT OF A NATIONAL INSTITUTE OF THE MEDICAL HUMANITIES

Since Windsor II, the Conference's plan for a national body to champion the healing powers of the arts is gradually being realised.

Britain's first national co-ordinating centre for integrating the arts into the NHS has been established, with the aim of creating a more humane, patient-friendly and effective health service for the new Millennium. The Centre for Arts and Humanities in Health and Medicine (CAHHM) has been founded at the University of Durham, where Sir Kenneth Caiman, former Chief Medical Officer, Department of Health, is now Warden and Vice Chancellor. The Nuffield Trust, a leading health policy think-tank, is supporting the venture. The national co-ordinating centre has three principal aims:

1. Co-ordinating activity in the field, and creating a network of collaborative links with institutions around the country with records of achievement in education, or research in the arts, humanities and health care.
2. Pooling information and making research evidence more widely available to professionals, groups and funding organisations interested in innovating 'arts for health' projects in communities and workplaces, hospitals and surgeries.
3. Bringing the arts and humanities into the mainstream of medical and health care education at both undergraduate level and in continuing professional education - so as to encourage a more compassionate and intuitive rising generation of doctors and other practitioners.

Arts on Prescription

A national strategy for offering 'arts on prescription' throughout the UK was first sketched out at the first Windsor conference in 1998, by a multi-disciplinary group led by Sir Kenneth and colleagues. A framework for promoting the arts in the area of professional education, in therapeutic and health care settings, and in communities formed the centre-piece of the 'Declaration of Windsor', issued by the conference.

The therapeutic value of artistic activity - dance, music, literature, painting and drama - has been demonstrated in many research studies and local projects over the past 20 years, but not

extensively exploited in the NHS. One task of the new Durham centre will be to help professionals and academics find sources of funding to evaluate 'up and running' arts-for-health projects, and so help convince health authorities and NHS managers of the business case for supporting future innovations, such as 'healthy living centres'. Another aim will be to encourage more flexible ways of working, and more entrepreneurial approaches, building on the pioneering work of the Reverend Andrew Mawson at the Bromley-by-Bow Centre, in east London. One working group at the conference considered the idea that the artistic community might itself use some of the marketing techniques of the pharmaceutical industry - so that 'art reps' become as familiar callers on doctors in surgeries and hospitals as 'drug reps', for example.

Advocates of the 'arts on prescription' philosophy argue that the long-term potential benefits to society of investing in such an approach are considerable. In the words of one conference participant, Dr Martyn Evans of the Centre for Philosophy and Health Care, University of Wales, Swansea, it could 'reach the parts that conventional medicine fails to reach'. Specifically, the anticipated benefits include:

1. Better educated, and more 'rounded' doctors and other health practitioners;
2. Patient empowerment through creative expression;
3. Reduced dependence on anti-depressant prescription drugs;
4. Growing confidence and self-reliance of individuals and communities;
5. Helping to combat social exclusion;
6. Healthier NHS buildings - and staff.

The CAHHM is seen as a key module of the proposed virtual National Institute of Medical Humanities. These developments followed the recommendations of the Windsor II conference. A broadly based Forum for the Medical Humanities, as a Steering Group, supported by the Nuffield Trust, was established to ensure that action was taken to foster development and seek appropriate funding for work needing to be undertaken.

THE PURPOSE AND ORGANISATION OF THE PROPOSED NATIONAL INSTITUTE OF MEDICAL HUMANITIES (NIOMH)

As noted above, the Nuffield Trust adopted the Windsor II conference, Working Group I, recommendation that a Steering Committee be established to oversee progress towards a possible National Institute of Medical Humanities. In 1999, the Trust set up a Forum for the Medical Humanities, under the Chairmanship of Professor Michael Baum. Its remit was to explore ways of furthering steps that had been taken in the Windsor I and II conferences to improve the networking and collaboration amongst organisations working for the medical humanities and to consider the purpose and organisation of the proposed National Institute of Medical Humanities. The Forum considered its remit under the following headings:

(a) A reminder of our purpose

There is a growing and legitimate concern that with developments of 'the new biology' and the decoding of the human genome, the human subject as a sensate being living within a social grouping, might somehow become overlooked. [This concern was explored in the report of the Windsor I conference (q.v. pages 20-23,25)] In no way are we intending to

denigrate the potential importance of molecular biology to solve many of the puzzles of human disease, but simply to recognise the potential hazard of molecular reductionism to 'brutalise' medicine. To an extent the General Medical Council has already recognised the importance of the Arts and Humanities in checking this drift whilst the Council of Deans of the Medical Schools have embraced the concept of the formal introduction or re-introduction of the teachings of Arts and Humanities in professional development. In parallel with these thoughts concerning medical education has been the realisation that one of the major determinants of health is the social and occupational environments within which we work and play These in themselves directly or indirectly influence life style choices which may have an adverse impact on health. These latter issues are outside the control of the Medical Schools and are problems that have to be grappled with by government agencies other than the Department of Health and the Department of Education and Employment.

The first two Windsor conferences have recognised these issues and right from the start there have been three discussion groups under the broad headings:

1. The teaching of Humanities in professional development.
2. Arts and Humanities in community development.
3. The Arts in health and health care.

In addition there has been the general acceptance that we must bring the same quality of critical thinking and evaluation to these areas of human endeavour as we would for the more conventional teaching and therapeutic developments of main stream medicine. To do otherwise would suggest a double standard and a 'softening at the centre'. However, before one can even contemplate an evaluation it is important to agree on the outcome measures. These were discussed and tabulated at Windsor I and Windsor II conferences and are cited in the Introduction to this report. They are re-iterated here in the context of the NIoMH, as follows:

1. The production of more compassionate doctors and other health practitioners who yet retain a healthy critical attitude to evidence;
2. Growing confidence and self reliance of individuals and communities;
3. Patient empowerment through creative expression;
4. Reduced dependence on antidepressant and anxiolytic drugs;
5. Healthy living centres and health action zones that combat social exclusion;
6. The encouragement of healthy life styles choices;
7. A recognition of the importance of global health issues as they impact on our National Health.

(b) Currently existing activities

Following the public announcement of the establishment of a National Institute of Medical Humanities, we have been impressed and humbled to learn of the enormous number of activities already up and running. All these have in common the promotion of the Arts and Humanities for health improvement. The worst thing we could do at the very start would be alienate the successful groups by challenging their ownership. If we are to be welcomed as an umbrella organisation then it must be clearly stated at the start that their ownership and credit for achievement is not challenged. We exist simply to facilitate exchange of ideas, to

widen spheres of influence, to publicise their activities at every opportunity, to help raise funding, to encourage the development of programmes for critical evaluation and to provide media for dialogues between all these autonomous units through journals and electronic communication.

(c) The Institute as a national resource

If we can achieve our goal of encouraging all these currently existing organisations to work together, if we can develop acceptable criteria of evaluation, and establish a readily accessible data base to describe existing and emerging activities on all these fronts, then we will rapidly be seen as a national resource. We will then have to open up lines of communication with organisations such as the King's Fund, the General Medical Council and the Council of Deans of the Medical Schools. We would also need the clout and credibility to negotiate directly with the Departments of Health, Education and Science, the Environment and the Department of Culture and Sport. With all these complex factors in mind, the following structures are envisaged to support, facilitate and encourage the functional well-being of the organisation.

(d) The structure of the National Institute of Medical Humanities

At the very outset we feel strongly that the name of our organisation should not be diluted or modified from its original concept. We should boldly state that we are The National Institute of Medical Humanities albeit that the 'Institute' exists in cyberspace very much along the lines of the Open University. The governing body will be its Forum which should meet at the Nuffield Trust. This in itself will be a constant reminder of the initiative and financial support from the Nuffield Trust that made this exercise possible in the first place. We suggest that the Forum has three sub-committees entitled Professional Development, Research and Public Relations (to include editorial and publication responsibilities). These will meet independently and report up to the Forum. There should also be a separate working group which we might entitle The Evaluation Unit which will have a responsibility for building up a data base and providing guidance on the appropriate techniques of qualitative and quantitative research for any projects emerging from the Forum or its federal organisations.

The building blocks that constitute this virtual National Institute naturally emerge from a federation of existing centres or other types of organisational units committed to the promotion of Arts and Humanities for health improvement. One of these will be the newly formed Centre for Arts and Humanities in Health and Medicine (CAHHM) in the University of Durham, but other examples are being identified. Individual membership of the National Institute will be encouraged via the identified centres, or through membership of some of the free standing units that make up a centre. For example, the picture that is beginning to emerge at University College London is that of a 'virtual centre' which has a Medical Humanities Unit based at the Royal Free Medical School, a Medical Ethics Group, a centre for global health issues, the Wellcome Institute for the History of Medicine, a Curriculum Committee for professional development, and a variety of groupings within the Faculty of Arts that share this vision.

We also need to decide whether there will be individual membership of the National organisation with criteria for recognition, or if all individuals should relate to the umbrella organisation via a federation of centres that reflect their geographical location or their special interests.

(e)A group identity for the Federation

We consider it inappropriate that there should be individual representation on the Forum of each of the possible federal organisations. This would just mean that the Forum was too large and unwieldy. Yet it is important that the encompassing federation has a group identity and a sense of ownership. One of the simplest ways of achieving this is with the design of a logo and headed notepaper. Criteria and standards for its use by partner centres are being established. In addition we propose an Annual General Meeting of the National Institute where representation of all the federal organisations would be appropriate. If necessary this could spread over two days and take over the Windsor conferences so that Windsor III would effectively be the first AGM of the federal organisation.

