Nuffield Trust Series No. 10

Beyond the Millennium

Windsor I
Cumberland Lodge, Windsor Great Park
12th & 13th March 1998

A summary of the proceedings of the first Windsor Conference

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Reverend Andrew Mawson
Sir Kenneth Caiman

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

Published by
The Nuffield Trust
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London W1M 7RD

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ISBN: 1 902089 24 3

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FOREWORD

In the government White Paper *The New NHS. Modern. Dependable'* it states that there will be a 'third way[1] for running the NHS - a system based on partnership and driven by performance. The purpose of this third way is to balance the autonomous needs of individuals with the needs of the community. Elevating the arts, health and wellbeing into a pivotal role across the spectrum of health care may be the real third way for health.

Humanities in Medicine: Beyond the Millennium, held at Cumberland Lodge, Windsor Great Park in 1998, brought together people from different background and practitioners from many of the health professions, the arts, philosophy and theology. The conference resolution *The Windsor Declaration* promotes the practical application of ethics and humanities in medical, health and professional education, in public health and community development and in caring for people of all ages and backgrounds and in promoting better health and well-being.

John Wyn Owen, CB
London: 1999

1. The New NHS. Modern. Dependable. (1997) Cm.3807. HMSO

ACKNOWLEDGEMENTS

This report addresses the Background, Proceedings, Conclusions, Recommendations and Action Plan of a conference: "The Humanities in Medicine: Beyond the Millennium", convened by The Nuffield Trust at Cumberland Lodge, Windsor Great Park, England, on 12-13 March 1998. It is the first of a series of intended outcomes.

We are indebted to The Nuffield Trust for sponsoring the conference and to all the participants for their active involvement and for so willingly contributing to what was widely considered a very successful meeting. In preparing this report we are extremely grateful to Mrs Heather Cook for her secretarial assistance in transcribing the audiotapes of keynote presentations and the discussions, and to Mrs Pamela Thorne, who, together with us, undertook the technical editing.

In the report, under one encompassing title: *The Humanities in Medicine*, we have attempted to link the topics discussed within each Working Group and to integrate the three broad themes of undergraduate medical student education, community development, and the arts in therapy and health care settings. We believe this report is an accurate account of all the deliberations. We do however accept 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.

Dr. Robin Philipp
Professor Michael Baum
Reverend Andrew Mawson
Sir Kenneth Caiman

1. THE WINDSOR I CONFERENCE

JOHN WYN OWEN

This conference, Humanities in Medicine Beyond the Millenium, subsequently known as "Windsor I", laid the foundations of a strategy to *"promote the arts from the margins into the very heart of healthcare planning, policy-making and practice".* It followed on from a meeting convened by Sir Kenneth Caiman, Chief Medical Officer, at the Department of Health, London, on 16 December 1996 in the presence of the Minister of Health, Mr. Gerry Malone. That meeting was convened to explore the possibility of developing the definition and scope of what might be covered in some as yet unspecified initiatives in "the humanities in medicine". At it, the Chief Medical Officer expressed his intention to take forward an increasing interest in the humanities in medicine through meetings of like-minded people who recognise that the "arts and health" is a subject "whose time has come". Possible outcomes that could arise from the meeting were suggested as:

- a network of addresses and interests, perhaps through the Internet;
- a regular newsletter,
- a library of reference sources;
- special interests groups, e.g. education, community arts, ethics, general practice, music, therapy etc;
- a seminar or conference;
- courses on specific issues.

It was agreed that Professor Michael Baum would co-ordinate the issues around medical education, Dr. Robin Philipp would co-ordinate the work related to arts and therapy, and the Reverend Andrew Mawson would co-ordinate the work related to arts in the community. The

meeting was reported as: *"Increasing interest in England for possible uses of the arts in health care and the humanities has led to the Chief Medical Officer, Department of Health, with the Nuffield Trust, convening a committee of artists, physicians, and other specialists to help find ways of taking forward these new therapeutic approaches"* (Caiman, 1996).

At the time, several and often quite independent initiatives were identified in different parts of the UK, as well as abroad, some of which were without any knowledge of activities going on elsewhere.

The underlying aim of the strategy is to elevate the arts 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.

Funding to help evaluate up-and-running "arts for health" projects and to extend their scope and number is to be sought from the Millennium Fund and New Opportunities Fund of the National Lottery. Innovative new schemes are beginning to emerge, including a two-year "arts on

prescription" project run by the Stockton Health Authority, and that developed by the violinist Yehudi Menuhin, which aims to prevent violence and racism by sending professional artists into underprivileged primary schools to teach music, singing, mime, dancing and martial arts (Phillips, 1998).

Sir Kenneth Caiman, the Chief Medical Officer, Department of Health, London, and Sir William Reid, a former Health Service Commissioner for England, Scotland and Wales, and now chairman of the Mental Welfare Commission, Scotland, were among those attending the conference.

Keynote speakers included Professor Sir David Weatherall, Regius Professor of Medicine, University of Oxford, Professor Michael Baum, Professor of Surgery at University College London Medical School, Dr Robin Philipp, Consultant Occupational Health &. Public Health Physician at the Bristol Royal Infirmary and Reverend Andrew Mawson, Chief Executive and Minister of Bromley by Bow Centre in East London.

THE OBJECTIVES OF THE WINDSOR I CONFERENCE:

Three objectives were identified by the Steering Group (Sir Kenneth Caiman, Professor Michael Baum, Reverend Andrew Mawson, Dr. Robin Philipp and Mr John Wyn Owen) before the conference:

- 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.

Delegates to the conference received an introductory letter from Sir Kenneth Caiman, the conference programme and terms of reference for the roles of chairman, rapporteur and panel members (Appendix I).

A 12-point action plan was drawn up and endorsed by conference participants (Section 9). It spans three areas for practical application: professional education; the arts in health, therapy and the healthcare environment; and the arts in community development.

2. GENERAL BACKGROUND

ROBIN PHILIPP, MICHAEL BAUM, ANDREW MAWSON AND KENNETH CALMAN

As Tessa Jowell, the Minister for Public Health, UK Government, has reported: *"Good health is not just about how long people live. It is also about the quality of life and how well people are during their extra years, so that they can enjoy the dignity and independence that we take for granted when we are well"* (Jowell, 1998).

Towards "good health", the therapeutic value of the arts in both preventing and treating illness has been demonstrated in many research studies and grassroots projects over the past two decades. Yet the healing powers of arts such as dance, music, literature, painting and drama, and their capacity to enhance quality of life in Britain's multi-cultural, multi-ethnic society, have yet to be fully exploited within the NHS, and beyond.

As reported in 1997: *"Health is about people, not just patients; and about patients, not diseases... Health care does not just start and end at the hospital or surgery door. Greater awareness of the need to encourage and enhance team-working, community development programmes and support for people to encourage healthier lifestyles has led to greater awareness of all the contributions from individuals within health care teams... The importance of effective multidisciplinary teamwork cannot be overstated yet it can be difficult to achieve... Teams need to contain the right balance of skills and knowledge and develop the flexibility to share their expertise; the foundations for such an approach need to be laid down during initial professional education and training, and reinforced in continuing professional development"* (Caiman, 1997a).

The Department of Health's long term strategy for public health also emphasises the need to promote healthier living in the community. As noted in 1997: *"The concept of 'potential' for health should be more widely recognised: potential is associated with the concept of energy - the capacity to work and play-, it implies an ability to transform, to change one form of energy into another: it suggests empowerment of individuals - a crucial factor in improving public health; it acknowledges a gap between what is now and what could be...Health cannot be narrowly defined; it is not just the absence of sickness, nor just about living longer, but about a better quality of life. Good health is possibly the ultimate 'feel-good' factor, and should be encouraged. Any strategy for public health must take into account these factors and be broadly based and holistic. Improving health is as much about employment, occupation, housing, transport, the environment, education and living standards - including poverty - as it is about treatment within the health service. This is a wide canvas, and can always be refined; the process is one of continual revision and renewal, and must therefore be grounded in values which are long-lasting and durable"* (Caiman, 1997a).