(f) Promoting our activities

It is now vital that we start promoting and publicising our activities. The first practical way would be the publication of the Nuffield compendium of essays which is close to completion. This report of the Windsor II conference is a second vehicle. The third such promotion tool is the 'Users Guide to the Arts in Health Care and Healthy Living'. The need for this project was identified by participants of the Windsor I conference [q.v. report of the Windsor I conference, pages 103-107].

As chance would have it, we are likely to have a partnership with the new journal 'Medical Humanities', from the British Medical Journal Publishing Group, that promotes our ideals, and through this reach a wider public. An editorial for the first issue has been produced by Robin Philipp and Michael Baum and is attached to this report (Appendix III).

The next task is to develop a computerised data base of current activities and make this available over our own web site. However, the development of this kind of IT is complex and costly. A commercially developed web site can cost up to £20,000, but we will need to seek advice and appropriate funding to get this on line as quickly as possible.

(g) Staffing

Much of what we have described has already been achieved or will be achieved in future, simply because of the enthusiasm and good will of many individuals, but it is inevitable that adequate funding must be secured for a permanent infrastructure. At present, thanks to the generosity of the Nuffield Trust, we have a part time secretary in place working with Professor Baum who will provide a contact point for member centres. This funding is available for the next 3 years. Professor Michael Baum, Chairman of the Forum, NIoMH, Dr Jane Macnaughton, Director, CAHHM, and Dr Robin Philipp, Deputy Chairman of the Forum, NIoMH will work together on the advice of the Forum to plan strategy and activities. It may be that as the role of the NIoMH grows we may need to seek funding for a full time administrator and, indeed, find financial back up for Professor Baum's role as Chair. Other funding will be required for data base management, web site management, publication initiatives, and even travel for Forum members who live outside London.

Funding in the short term is a major problem. A levy on the constituent members for the 'privilege' of joining the federation is therefore being considered. In return we must ensure there is 'added value' in their membership!

The Forum will need to discuss longer term funding for administration and running costs and for suggested activities.

A CHECKLIST OF KNOWN 'INDICATORS OF PROGRESS' SINCE THE WINDSOR II CONFERENCE

Progress towards a firmer foundation for the Arts and Humanities in Health and Medicine can be seen below in a time sequence of events which have taken place since the Windsor II conference.

1. On 10 October, 1999, The Nuffield Trust held a Press Conference for 'Arts, Health and Well-being Beyond the Millennium: The Role of the Humanities in Medicine'.

2. On 11 October, 1999, a presentation to the Arts in Hospital Forum by a Nuffield Forum Steering Group member was given at St Bartholomews Hospital, London, on the work of the Steering Group of the Forum for the National Institute of Medical Humanities.

3. On 11 October, 1999, a Nuffield Forum Steering Group member was included in a BBC Radio 4 panel debate, with the Poet Laureate and the UK Government Minister for the Arts, for the roles of poetry and health.

4. On 6 November 1999, The British Medical Journal 1999; 319: 1222, published an editorial, 'Council aims to integrate arts and humanities into the NHS'. It reported that: *'The Nuffield Trust and the University of Durham are joining forces to form the United Kingdoms first national co-ordinating council and centre for integrating arts and humanities in the NHS.*

   The council hopes to encourage the health service to become more humane, empathetic, and patient friendly, mainly by bringing arts and humanities into medicine across all disciplines. Plans include encouraging the study of arts and humanities in medical schools (through intercalated degrees) and in continuing professional education....

   The co-ordinating council will be supported by a new organisation, the Centre for Arts and Humanities in Health and Medicine, which will be based at the University of Durham.

   The council believes that the 'arts on prescription' philosophy will lead to doctors having more depth and breadth in their education and to patients achieving mental well-being through creative expression.

   The council is, however, eager to dismiss ideas of such treatment being disassociated from evidence based medicine ....'.

   (This editorial also reported that further details of the Arts and Humanities health campaign can be found on The Nuffield Trust's website at www.nuffieldtrust.org.uk)

5. On 6 November 1999, the British Medical Journal; 319: 1216, published an editorial, Evans, M., and Greaves, D. 'Exploring the medical humanities: a new journal will explore a new conception of medicine'. It cited situations of professional detachment and where doctors *'can re-attach themselves to the human race and re-feel those emotions which motivate or terrify our patients'*. They reasoned (from: Collier, J.A.B., Longmore, J.M., and Hodgetts, T.J. Fame, fortune, medicine and art. *Oxford handbook of clinical* specialties. 4th ed. Oxford: 1995: 413) that *'every contact with patients has an ethical and artistic dimension, as well as a technical one* and that there is *'both the now familiar ethical dimension of the clinical encounter and also a more recently acknowledged creative or 'artistic' one'*. They

noted that *'focusing on the resensitising of medical practitioners risks overlooking the possibility that the collision of art and medicine might affect the nature of medical practice itself. These two emphases correspond to two conceptions of what are coming to be known as the medical humanities: an 'additive' view, whereby an essentially unchanged biomedicine is softened in practice by the sensitised practitioner and an 'integrated' view, whereby the nature, goals, and knowledge base of clinical medicine itself are seen as shaped by the understanding and relief of human suffering. This more ambitious view entails that the experiential nature of suffering be brought within the scope of medicine's explanatory models, if necessary by reappraising those models ...'*

6. The Editor's choice: Struggling towards coherence, front page, accompanying these two articles in the BMJ; Vol. 319 (q.v. 4 and 5 above), noted that: *'Reading this week's journal you might think there was a headlong rush to humanise medicine',* and that the subject of medical humanities at present can be compared *'to that of medical ethics 20 years ago - an absorbing academic discourse but not yet the integral part of medical education and practice that it has now become'.*

7. The Bulletin of Medical Ethics, November, 1999, pages 4-5, published an editorial, 'All art is useless... or is it?' It reported, from discussions at the Windsor I and Windsor II conferences that: *'Last month plans were unveiled to follow through claims that the arts and humanities have a vital role in healthcare provision. Britain's first National Co-ordinating Council has been founded with this idea in mind, and it will be actively supported by CAHHM: The Centre for the Arts and Humanities in Health and Medicine, to be based at the University of Durham.*

   The first target will be medical undergraduate programmes. Teaching methods are to include a greater use of plays and poems in order to improve students' narrative skills and help them empathise with their patients. Students will also be encouraged to undertake special study modules in arts subjects such as philosophy, giving them a broader education. The doctor's role should be regarded not merely as the impartial passing on of factual expertise; it must encompass a genuine understanding of the patient's well-being and interests.

   It is hoped that the revised undergraduate programmes will benefit both doctor and patient. Evidence, by way of patient survey, will need to show that patients necessarily feel less isolated when treated by a doctor with a comprehensive education. The nature of the doctor-patient relationship should, thus, be brought to light.....'

   In its comments on the proposals the article reported that: *'Such proposals endeavour to shift the health care system away from the reductionism of modern-day medicine. For example, too great a concentration on genetic science, including the examination of opportunities that could arise from cloning experiments, encourages an attitude towards life that undermines its intrinsic value. One must be wary of allowing over-emphasis on such measures to take us away from the real, underlying problems of the health service. The public complains about long waiting lists, underpaid staff and tragic cases of medical negligence, and this is the response. A call for a more comprehensive direction for the health care system, with a greater role for the arts, is only to be welcomed if it really does bring the benefits its proponents claim.... Are unreasonable assumptions made about what patients want from doctors? Even if patients feel that they would benefit from understanding doctors, what they primarily seek is doctors' professional advice, rooted in factual knowledge....'.*

8. The British Medical Association (BMA) News Review, November 1999, published an editorial, 'University draws on healing arts'. It reported that:

   'The *benefits of the arts and humanities to patients and doctors will be explored and promoted by a new national co-ordinating council led by some of the UK's leading doctors.*

   The initiative, led by the Nuffield Trust, includes the establishment of the Centre for Arts and Humanities in Health and Medicine at Durham University and will seek to challenge the science and technology bias that dominates health service culture.

   It aims to find an evidence base to show painting, music and other art is of benefit to patients and to co-ordinate the uptake of arts and humanities in medical institutions around the UK.

   Former Chief Medical Officer for both England and Scotland and now Durham University Vice Chancellor, Professor Sir Kenneth Caiman said at the launch: 'We are going to be a world leader in the development of the arts in health'.

9. A medical student, reporting her personal diary entries in the British Medical Journal, November 1999, commented on her 'humanities in medicine learning module and the worth of her experiences with a writer in residence at a healthy living centre, and in patient-doctor role playing interactions with members of a local repertory theatre and members of the local osteoarthritis support group' (Maxwell, 1999).

10. In 1999, a review of the book: The Arts in Healthcare: a Palette of Possibilities (Kaye and Blee (eds), 1998), commented on its worth and inclusion of *'an excellent paper on evaluation, incorporating a review of the work done so far, along with a call for further efforts and useful guidelines on how this can be approached'* (J^{onn}> 1999).

11. In 1999, Oxford University Press, published a book, 'The Potential for Health', written by Sir Kenneth Caiman, former Chief Medical Officer for England, in which the importance of the medical humanities is discussed.