The arts have a role in realising this potential for health and in supporting community development. The medical profession does, however, need 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. It should for example, be remembered 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, JRCGP, 1983). Core values identified by the British Medical Association for the profession do too, include the *"ancient virtues of competence, integrity, confidentiality, compassion, and commitment practised with an enquiring and impartial mind"* (BMA, 1994). It is therefore important to recognise some of the commonalities between scientific, artistic and humanitarian modes of thought, all of which can lead to the desired educational goals (Smith and Taylor, 1996). We can learn from the arts by *"imaginative identification with situations or characters depicted, and by having our imaginations stretched through being made to enter into unfamiliar situations or to see points of view other than our own"* (Downie, 1994).

The arts in health care movement gained momentum in 1988 as a new national initiative (Sheeran, 1988) and has since been well described (Senior and Croall, 1993; Kaye and Blee, 1997). Practical advice has been given on such themes as beautifying old hospitals (Baron, 1984), funding works of art in new hospitals (Baron and Greene, 1984) and the aesthetic principles of design for health care buildings (Critchlow and Allen, 1994). A framework for evaluating the effectiveness of the arts in health care has been also described (Philipp, 1997a).

In September 1997 an international multidisciplinary conference entitled **The Arts in Health Care: learning from experience,** was held at the Roehampton Institute, London. It focused on research in progress, addressing the following themes:

- the benefits of the arts in health care;
- design of hospitals and health care buildings;
- uses of different arts in treatment;

- artists-in-residence;
- the demands and nature of site-specific art;
- ways of involving patients and staff in the selection and creation of works of art.

Benefits of such activities reported at the Roehampton Conference included:

- improved quality of healthcare environments to the benefit of patients, visitors and staff;
- help with recovery;
- alleviation of stress and boredom,-
- encouragement of well-being;
- reassurance, comfort, humour and motivation for patients and visitors;
- addition of purpose and dignity to people's lives;
- development of closer links between the health service and the community,-
- improved wayfinding systems and the establishment of landmarks.

More research evidence is however now needed to support the claims of health gains associated with attention to these themes, and 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)?

Amongst conclusions reached by participants in 1997 at the Roehampton Institute Conference were that:

- there is increasing awareness and interest in the role of the arts in healing;

- what artists offer is distinguishable from the specialised clinical activities of art therapists;
- hospital planning and design, and use of the arts in health care environments should involve arts administrators and artists in residence;
- the benefits of employing arts professionals in health care and their roles, job descriptions and professional codes of ethics need further clarification;
- improved networking and a central point of information in the UK would enable these issues to be addressed;
- expansion of present projects and programmes is likely where purchasers and providers of health increasingly recognise the value of responding to factors perceived by patients, staff and visitors as important in a caring environment.

How then might the arts in health care movement develop further and for community development and personal well-being? The concept of "health for all" is, after all, about having a life with meaning (Caiman, 1997b). It embraces concepts of "a life worth living" and of "an environment worth living in".

In the USA, Arts and Humanities electives in medical education are one response. They are designed to teach communication skills, help medical students learn to be effective doctors, and provide methods of dealing with job related stress. Their components include:

- life drawing to provide a greater understanding of human anatomy, to teach drawing skills, and provide a forum for creative outlet;
- improvisational acting to help team building, listening, observation and related skills,

- creative writing assignments in poetry, plays and literature as a means of self-expression, communication and discovery.

In the UK, for the humanities in medicine it has been suggested that the "non-biological arts" should be included in the medical curriculum (Smith and Taylor, 1996; Macnaughton, 1997). Short courses on literature and medicine have been successfully piloted (Caiman et al, 1988: Downie et al, 1997).

3. SCENE SETTING

POINTS FROM THE OPENING PRESENTATION OF *SIR KENNETH CALMAN*

What is entailed in the title of this meeting - is it about the arts and health? Humanities in medicine? Medicine and clinical practice? How are the humanities defined here? There is a whole range of things that we can do and use to make us think a little bit more. An objective for the next twenty-four hours might be to consider:

- how we can help to improve the quality of life of individuals and communities;

- how we can help professionals in the caring sector to be more compassionate and think a little differently.

A course run some time ago in the University of Glasgow illustrates how literature might be used in relation to professional education (Caiman and Downie, 1988; Caiman et al, 1988). It was designed to introduce medical and nursing students to what literature was about, to broaden their experience and encourage them to examine their attitudes to professional practice. It was an interactive course, looking at a whole range of fiction and non-fiction and the student response was interesting because evaluation is a key issue. The aims of that course were to try and make people think differently; to create the educated doctor, as opposed to the trained doctor; to stimulate people's imagination and help them to look at the human predicament through the eyes of someone else. The artist can portray a different perspective that can be used to teach communication skills.