12. The inaugural meeting of the co-ordinating forum for the Arts and Humanities in Health and Medicine was held at The Nuffield Trust, London, on 17 January 2000.

13. In January 2000, an Arts and Development Group started as an initiative of the Cornwall and Isles of Scilly Health Action Zone and South West Arts, with a County-wide brief 'to promote within all sectors of health care, individual and community well-being through participation in arts activity (Headland Printers, Cornwall, brochure).

14. The British Medical Association News Review, January 2000, pp. 26-27, published an editorial article, 'A Picture of Health', reporting the opening of the Centre for Arts and Humanities in Health and Medicine, (CAHHM), University of Durham, the roles of literature, visual arts, imagery, and student learning opportunities involving the arts in medicine and the favourable comments from medical students who have availed themselves of such opportunities.

    This new academic Centre for the Arts and Humanities in Health and Medicine (CAHHM) was established at the University of Durham. The role of the Centre has been described:

'Its *Director is Dr. Jane Macnaughton who, until taking up this post, was a part-time General Practitioner and Lecturer in General Practice at the University of Glasgow where she had set up modules using philosophy and literature in the teaching of medical students The Centre has administrative support from The Nuffield Trust. It is largely the brainchild of Durham's new Vice Chancellor, Sir Kenneth Caiman (formerly the Government's Chief Medical Officer), who has a long-held interest in the humanities in medical education. The North east has also been involved in community-based arts and health projects for more than a decade. Moreover, the University of Durham, which already has a reputation for excellence in education and research in the arts and humanities, is to open a new medical school in October 2000, offering opportunities for innovation in the curriculum. CAHHM intends to make use of these strengths in building up new teaching and research activities.*

The overall intent of the CAHHM is that it will be dedicated to the role of the arts and humanities in the improvement of the quality of community life and of the lives of individual patients and health professionals. In addition to this broad aim, the CAHHM will also:

- *raise awareness of the new 'specialties' of medical humanities and arts in health amongst health care workers, NHS Trusts and Universities, and*
- *encourage and facilitate career development in the new specialties.*

The CAHHM will go about achieving these aims by educational activities, research, co-operation with other agencies and by dissemination and publication of information and research work' (Macnaughton, 2000).

15. In February 2000, Lapidus News, the newsletter of the Association for the Literary Arts in Personal Development (LAPIDUS), Issue 11, published an article, 'Lapidus links to frameworks for health development', reporting the need with the arts and humanities to identify *"collaborative ways forward for users and researchers that might ensure sustainable educational development, appropriate standards setting, criteria for 'best possible' professional practice, ways of disseminating information and better empowering of public actions".*

16. On 18 March 2000, the British Medical Journal published a review of the King's Fund book, *'The Arts In Healthcare: Learning From Experience',* edited by Duncan Haldane and Susan Loppert. This review reported that *'after more than 25 years of distinctive practice, there is a need to move the debate forward, to consolidate the whole gamut of arts practice within this context, and to provide identities and clarification to the many different genres and the roles they fulfil, as promoted by the 12 point plan endorsed by the Nuffield Trust conference of 1998, which recommended the creation of a taxonomy of the field'...* and that… *'the benefits of arts in health care may only be made truly tangible in analysis by taking a qualitative approach'* (Beadle, 2000).

17. On 30 March 2000, the Royal Society of Arts, supported by Pfizer Pharmaceuticals and the Nuffield Trust, the Medical Humanities Unit, Royal Free and University College Medical School, London, organised a one-day healing arts conference, 'The Role of-the Humanities in Medical Education'. The conference asked what role the humanities should play in the education of healthcare professionals, whether the integration of the humanities within the traditional curriculum is a worthwhile goal, and if introducing the

humanities into the education of the caring professions is really enough to allow us to rediscover a more humanistic approach to healthcare. It explored work of the new Nuffield Trust Forum for the Arts and Humanities in Health and Medicine and the Medical Humanities Unit of the Royal Free and University College Medical School, aspects of moral philosophy, medical ethics, and uses of narrative and writing for health and in clinical practice. The proceedings of this conference were subsequently published by the Royal College of Physicians of London (Kirklin and Richardson, 2001).

18. On 14 April, 2000, Arts for Health, Manchester Metropolitan University, held an 'Arts for Health National Seminar'. It was convened to discuss the different models emerging for culture, health and the arts, and how, in the UK, practices might be shaped and prioritised. It explored a proposal to establish Regional Arts and Health forums as means of generating good practice, training, research and partnership funding to ensure sustainability. Delegates were informed of the Arts for Health International Network and its benefits, and of the latest national initiatives in the context of current government policies.

19. On 9 May 2000, The Times, Section 2; p. 15, published an article, 'Can poetry replace pills?', exploring present work to strengthen the present research evidence base for this area of arts and health development.

20. On 9 May 2000, the BBC Radio 2, 'Drive Time' programme, interviewed one of the Nuffield Trust Forum members about current research in poetry and health, developments of a possible Institute with the Nuffield Trust, and the background to this work.

21. At least one NHS Research and Development Annual Report (United Bristol Healthcare NHS Trust, May 2000) has commented on research to meet the need for an evidence base for the arts and humanities in medicine; it was reported there that: *'in collaboration with a number of external partners the following areas are under investigation: the evidence base for the use of arts and humanities in healthcare; educational and research needs; priorities for service development; and policies to help develop this area'* (Palmer, 2000).

22. On 3 June 2000, Exeter Health Care Arts held a one-day seminar at the Royal Devon and Exeter Hospital (Wonford), Devon, to launch 'The Exeter Evaluation'. The keynote address was given by Professor Michael Baum, Chairman of Forum for the Arts and Humanities in Health and Medicine.

23. On 14 June, 2000, the Centre for Arts and Humanities in Health and Medicine (CAHHM), University of Durham, held a one-day conference to launch its programme of work. The conference outlined the aims of the Centre, to showcase the range of activity in arts and health in the North East and indicate likely areas for research. Three sessions took place: (i) the development and scope of CAHHM; (ii) the clinical interface of arts and health in communities and hospitals; (iii) the academic interface with other departments of the University of Durham such as Music and music therapy, English Studies, Ethics and history of medicine, and Community and Youth Work Studies.

24. In June 2000, the British Medical Journal Publishing Group launched a new journal, 'Medical Humanities'. It is a response to recognition that a forum dedicated to such inquiry and to serious discussion of the need and scope for engaging with the humanities in medical education and professional development - as *Tomorrow's Doctors* (GMC, 1993), urged - is needed (Evans and Greaves, 1999).

    The editors of Medical Humanities have reported that: *'The journal is an interdisciplinary exploration of how humanities disciplines can engage and illuminate the nature, goals and practice of medicine. It explores the integration of the scientific understanding of physical nature and the humanistic understanding experience'.* As such: *'Medical Humanities reflects doctors' growing recognition of the need to understand the 'science of the human'.*

    'As well as offering a forum for the medical humanities in general - in which qualitative empirical studies and original creative writing will also he welcome - the new journal will explore the integrated conception of the medical humanities and the prospects for an extended understanding of medicine's own explanatory models. In doing so it will offer a distinctive British and European voice in a discourse that is presently only fragmentarily developed in the United States and is now emerging as a genuinely international inquiry' (Evans and Greaves, 1999).

    Sections of the journal will include:
    - Substantive papers (4000-6000 words)
    - Short discussion articles (2000-4000 words)
    - Reviews
    - Letters
    - Discussion
    - News
    - Book reviews

    Initially, the journal will be published twice yearly. It can be ordered from the BMJ Publishing Group, Journals marketing Dept, PO Box 299, London WC1H 9TD, UK. FAX orders to +44 (0) 20 7383 6402. The order form website is www.medicalhumanities. com

    Papers should be submitted to Martyn Evans and David Greaves: Medical Humanities, Centre for Philosophy and Health Care, School of Health Science, University of Wales, Swansea SA2 8PP, UK.

25. In July, 2000, the National Network for the Arts in Health emerged from research conducted by the King's Fund. It was established to share and extend information and expertise. Membership is open to individuals and organisations with an interest in the relationship between the arts and good health. NNAH seeks to ensure that through the use of the visual, performing and multi-media arts, health care environments continue to be enhanced, and the experiences of health care users and practitioners continue to be improved. Their interactive website is: www.nnah.org.uk

26. In October and November, 2000, the journal, Hospital Development, reported their Second Hospital Development Forum. It discussed the role of architecture in helping hospital patients and the need for cost effectiveness studies as part of building the evidence base (Editorial, 2000e; Editorial, 2000f).

27. In October, 2000, at the International Conference: 'Green Cities, Blue Cities of Europe', in Forli, Italy, the AESOHP programme (A European Sense Of Healthy Place and Purpose) was established. It is, initially, a collaboration of: WHO; the Centre for Health in Employment and the Environment, (CHEE), Bristol Royal Infirmary, England; the Centre for Medical Humanities, Royal Free and University College Medical School, London, England; the Centre for the Arts and Humanities in Health and Medicine, (CAHHM), University of Durham, England; the Department of Epidemiology and Public Health, School of Health Sciences, The Medical School, University of Newcastle; the WHO Collaborating Centre for Tourist Health and Travel Medicine, Rimini, Italy; Arts Access Aotearoa, New Zealand; Arts for Health, Manchester Metropolitan University, England; the Centre for Philosophy and Health Care, School of Health Science, University of Wales, Swansea; and The Nuffield Trust, London, England. The collaboration is contributing to the research and education evidence base for roles of the arts and humanities in health, medicine, and humanitarian work, helping to improve the quality of the evidence produced, extending the range of information available, and exploring ways of using the arts to help bridge the needs of patient-centred and evidence-based medicine.

28. In December 2000, The Poetry Society reported in a review of health gains and its 'Poetry Places scheme', the background leading to the Windsor I and II conferences, the work of The Nuffield Trust Forum for the Medical Humanities, and establishment of CAHHM (Mann, 2000).

29. On 27 March 2001, the Medical Humanities Unit, Royal Free and University College Hospital, London, based in the department of Primary Care and Population Sciences, held a conference, "The Healing Environment: without and within", at The National Gallery, London, to explore the importance of the environment in health, (Meakin, R. personal communication).

30. In April, 2001, the first professorial chair in medicine and the arts at a UK university was advertised at King's College, London. It is intended to give medical students high-quality teaching in the creative, literary and performing arts (Editorial, 2001b).

THE WORK OF THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES

The tasks of the Nuffield Forum for the Medical Humanities were, as outlined earlier in this report, to:

(i) consider the purpose and organisation of the proposed National Institute of Medical Humanities;
(ii) explore ways of improving the networking and collaboration amongst organisations working for the medical humanities.

In considering these tasks, it was considered essential to have frameworks in mind that would help to encourage the developments to evolve. Seven areas were considered:

1. STRENGTHENING THE ARTS AND HUMANITIES EVIDENCE BASE

In 1999, The UK Government, Department of Health report, *'Saving Lives: Our Healthier* Nation', noted that: *"Research plays a major role in helping us understand better the causes of ill-health, including the different ways our lifestyle and environment affect our health and our children's health. Public health research is also important in establishing the effectiveness of health programmes but we need to widen the scope of the methods used beyond the randomised controlled trial. In the past it has been the gold standard for research but it is no longer applicable to all the kinds of research questions which need to be answered"* (Department of Health, 1999). In moving forward with research and development that helps to strengthen the evidence base for the arts and humanities in medicine, the words of Professor George Salmond, former Director General of Health in New Zealand, are very relevant:

"If progress is to be made in improving the nation's health, new concepts, knowledge and skills must be introduced. Analyses are needed which break away from the narrow confines of biomedicine and economic rationalism, and which encompass more socially and ecologically conscious constructs. The latter would empower people and involve communities in democratic approaches aimed at enhancing well-being and health status" (Mooney, 1995).

Indeed, it was reported at the Windsor I conference that although now recognised as interventions, there is limited evidence to date that:

(a) artistic understanding, appreciation and expression helps to improve health;

(b) art works in the built and natural environments and the artistic quality of these environments affect personal and community health and well-being;

(c) artistic expression as a recognised treatment and undertaken with guidance from qualified art therapists, has sustained cost effective health gains (although many, and mostly cross-sectional, qualitative studies have been undertaken).

Participants of the Windsor I conference therefore noted that, for the role of arts and health, further studies are needed of:

- the evidence base;
- educational and research needs;
- priorities for service development;
- policies to help develop these areas (q.v. report of the Windsor I conference, page 97)

Additional evidence is needed to show:

- what people have already achieved with ideas and uses of the arts for health;
- what kinds of people are actually working with the ideas and uses of the arts and how much success they have achieved with them;
- if the uses have shortened hospital stay or recovery from different problems, and in different areas of health care, or in levels of well-being associated with different problems;
- if the interventions have reduced General Practice or hospital specialist attendances;
- if the arts have been used with benefit to prevent suicides, marital and other family breakdowns, and reductions in the need for different medications and other interventions for ill-health.

The report of the Windsor I conference (pages 87-93, & 95-96) introduced the need for formal studies of the benefits in health care and health promotion of arts interventions and the concept of *'quality of life',* and considered qualitative and quantitative methods.

It has been reported that: *'it is of course very difficult to measure in any scientific way claims made about the effect of the arts and visual environment on patient recovery' ....* that ... 'most *of the evidence* is *anecdotal' ...* and that ... *'unfortunately, scientific evidence to back up this widespread view is in short supply'* (Senior and Croall, 1993). It has also been noted that: *'Clearly, there can be no purely 'objective' testing of the relationship between medicine and the arts. But there is already evidence coming from social psychologists such as Michael Argyle that 'happier' people tend to be 'healthier' people and it should not be beyond the wit of social science to prepare tests of validity of what you are about. And if it proves to be valid, then it has important implications for our National'Health' Service'* (Rigler, 1997).

In 1993, arts practitioners and researchers themselves recommended that:

"Research should be commissioned to provide proper scientific evidence of how the quality of life of patients in receipt of health care is improved by contact with the arts, and how such contact affects rates of recovery, uses of medical resources, and other kinds of behaviour" (Senior and Croall, 1993).

In 1994, (q.v. report of the Windsor I conference, page 15), it was also pointed out that:

"Research is needed to answer the questions: should art be developed as an object for contemplation or activity for participation and to what extent are there measurable benefits to patients and staff?" (Miles, 1994).

Moreover, in 1999, at the four-day World Symposium on Culture, Health and the Arts, held at The Manchester Metropolitan University, England, there *"was clear acknowledgement of the need to define research methods to* assess *the beneficial influences of the arts on health care provision. This reality was expressed succinctly by Sir Kenneth Caiman, chair-man of the WHO*

Executive Board: 'At the end of the day, those who give out the money need to know that there is some value'... Sir Kenneth challenged arts practitioners to devise replicable methods of evaluation, to take arts in heath care beyond anecdotal expressions of benefit" (Martin, 1999). This Manchester symposium addressed three broad areas of use for the visual and performing arts in health care:

- humanising the education of health-care professionals;
- improving the quality of care provided to patients in health care settings; and
- developing healthier communities.

In respect of the need for research, a general lack of explicit aims and objectives for the arts in health care has meant that, until recently, two somewhat different viewpoints have existed within the arts and health care professions:

- *Artists and arts administrators have commented that: 'We know that the arts have an important role to play in health care and that what we are doing is useful and helps people';*
- *Health service mangers have noted that: 'We know that the arts are being used in health care work but we do not know how the applications of them benefit patients, by how much, and if there are benefits whether or not they are cost-effective* (Philipp, 1997).

It has been noted that: *"So that managers can further consider the worth of arts projects and programmes in health care, the development and audit of suitable performance indicators is being sought. Measures are needed for the reliability and validity of'inputs' such as manpower, equipment and finance, for the different 'processes' of arts delivery in health care, the 'outputs' in terms of changes in levels of physical and mental health and for the 'outcomes' that are often assessed as savings in direct and indirect health care costs"* (Philipp, 1997).
Arising from this background, at the final plenary session of the World Symposium on Culture, Health and the Arts, 13-16 April, 1999, at Manchester Metropolitan University, England, a Recommendation was tabled from the floor for further and widespread consideration:

"Health care purchasers and technical programme directors of the World Health Organisation and the World Tourism Organisation are seeking further research evidence of high quality for the effectiveness of arts interventions in health care and health promotion. They also seek improved understanding of the effects of aesthetic quality of the built and natural environments on human health and well-being. Present interdisciplinary collaboration to strengthen this evidence base includes initiatives in the UK of Arts for Health, The Nuffield Trust, King's Fund, Health Education Authority and the British Council, of Arts Access Aotearoa, New Zealand, and specialist centres in for example, the USA, Scandinavia and Japan. This networking could be usefully extended and co-ordinated with the objectives of multi-centre studies and widespread dissemination of the findings of qualitative and quantitative research evidence that have been published in the peer-reviewed literature" (Philipp, R. Director, Centre for Health in Employment & the Environment, Bristol Royal Infirmary, England, and Eames, P., Director, Arts Access Aotearoa, New Zealand).

Reports of this World Symposium have been published in the following journals: The Lancet (Martin, 1999); the Journal of the American Medical Association (Friedrich, 1999); and Hospital Development (Parker, 1999).

2. THE BROAD AIMS OF THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES

The broad aims of the Forum include its work:

- to encourage all health professionals to become more aware of the humanities and to apply them in the way they work and think when bridging evidence-based and person-centred health care;
- to evaluate interventions of arts and humanities initiatives, programmes and projects for the intended improvement of health and in the quality of health care;
- to help the public understand and use the arts and humanities to enhance their community development and personal well-being;
- to help stimulate the highest standards of teaching and research for the medical humanities that will strengthen health-associated development of the arts and humanities within a supportive environment where opportunities for individual growth and personal fulfilment are encouraged.

The objectives include helping people:

- to become more aware of the arts and humanities as important factors in the aetiology, management and prevention of ill-health and the promotion of well-being;
- to understand how the arts and humanities are important in their responsibilities as employers and employees;
- to recognise roles the arts and humanities have in preventing and alleviating inter-personal and community conflict.

3. A PROPOSED MISSION STATEMENT OF THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES

'The Nuffield Forum for the Medical Humanities is dedicated to improving the health of people by promoting the arts and humanities based on the best evidence of effectiveness and the efficient use of resources. It seeks to achieve this through a network ofprofessionals in different disciplines who work together to build and sustain institutional capacity for excellence and relevance in research and education for arts, humanities, health and well-being'.