The other two themes for this particular meeting are the role of arts in therapy, and arts in personal and community development. In hospitals around the country people are beginning to think more about things and one increasingly finds examples of sculpture, or music groups which were not there years ago. Equally important are arts initiatives which change communities.

Many of the issues are the same whether you are thinking about professional education, arts in healthcare or community development. It is important not to forget the patient experience because that may be what begins to change our own views. Patients tell us remarkable stories at times, which we sometimes just need to listen to, and it is the same in the community (Caiman, 1997c).

Bringing all of this together is not very easy (Caiman and Downie, 1996). Many conferences, meetings or happenings on this theme are taking place but it can be extraordinarily difficult to find out about it if you are not on the right circuit. It may be that there are other ways in which we could find out about things which perhaps we should know about. For example the publication *Artery*, the journal of Arts for Health, set up as a national resource and development centre by Peter Senior.

What we are really here for is to discuss the issue of how important and relevant these things are. Does having music in hospital or encouraging medical students to read more books make a difference or not?

The key task of this conference is to assess the evidence that such interventions can bring about worthwhile change. If funds are to be invested in this area, the donors or grant-giving bodies need evidence that the community will get something back.

POINTS FROM THE OPENING PRESENTATION OF *SIR DAVID WEATHERALL*

The art of the practice of the science of medicine

The art of healing versus the science of healing is a very complex issue; the scene has changed quite dramatically over recent years.

Although scientific medicine is often dated back to William Harvey's discovery of the circulation of the blood in the 17th century, science had no impact on day to day clinical practice until the microbiology of the middle of the 19th century. Only very recently has medicine become somewhat scientific with statistics and epidemiology applied to patient management and modern high-tech medicine, which is basically applied physiology.

The last ten or fifteen years have seen a change of emphasis from the whole patient and whole organs to disease of molecules and cells. There is concern that molecular medicine is reductionist and dehumanising.

Tension between the art or practice of medicine and the science of medicine has existed since Thomas Sydenham, who felt that the extraordinary discoveries in physiology of his era were a waste of time. For him medicine was bedside observation and the ability to

interact with people, and it was learned like an apprenticeship to a trade. Scepticism about the scientific basis of medicine remains today in our teaching hospitals.

This dichotomy between science and medicine was very well expressed a little later by the cardiologist Thomas Lewis as the different attitudes of mind of the scientist and the practising clinician:

> *the clinician at the bedside needs **self-confidence** which breeds faith and hope; a scientist requires **diffidence** to breed inquiry.*

The attitude of mind required by medical students attempting to understand disease today is indicated by Ernst Mayr's definition of biology:

> *what we actually see, i.e. descriptive biology,*
> *how things came to be that way and why:*
> ***proximate causes** - the basic workings of biological systems,*
> ***ultimate causes** evolutionary biology, transmission genetics, ecology, aetiology.*
> *(Mayr, 1997).*

This blueprint can be used to illustrate the many layers of biological complexity found, for example, in the genetic blood disease Thalassaemia. This is enormously common in many parts of the world, but in different regions, children with the disease have different genetic backgrounds and different responses to infections. A further

layer of ecological complexity is added by differences in: nutrition,- exposure to infection; climate; availability of medical care; and by geographical, racial and religious variations in social attitudes.

Similarly, diseases of western society now are complex interactions between many genes, the environment we have created, and the complex pathology of ageing. The doctors of the future will need to deal with an issue of enormous complexity. In the next millenium medicine will involve:

prevention - some reduction or removal of risk factors;
major changes in screening technology-,
social engineering;
control of disease;
non-invasive technology;
biotechnology etc.

A reductionist approach to disease has led to an understanding of evolutional biology which has shown that each human is unique. So this essential phase in the development of medical knowledge has brought together medicine and biology, not separated it; we will now start putting the bits back together again, with specialists working together and using the same technology. The old skills of clinical practice, the ability to interact with people, will be as vital in the next millennium as they have been in the past.