In its work, The Nuffield Forum for the Medical Humanities (NFMH) recognises and endorses a view that:

- each profession possesses distinctive strengths, experience, expertise, training and Continuing Professional Development programmes which, working in synergy with the aims and objectives of the NFMH, can benefit different health professionals and the public health;
- working together in a spirit of collaboration and mutual support will provide optimal leadership at this time of opportunity for the medical humanities and related professions.

The NFMH is therefore committed to work in partnership through:

- communication
- co-operation
- co-ordination
- collaboration

in support of our common goals to:

- reduce the incidence and prevalence of ill health;
- improve the health and well-being of people regardless of race, class, ethnicity, gender or other potentially discriminatory factor;
- provide excellence in practice through education, training and research;
- secure and enhance the future of the practice of the medical humanities.

(In preparing this Mission Statement, the NFMH is indebted to Surgeon Captain JJ.W. Sykes, President, Faculty of Occupational Medicine, (FOM) Royal College of Physicians, London, for permission to adapt the FOM Joint Partnership Agreement, of 30 March 2000, with the Society of Occupational Medicine).

To help achieve its aims, the NFMH hopes to form alliances within and beyond the UK. In doing so, it is mindful of the concept of ' *"globalisation" - the process by which all scientific, cultural, religious and economic human activity is being integrated into one worldwide network. Humans oj all ethnic groups, all nations, all cultures and all religious traditions are being drawn together into one global community. Without exercising much individual choice, we are becoming part of a global interchange of news, knowledge and ideas; we are increasingly dependent on one global economy, and influenced by a developing global culture. This is in spite of our diversity, our frequent mutual animosity and our all too common fear and distrust of all things foreign'* (Geering, 1999).

4. CRITERIA BEING DEVELOPED FOR THE AFFILIATION OF ORGANISATIONS

Criteria being developed for affiliation of organisations to the Nuffield Forum for the Medical Humanities include demonstration of their:

- educational aims and objectives;
- research commitment;
- measures of professional integrity;
- structured audit programmes and the methodology of these programmes;
- code of ethics or other evidence of ethical and moral integrity;
- university and/or National Health Service links;
- committee structure.

The WHO Collaborating Centre model has been adopted to explore appropriate frameworks for an *"inter-institutional Network of Collaborating Centres".* From the WHO model, (WHO, 1987), the NFMH mission statement and its aims and objectives, the Co-ordinating Council is studying possible 'common denominators' for this network and possible criteria for

designation of a 'Centre'. For example, the WHO criteria for consideration of such designation include:

- the definition of a Centre, its stated functions and roles;
- the quality of its leadership and staff, the institution's stability in terms of personnel, activity and funding, and its ability, capacity and readiness to contribute to the overall aims and objectives;
- agreed objectives, written plans and technical programmes of research and/or educational development work;
- the procedure for designation;
- titles and use of names and logos;
- management;
- annual reports;
- evaluations, audit and monitoring.

In applying these criteria to educational and research organisations an *"evidence-based mutual investment model"*, such as with the AESOHP programme (A European Sense of Healthy Place and Purpose), is envisaged. In this model, affiliated organisations would be expected to show how:

(a) students invest in staff to gain academic achievements - the students are purchasers of education and providers of help with research;

(b) staff invest in students for gains in their research output - the staff are providers of education and purchasers of help with research;

(c) providers of arts and humanities services invest in the purchase of education, research and information to help improve the quality of their practice;

(d) public purchasers of personal support from providers of arts and humanities services invest in understanding, information, workshops, courses and tools for their personal use, and which can be shown to benefit their health.

When exploring 'relevance' to the aims and objectives of the NFMH, the following criteria are also useful. They were developed by 'Health Promotion Wales, UK', to search for effective mental health promotion interventions:

1. An intervention should focus upon the development of coping skills, family and social relationships, healthy environments, meaningful activities, and social policy or upon the reduction of life stresses.
2. The programme should be replicable. Sufficient information should be provided to enable other researchers or practitioners to implement the same or a very similar intervention within a different culture.
3. There is convincing evidence of change which is not only statistically significant but also practically meaningful.

The change could be in a risk or protective factor or in a mental health outcome (Hodgson and Abbasi, 1995).

The principles developed by the Swiss Commission for Research Partnership with Developing Countries also give useful guidance for the development of appropriate criteria for collaboration:

- Decide on the objectives together;
- Build up mutual trust;
- Share information, develop networks;
- Share responsibility;
- Create transparency;
- Monitor and evaluate the collaboration;
- Disseminate the results;
- Apply the results;
- Share the profits equitably;
- Increase research capacity;
- Build on achievements (Edejer, 1999).

5. THE PROGRAMME OF WORK OF THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES, 1999 - MARCH 2001

The NFMH programme of work included:

- consolidating existing links and helping to develop a co-ordinated strategy with, for example, the Arts Councils, National Health Service Executive (NHSE), Department of Health (including its Health Strategy Unit), Regional Arts Boards, Kings Fund, Museums, Social Services and Education Departments, Health Authorities, Health Trusts, District Health Promotion Departments and the UK Community Action Network of Healthy Living Centres (q.v. report of the Windsor conference, pages 58-59);
- linking with the WHO Healthy Cities and Healthy Settings programmes;
- developing, with The Nuffield Trust, the 'Nuffield Collaboration' as a network of Collaborating Centres with agreed objectives and programmes of work;
- collating evidence for reviews of the effectiveness for the public health of outcomes from arts and humanities interventions;
- developing peer-reviewed research methodologies and co-ordinating multi-centre studies;
- encouraging wider availability and use of tried and proven research methods, questionnaires and protocols;

- promoting wider dissemination and comparison of findings where similar methods have been applied and from these steps, helping to improve policy and service programmes and the quality of their audit;
- assisting student researchers to formulate, review, appraise, defend or plan their research programmes;
- exploring ways the medical humanities can contribute to national and international continuing medical education, which Davis (1998) considered as: *'including projects in needs assessment, having a wide variety of formats and strategies, utilising electronic mail and the internet and involving a delivery and organisation that can be altered by social, political or financial, professional, technological, and educational forces'.*

The Conference of Metropolitan Medical Deans in London has endorsed these such developments of the NFMH, and the sharing of resources for intercalated degrees in the medical humanities. Guidelines for the developments will be needed. In this context, it has been noted that: *'a cornerstone of revalidation, and the modern practice of medicine, is the ability to assess and integrate quality evidence into day-to-day practice'* (Editorial, 1999c). Guidelines are needed. One definition of them that has been reported as being widely accepted *'is that they are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances' ... The method by which a set of guidelines is developed is important, particularly as it influences the quality of the guidelines and their likely effectiveness in achieving the health gains expected from them'* (Thomson, 1999).

Methods are available to help develop such guidelines:

Table I: The method by which a set of guidelines is developed (Thomson, 1999)

Informal consensus	development group has poorly defined (implicit) criteria (global subjective judgement) for decision making
Formal consensus	Greater structure to analytical process, but may fail to provide an explicit link between recommendations and the quality of the evidence
Evidence-based	Explicit linkage of recommendations to the quality of the supporting evidence
Explicit (evaluative)	Evaluates the benefits, risks and costs of potential interventions by probability estimation, thus developing a balance sheet to facilitate decisions about alternative treatments

To develop further the arts and humanities in medicine, the relationship of the population, 'evidence-based' and the individual 'patient-focused' approaches to medicine will need further study. Of relevance for this work, it has been reported that *'we need to find ways of acknowledging the tentative nature of clinical guidance and adapting it to the values and*

aspirations of individual patients. Decision analysis offers some hope of achieving this by incorporating the utility value the individual attaches to the various likely outcomes of disease or its treatment' (Heath, 2000).

Information in the four interlocking reports on the arts and humanities to date from The Nuffield Trust provide a robust response to the question: *'Why now a Forum for the Medical Humanities?'*. Questions that arose for its programme of work included:

- Whom should the NFMH seek to influence with its thinking?
- Which organisations should the NFMH liaise with?
- Which of the relevant disciplines and core/key Research & Development Centres for these disciplines should be represented on the NFMH?
- What are the criteria for being recognised as a 'centre of excellence' in the medical humanities?

6. GLOBALISATION, THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES AND VIRTUAL NETWORKING

At the final plenary session of the World Symposium on Culture, Health and the Arts, Manchester Metropolitan University, England, a Recommendation for improved international collaboration for developments with the arts and humanities was accepted (op cit above, background to the NFMH). At least one other country, Israel, is also known to be establishing a Centre for the Medical Humanities, and with some $7million of development funding (Baum, M. 2000, personal communication). The concept of fresh initiatives for the arts and medical humanities therefore has interest beyond the UK. Accordingly, there are now possibilities for improved international networking and wider collaboration, especially with recent advancements in global communications and in support of the WHO strategy for global health (op cit above, Introduction).

The internet, for example, *'is the world's largest library, shopping mall, business market, museum, university, health information provider, and entertainment vehicle. It facilitates the sharing of ideas, data and tools, creating an ethos of co-operation and collaboration; has the potential to empower patients and to bring evidence into medical practice; but also creates an environment of chaos and information overload. Both sides have to be kept in mind and all possible measures should be evaluated to push the balance towards beneficial effects'* (Eysenbach, 1999). On Easter Sunday, (23 April 2000), the Archbishop of Canterbury warned British society that "the glitter of 'dotcom society' should not blind people to real spiritual values" (Bonthrone, 2000). Nevertheless, with care and commitment, it seems that use of the internet for virtual networking of the NFMH could help to benefit the public health.

The concept of the NFMH as a 'virtual organisation' has certain recently formulated precedents. For example:

Creation of the National electronic Library for Health (NeLH) is being seen as an attempt to harness electronic technologies to solve the information paradox of modern healthcare professionals who are overwhelmed with information but cannot find particular information when and where they need it. The NeLH aims *'to provide easy access to best current knowledge*

to improve health and health care, patient choice, and clinical practice ... The metaphorical architecture of the NeLH will comprise an atrium with help desks and virtual branch libraries, know how (guidelines and audit), knowledge (best current evidence), NHS Direct Online (information for patients), and knowledge management (training in better presentation and use of knowledge) ... The NeLH will be a virtual organisation, connecting both sources of knowledge and users, who are all too often isolated' (Muir Gray and de Lusignan, 1999). In the words of its protagonists: *'were 1 to have a motto, it would be difficult to better* E.M. *Forster's oft quoted 'Only connect'* (Muir Gray and de Lusignan, 1999).

The phrase, *"Only connect",* was also used at the Windsor I conference with respect to the development of healthy living centres, health action zones and social entrepreneuring (q.v. Windsor I report, page 78).

Nevertheless, although the industrial age, only 300 years old, has now been superseded by the information age, and computer systems and the internet now provide access to an unbelievable amount of information, information needs to be distinguished from knowledge. As Professor Lloyd Geering, a New Zealand theologian, has noted: *'Having access to information is not the same as being knowledgeable, just as the possession of knowledge does not necessarily produce wisdom. To be knowledgeable we need to absorb and master the information. But the time has long passed since any one person could absorb more than the tiniest fragment of the total body of available, reliable information. One can now be a specialist only in a very confined area .... Speed of travel, the intensification of communication, and the rise in the average level of education have also meant that the various aspects of western modernity have spread quickly around the globe. We are beginning to be aware that, no matter where we were born and whatever our culture, we share a common story - the story of human origins within the more complex story of the evolution of life on the planet. As the once separate cultures meet and cross-fertilise one another, humankind is beginning to share more and more values - such as the concern for human rights and personal freedom'* (Geering, 1999).

'Connecting' and the concept of social entrepreneuring noted by the Rev. Andrew Mawson at the Windsor II conference (op cit), deserve further examination. As we move though, towards a more open society, in which boundary lines are less distinct than in a closed society, so that people can leave or join with relative ease, there are inherent difficulties. *'Any vigorous human society draws its identity from a shared tradition of common beliefs, values and practices. The growth of individualism and personal freedom can damage such traditions, and this in turn damages social cohesion. Thus globalisation and the advent of the open society, while bringing great benefit to the individual, can have serious consequences for human society. These consequences are the more serious if we remember that our very humanity, as individuals, relies upon human society and what we receive from it ... Globalisation is further exemplified by the great increase in international commerce and trade ... Production of goods, marketing, financial backing and promotion are all increasingly planned at a transnational level ... Organisations such as the International Monetary Fund, and the World Bank have been formed by the powerful nation states to foster globalisation. Initially started by the United States and Britain during World War II to assist postwar international financial and economic co-operation, these have been joined by others such as the World Trade Organisation, and act as brokers for the free market '* (Geering, 1999).

These organisations, with the World Health Organisation, are nowadays increasingly interested in the concept of social capital and the need in respect of 'enlightened self interest', for partnerships involving industry to emerge. These partnerships are being encouraged to undertake social investments for health, even if only as a means of increasing the size of their global markets. A healthier population it is reasoned, will become less dependent on health care. This, in turn, will release public funds for social development uses (Gro Harlem Brundtland, Director General, World Health Organisation, Reith Lecture, BBC, England, May 2000).

In these respects, according to its charter, the United Nations aims to save succeeding generations from the scourge of war, to reaffirm faith in fundamental human rights, to promote worldwide co-operation in the solving of international economic, social, cultural and humanitarian problems, and to maintain international peace and security" (Geering, 1999).

[The issues of human rights and the UN Declaration of Human Rights were explored in the report of the Windsor I conference (page 84), as was the concept of 'social entrepreneuring' and 'social capital' (q.v. pages 56-59)].

Given these viewpoints, with virtual networking and encouragement of partner organisations beyond the UK, could the evolving work of the NFMH help to foster more widespread collaboration for the public health? It has, after all, been reported that *"the phenomenon of globalisation has already begun to generate what may be called global consciousness. This new and developing form of human consciousness is still far from universal, but the world that we each create in our heads (our mental picture of reality), is now being constructed rather differently, by absorbing innumerable bits of knowledge and information from all over the world, not just from our own small locality .... Global consciousness is causing us to discover and acknowledge both cultural diversity and cultural relativity ... All this is evidence of a massive and far-reaching change reshaping the sort of creatures we humans are. We are now conscious of the ways in which our social, cultural, economic and even our mental life is being interwoven with that of others. We are becoming more interdependent, and are having to learn how to become one global society whether we wish to or not" (* Geering, 1999).

Again, as Professor Geering has reported: *"Globalisation means that all kinds of allegiances - personal, family, religious and national - are increasingly subject to global concerns. We can still value, and feel some loyalty to, our own personal circle and cultural background, but these loyalties are now becoming subject to the imperatives laid upon us by globalisation. The citizenship of each particular nationality must take its place alongside global citizenship, our current cultures and our religious allegiance alongside an emerging global culture. But what will be the character of this culture and will it come at all? I would venture that any coming global culture will need to be humanistic (rather than traditionally religious), naturalistic (rather than supernaturalistic) and ecological (designed to promote the health of all planetary life) ...An important aspect of globalisation is that no human problem of any size exists in isolation. It therefore does not lend itself to any simple solution. What happens in one geographical area and/or in one aspect of life is quickly reflected elsewhere. Human life on this planet has the capacity to become a complex social organism ... Globalisation is currently rolling along without any one person, organisation or nation controlling it. Like the march of time, it is going on its own way relentlessly. There is very little possibility of holding it back or of*

directing it ... It could lead to a form of human existence more wonderful and exciting than we can possibly imagine - a veritable heaven on earth. Or some of the trends that have been encouraging globalisation may have disastrous consequences far beyond human control ... Globalisation has intensified the inter-dependence of economics, health, education, culture and religion ... The most exciting breakthroughs of the 21st century will occur not because of technology, but because of an expanding concept of what it means to be human" (Geering, 1999).

"This global culture will rest on a shared view of the universe, a common story of human origins, a shared set of values and goals, and a basic set of behavioural patterns to be practised in common ... The global culture will evolve, if it evolves at all, out of the spread of global consciousness - a consciousness of the human predicament, an appreciation of humanity's dependence on the earth, and a willingness *to act jointly in response. These are the very things which may be said to constitute the raw material of the spirituality of the coming global culture"* (Geering, 1999).

Perhaps, therefore, the *'inner* reality' within each of us is as important as the *'outer* reality'. As Victor Hugo once remarked:

'You can resist the invasion of an army but you cannot resist the invasion of ideas'.

7. TARGETS AND THE MEDICAL HUMANITIES

On 16 December 1996, Sir Kenneth Caiman, then Chief Medical Officer, Department of Health, England, at a meeting convened in his office for the humanities in medicine in the presence of the Minister of Health, the Right Honourable Mr. Gerry Malone, noted that " *the 'arts and health' is a subject 'whose time has come'* ". The Nuffield Trust initiative for the humanities in medicine arose from that meeting (q.v. report of the Windsor 1 conference, page 8). The initiative was then, and is still now, an educational opportunity. In the words of Jean Piaget, *'the purpose of education is to produce men capable of doing new things, not simply repeating what others have done'.* Adapting the closing words of a recent editorial that explored ways of building a research capacity for occupational medicine, (D'Auria, 2000), there is a need for the medical humanities, *"to exploit the opportunities of increased international ties and collaboration to examine the lessons from which we can all learn. But, at the same time, we need to invest in skills and people capable of doing new things - and too, in improving the capacity of persons to become capable themselves of doing new things".*

A challenge now for the Nuffield Forum for the Medical Humanities is the setting of targets in order to focus its actions. As identified at least for occupational health issues (Gibby, 2000), the targets should be 'SMART':

- specific
- measurable
- achievable
- realistic and
- time-based.

8. WHAT THE NUFFIELD FORUM FOR THE MEDICAL HUMANITIES HAS LED TO: WAYS FORWARD FOR THE ARTS AND HUMANITIES IN MEDICINE, HEALTH AND HUMANITARIAN WORK

To help take forward progress that has been achieved for the arts and humanities in medicine, developments in research, education and policy are needed. Greater attention has to be given to the interface and inter-dependence of patient-focused and evidence-based medicine. New partnerships, different stakeholders and fresh ways of addressing the issues are fortunately occurring. For example, throughout 1999, the Millennium Festival of Medicine conducted a poll through the British Medical Journal. In it, readers were invited to send responses to questions that included: 'What do you consider to be the critical challenges and dilemmas now facing medicine and healthcare?' (Editorial, 1999g). The predominant replies (BMA, personal communication), listed below, to this question are all pertinent issues for the arts and humanities:

- new diseases
- environmental issues
- training and education
- patient expectations
- end of life issues
- antibiotic resistance
- ethical issues
- research and development
- global inequalities
- partnerships
- an ageing population
- cost versus best practice
- quality of life issues

The health problems of the world will not disappear. Indeed, the Greek philosopher, Zeno of Elea, commented that: *"if a traveller goes halfway to his destination each day, he can never reach his final destination, since there is always another halfway to go"*. Yet, the contemporary social philosopher, Alvin Toeffler, in noting this, reported that: *"in the same manner, we may never reach ultimate knowledge about anything, but we can always take one step closer to a rounded understanding of any phenomenon. Knowledge, in principle at least, is infinitely expandable"*, and that *"unlike many material things, we can use the same knowledge either for or against each other"* (Toeffler, 1990).

Earlier this year, a consultant surgeon also commented that *"it is partially up to us to keep the fires of enthusiasm burning"* (Kirby, 2000). This second report of The Nuffield Trust Windsor conferences has identified that attention to the arts and humanities is one way of linking personal interests with our professional lives and at the same time, helping to contribute to the health and welfare of individuals and mankind. Experts, too, reportedly agree that the only way to achieve competitive advantage is through innovation and that organisations, irrespective of size, need creativity and inventiveness to stay ahead of the pack. (D'Auria, 1999). We should therefore perhaps note that *'sustainable diversity'* is essential. Accordingly,

the Nuffield Trust initiative for the arts and humanities in medicine deserves further development.

What is now needed to help progress work of the arts and humanities in medicine is:

education to:

- build awareness
- increase sensitivity;

research to:

- move from what has been principally a conceptual and advocacy framework, to strengthen the quality of the information and its evidence base;

policies to:

- help develop appropriate services.

Partnership arrangements and networking will be needed to help the Nuffield Forum for the Medical Humanities (NFMH) achieve its aims and objectives. They need to include professional organisations and forums for policy development. Such policy forums include the UK Partnership for Global Health (q.v. the Introduction to this report), the British Council and possibly the newly formed WHO European Centre for Health Policy which is seen as an 'evidence-based think tank for shaping health policy action', or the new European Observatory on Health Care Systems whose members include the WHO Regional Office for Europe, the European Investment Bank and the World Bank (Richards, 1999). It may also be possible to link the NFMH work with longer term policies to raise the profile of the environment and health, and arising from activities of the European Environment and Health Committee set up as a consequence of the Ministerial Conference on the Environment and Health in Helsinki in 1994. That committee brought together many partners including the EU, WHO, UNDP, UNEP, UN/ECE, OECD, World Bank and EEA. It was chaired by Sir Kenneth Caiman (Fenger, 1999).

It has been suggested too, that in developing an understanding of many of the challenges which face society *"the focus on science and technology research downplays the role of the arts and humanities in the wider world, and that arts and humanities research is becoming more widespread and systematic"* ..., that ... *"arts and humanities research now require the level of management and direction that a Research Council would impart"* ..., and that ... *"the Dearing Committee had undervalued the intrinsic benefits of research in the humanities, and more generally the contribution of higher education to the nation's spiritual, moral and social well-being"* (Williams and Wilson, 1997). Linked with such concern it is possible that within the UK, the present Arts and Humanities Research Board could soon become the national Arts and Humanities Research Council. The NFMH may therefore find its aims and objectives are relevant for the work of this Board/Council.

Virtual networking is a distinct possibility. As an example of what can evolve, Doctors.net.uk is a new UK service set up for use of the medical profession, provided free-for-life to every doctor who joins. There are apparently 25,000 doctors now using the service. It relies upon its members to tell it what services and resources they would like to see on the virtual site.

Specialists in each field are at present required who have a particular grasp of key issues within their discipline. They are known as *'knowledge miners'* and it is the view of this network that the more views in Doctors.net.uk, the richer the discussion in the forums. The network can be contacted at: Doctors.net.uk, FREEPOST (SCE6579), Abingdon, Oxon, OX14 4YG, FAX 01235-862 791.

It should also be noted that *"the UK Government Department for International Development (DID) is responsible for taking forward the strategies and actions set out in the Government White Paper on International Development, 'Eliminating World Poverty', (November 1997). Given that ill-health is a major contribution to poverty, the Department has an extensive programme to improve the health of poor people in poor countries"* (Editorial, 2000c). The DID has an interest in mental health, a Conflict and Humanitarian Affairs Department, a Development Economics Research Department and a Director of Human Development. Its website (http://www.dfid.gov.uk) reports that its *"priorities lie in poverty elimination, creating sustainable livelihoods for poor people, promoting human development, mainly in the areas of health and education ... and conservation of the environment"*, that *"DID provides financial support for projects or programmes to promote greater awareness of development issues in the UK"*, and that it *"has set up a Business Partnership Department which is responsible for promoting and co-ordinating partnerships and dialogue between business and DID ... DID invests about 5% of its budget in the dissemination of knowledge and forges partnerships with universities, non-governmental organisations and the private sector to create the capacity to use knowledge effectively"*. The DID is therefore a major UK stakeholder in the area of work engaged in by the NIoMH. Linked with its work, a United Nations Environment and Development (UNED) 5 Year Review of the World Summit for Social Development (WSSD+5) took place in Geneva in June 2000. Its website (http://www.earthsummit2002.org/wssd) provides a forum for all stakeholders allowing exchange of ideas and co-ordination of activities" (Editorial, 2000d). Discussion by the NFMH with DID colleagues and the British Council could therefore help to identify worthwhile, specific collaborative projects for its members and the federation of member organisations.

Fostering training in the humanities it is concluded, can help considerably to effect sustainable development in contemporary society and for widespread potential health benefits of mankind. His Royal Highness, the Prince of Wales, noted four relevant points in his year 2000 BBC Reith Lecture:

- *"self-interest is a powerful motivating force for all of us, and if we can somehow convince ourselves that sustainable development is in all our interests then we will have taken a valuable first step towards achieving it";*

- *"in this technology driven age it is all too easy for us to forget that mankind is a part of nature and not apart from it";*

- "we *need to restore the balance between the heartfelt reason of instinctive wisdom and the rational insights of scientific investigation";*

- "as *Gro Harlem Brundtland* (Director, WHO, in her year 2000 Reith Lecture) *has reminded us, sustainable development is not just about the natural world, but about people too"* (http://www.bbc.co.uk/radio4).

Greater commitment to acquiring an improved understanding of the potential health benefits from the medical humanities is however needed. As Zen Buddhists have noted, what is needed for this sustainable development are: *"the three qualities necessary for training:*

Great faith
Great doubt
Great effort" (Bell-Hall, 1999)

The effort will need to be sustained and widespread. Work in the Nuffield Forum for the Medical Humanities collaboration is part of this sustained effort. Involvement is welcomed.

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APPENDICES

APPENDIX I. DECLARATION OF WINDSOR

(reproduced from the Report of the Windsor I Conference, pages 111-113)

THE ROLE OF HUMANITIES IN MEDICINE

ARTS, HEALTH AND WELL-BEING: BEYOND THE MILLENNIUM

The Nuffield Trust called together a conference at Cumberland Lodge, Windsor Great Park, on 12th & 13th March 1998. Its purpose was to learn about and assess current activities, perceptions, beliefs and models of effective practice in medical undergraduate education in the United Kingdom and in the USA; and about the place of the arts in therapy both in the community and in the health-care environment.

The conference considered how to promote the practical application of ethics and the humanities in medical education, in public health and community development and in caring for persons of all ages and backgrounds and in promoting better health and well-being. At a time of what was described as *amazing opportunity* the conference brought together people from different backgrounds and practitioners from many of the health professions, the arts, philosophy and theology. Hearing from those who had made innovatory changes in therapy, in education and in general practice and hospitals, the participants concluded that the time was ripe for making significant intersectoral advances involving users as well as providers.

Those taking part exchanged views on how to make as widely available as possible the information about developments in community self-reliance, in co-ordinating the efforts of public authorities and voluntary organisations and improving communications among all who care for those who are ill, and in providing - through the arts of architecture, dance, drama, literature, music, painting and sculpture - support for people's well-being and help for those whose health is impaired. The conference recognised with much concern that there could exist failures of empathy and of communication between health or social work professionals and patients. Those failures need to be understood and put right.

The conference placed a high priority on gathering information on best practice. It placed an equally high priority on making such information readily available with the help of new information technology in regularly updated form. That information is needed not just by those who have to provide resources and facilities for health care but also by those who require and use health care facilities in whatever circumstances. Information has to be used, not kept in a closed circle. That is why the conference commissioned a number of action plans as well as identifying examples of benefits arising from the application of arts to therapy and good health. In order to make available the results of the conference some of those present were asked to draft material to be used in sharing with a wider public, examples of successful initiatives, ideas for practical implementation and a time-limited plan for further actions.

Examples were identified of projects which are likely to be funded by the Millennium Fund and the New Opportunities Fund of the National Lottery. Other projects were sketched out which will be taken a step further and stock will be taken of progress at a second Windsor conference to be arranged by the Nuffield Trust in the Autumn of 1999.

The participants recognised that some improvements in professional education and in the delivery of service can be made by rearranging existing resources. But there was also a realisation that some pump-priming would be needed in order to get desirable and necessary work started. A crucial part in ensuring success would be the involvement of all those in society who would be likely to benefit from changed priorities and initiatives. That lessons of 'only connect' and 'be involved' should apply to care in the community, to the education of medical students and to the preparation of those who provide education for those in the health care professions.

The conference emphasised that change must accept that Britain, part of Europe as well as of the Commonwealth, is a society of many races, cultures, religions and habits. Those who are to receive an education and to continue it throughout life, whether for the health professions or not, must be made aware of the need to understand such diversity, to learn how to communicate with persons of whatever background and be prepared to initiate, adapt to and comprehend change.

The conference adopted the following:

- to **use** existing resources and talents to better purpose
- to **develop** and expand existing skills, expertise and knowledge
- to **prepare** a taxonomy of what has already been achieved
- to **promote** collaboration in the education of health professionals by the use of distance learning and information technology
- to **emphasise** that health professionals need to know how to deal with people sympathetically and without condescension
- to **encourage** the growth of projects involving various sectors of public service and voluntary efforts - no department is an island.

Conference participants endorsed a 12 point action plan spanning three areas for practical application: professional education; the arts in therapy and the healthcare environment; and the arts in community development.

APPENDIX II. **THE 12-POINT ACTION PLAN**

DRAWN UP AND ENDORSED BY PARTICIPANTS AT THE WINDSOR I CONFERENCE

(reproduced from the Report of The Windsor I Conference, pages 114-117)

Professional education

- Medical students should be given the opportunity to study the humanities during their undergraduate education to help them develop a more compassionate understanding of the individual in society, to inspire empathy with patients and colleagues, and to become more 'rounded' people themselves.

- All university medical schools should incorporate the humanities - in particular, moral philosophy, theology, and literature - on the five year undergraduate curriculum, perhaps enabling the doctors of the future to qualify with Bachelor of Arts degrees. History, creative writing and painting should also be considered for inclusion in humanities courses.

- Studying a mix of arts and science subjects at A level should be no bar to securing a place at medical school. If doctors are to resist gathering pressures that threaten to reduce their perceived role to that of 'technician' they must receive a more liberal education, one that helps to bridge a gulf between science and arts.

- Create a national database of practice and research in medical humanities to spread awareness and knowledge of the field and co-ordinate activity, and encourage 'life-long learning' as medical professionals progress through their careers.

Arts in therapy and health care settings

- Produce a 'user's guide' to the practice and benefits of arts in healthcare and healthy living initiatives for NHS managers responsible for budgeting and commissioning services.

- Publish other documents on the vital contribution of arts and design in hospitals, surgeries and other healthcare settings, outlining the cost-effectiveness and the potential of improving quality of life for patients, visitors, staff and the surrounding community.

- Catalogue the qualitative and quantitative research evidence, create a taxonomy of the field; list relevant professional associations and organisations specialising in arts in health.

- Spread awareness of current activity and opportunities for practical applications among professional organisations and patient groups; pool information and make widely available to public and professionals alike through the use of information technology and distance learning.

- Develop 'taster' courses at undergraduate level for healthcare practitioners.

Arts in community development and health

- Promote the notion of arts as a means of self-expression and a catalyst for strengthening and energising communities and enhancing the psychological, physical and emotional health and well-being of the individuals who make up those communities.

- Integrate arts into the Health Action Zones identified by the Department of Health and emphasise the need for the arts to permeate policy across Government departments.

- Revive and promote the notion of 'healthy living centres' such as the Pioneer Health Centre in Peckham, London, so that arts activity may become woven into the fabric of everyday life; and to maintain and extend skills of those who practise arts therapy and promote the recreational value of arts to health.

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APPENDIX III. THE NATIONAL INSTITUTE OF MEDICAL HUMANITIES

(A synopsis of how we got to where we are - published in June 2000, in the first issue of the new journal, 'Journal of Medical Ethics: Medical Humanities', Vol. 26(1): 63-64, of the BMJ Publishing Group)

Professor Michael Baum and Dr. Robin Philipp

During the past seven years interest in roles of the arts in health and health care has evolved rapidly amongst health professionals. Much of the present interest is moving from advocacy to include evidence. Amongst health care purchasers it is centred around the need for good qualitative and quantitative research to improve the 'evidence base' of health benefits from different and specific interventions and to help justify the provision of services [1]. Nevertheless, an arts-science gradient is clearly recognised. It "spans the artistic, intuitive, inspirational and subjective viewpoints, and the measurable, objective, deductive, logical and scientific perspective" [2]. Arts practitioners, health professionals, service users and members of the public are now keen to determine possible collaborative ways forward that might ensure sustainable educational development, appropriate standards setting for group work and for courses and research, criteria for good professional practice, improved ways of disseminating information and better empowering of public action.

Against this background, Sir Kenneth Caiman, the then Chief Medical Officer, Department of Health, London, and now Vice Chancellor, Durham University, convened a meeting on 16 December 1996, in the presence of Mr. Gerry Malone, UK Government Minister of Health, to explore the definition and scope of 'the humanities in medicine'. Arising from the meeting, in March 1998 a two-day Nuffield Trust conference at Cumberland Lodge, Windsor Great Park, was held to explore the potential benefit of the arts in medical education, health care environments and the community, and to formulate a strategy to promote uses of the arts in health care planning, policy making and practice. The conference noted that "The Humanities'" have been defined as "the *study of human nature and the practice of compassionate concern for the advancement of mankinds welfare",* and that "the WHO *definition of health represents a balanced relationship of the body and mind and complete adjustment to the external environment" [2].* The conference report included details of the background, papers presented, working group discussions and conclusions, a bibliography and references for additional reading, biographies of participants, a 'Declaration of Windsor and a 12-point action plan [2].

A follow-up Nuffield Trust conference in September 1999 reviewed progress with aims promulgated in the Declaration of Windsor and discussed ways forward for the arts and humanities in medicine. A report of this second conference and 'A Users Guide to the Practice and Benefits of Arts in Health Care and Healthy Living' will be published by The Nuffield Trust. This Nuffield Trust initiative has now been endorsed by the President of the General Medical Council, the Chairman of Council of the British Medical Association and the Chairman of the Committee of Vice Chancellors and Principals of UK Universities, Sir William Reid, former Health Service Commissioner for England, Baroness Hayman and Baroness Jay, former Under-Secretaries of State for Health, the Right Honourable Chris Smith MP, and the Right Honourable Mr Alan Howarth, MP.

In Autumn 1999, in the next steps with its co-ordinating role, The Nuffield Trust helped to establish a Centre for the Arts and Humanities in Health and Medicine (CAHHM) at Durham University [3], and a new National Institute of Medical Humanities. The National Institute, with its Council Forum chaired by Professor Michael Baum, Professor of Surgery, University College Hospital, London, and an expanding Federation of Collaborating/Partner Centres dedicated to the promotion of arts, health and well-being in health care, is now setting up research projects and courses for trainee doctors and other health professionals. This Council Forum first met on 17 January 2000 at The Nuffield Trust. The WHO Collaborating Centre model has been adopted to help develop work of the Institute and to define the roles, criteria for selection, procedures for designation, titles and use of names and emblems, management, plans of work, annual reports, evaluation and monitoring of collaborating centres.

The collaboration is studying:

- the evidence base;
- educational and research needs;
- priorities for service development;
- policies to help develop these areas.

Anticipated benefits from this work of the National Institute for the Medical Humanities include:

O more compassionate, intuitive doctors and other health practitioners;

O improved patient empowerment through creative expression;

O reduced dependence on anti-depressant and anxiolytic medication;

O enhanced confidence, self-reliance and mental health of individuals and communities and reduced social exclusion.

It is hoped that this journal together with a linked web site will act as the mouthpiece for this evolving collaboration, so that what starts out as a virtual centre in cyberspace will eventually end up as a network of "concrete" entities sharing ownership and a common goal.

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References to Appendix III:

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APPENDIX IV. THE WINDSOR II CONFERENCE: PROGRAMME AND PARTICIPANTS

WINDSOR II: MAKING IT HAPPEN

Cumberland Lodge, Windsor Great Park
Monday 6th and Tuesday 7th September 1999

PROGRAMME

Monday 6th Sept

3.00 p.m.	Arrival
3.30 p.m.	Tea
4.00 p.m.	Welcome - John Wyn Owen
4.15 p.m.	Progress since Windsor I - Professor Sir Kenneth Caiman
4.25 p.m.	Introduction to Group 1: Research and Evaluation Dr Robin Philipp
4.35 p.m.	Introduction to Group 2: The Virtual Institute of the Medical Humanities Professor Michael Baum
4.45 p.m.	Introduction to Group 3: New Ways of Working Reverend Andrew Mawson
4.45-7.00 p.m.	Group sessions
7.00 - 7.30 p.m.	Break
7.30 - 8.00 p.m.	Pre dinner reception and launch by John Wyn Owen of Humanities in Medicine: Beyond the Millennium. A report of the proceedings of Windsor I.
8.00 p.m.	Dinner
9.30 p.m.	Recital by Dr Emer Gilloway

Tuesday 7th September

7.45 a.m.	Breakfast
8.30 - 11.30 a.m.	Group sessions (coffee break at 10.00 a.m.)
11.30-noon	Coffee break
Noon - 1.00 p.m.	Report back from groups (10 minutes each group with 10 minutes response from the floor)
1.00-2.00 p.m.	Lunch
2.15 - 4.00 p.m.	Resolutions: Sir William Reid

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