Both conventional science and sympathetic empiricism are needed in medical education and the biggest problem is how to maintain a lifelong critical attitude in doctors. There is no need for fundamental change,- the principal need is still the skills of good clinical method. We will

always get back to patients as individuals and so it is self-evident that the humanities are important. Art subjects as well as science should be studied for A levels to develop these attitudes of mind long before medical school (Weatherall, 1994).

The medical curriculum is already overloaded, and does not need extra material added to it. The humanities and arts should not be included as examined subjects, but they are vitally important and should be made available, ideally as a break in the middle, or a voluntary special study module.

4. WORKING GROUP I:
HUMANITIES IN MEDICAL UNDERGRADUATE EDUCATION

KEY POINTS FROM THE BACKGROUND WORKING PAPER PREPARED BY GROUP CHAIRMAN:

PROFESSOR MICHAEL BAUM

AGENDA

1 The justification

A personal view of one medical educator

Open discussion on the role of teaching humanities within the medical curriculum.

2 Prioritization

Prioritising arts and humanities in core curriculum - what should be taught.

Are there examples of successful integration?

Experience in other countries.

What are the problems?

3 Implementation

How can we make it happen?

Curriculum development

Elective periods

"Arts streams" v "Science streams"

Intercalated degrees e.g. B.Med.A.

Qualitative evaluation

Funding

An agenda for Windsor II

Art and humanities for medical students

Science and the Arts are the twin pillars upon which our Western cultural heritage is supported, yet little progress has been made since CP Snow's seminal essays of the 1960s demonstrated the separation of these two cultures. The polarisation of these two bodies of knowledge is perpetuated by our education system to the impoverishment of all. Even the best educated amongst our political and academic leaders have lost close on 50% of their cultural inheritance and the renaissance man has all but disappeared from modern society.

Revolutionary thinking about an undergraduate medical curriculum may see the profession of medicine as the natural bonding medium between these two cultures. This would not only be of value for the individual doctor but inevitably for the patient he or she treats and ultimately for society as a whole. An undergraduate medical curriculum that includes the Arts and Humanities will humanise the practice of medicine, whilst paradoxically making the doctors more scientific in their attitudes.

Over the last two decades, recombinant technology, the decoding of the DNA blueprint and molecular research have advanced science but deconstructed the human subject to a molecular level. Better understanding of human disease and better treatments will emerge from this process but so far we have been unable to reconstitute the complex human organism, through the various hierarchical levels, to that of a successful and healthy personality existing comfortably within his own society.

When treatments were least effective, the humanitarian instinct of the doctor was virtually all that was on offer. But as treatments become more effective, doctors are in danger of losing their humanitarian instincts to become mere technocrats and some aspects of human behaviour are being inappropriately medicalised (Porter, 1997). From thirty years personal experience as a clinical scientist, it seems that the Arts/Science dichotomy in the practice of medicine is entirely fallacious as both are integral to the skilled practice of modern medicine.

How arts and humanities can contribute to the science and practice of medicine

Philosophy of science

In Japanese thinking, the concepts of Kansei and Chisei represent introspection or essence and extrospection or ego.

Kansei	**Chisei**
Introspection - Essence	**Extrospection - Ego**
Immeasurable	Measurable
Non-Duplicable	Dupli cable
Non-Recurrent	Recurrent
Ineffable/Effulgent	Pragmatic
Transcending Time	Actually Located in Time
Without Profit	Productive of Profit
Changeless over Time	Inevitable Changes with Time

Although it is often tempting to search amongst the thinkers of the ancient orient for enlightenment and wisdom, we should also be proud of our western heritage for scientific philosophy. Science as a

philosophy was founded once in the history of mankind in the golden age of Pericles in ancient Greece, and the development of science as a philosophy can be traced from Aristotle via the age of enlightenment in Western Europe, to the late 20th century. To this day we often describe our teaching methods as Socratic when we encourage students to think for themselves rather than handing down received wisdom. Our Western tradition of philosophy has emphasised that scepticism is a healthy attribute. For example, Maimonides (12th C. Alexandria) had the dictum "teach your tongue to say I do not know and thou shalt progress". The essays of Michel de Montaigne (16th C. France) taught us to develop an antithesis when anyone wished to impose the received wisdom on his thinking. He even went so far in one essay as to ask the distasteful question "what is fundamentally wrong with cannibalism?" A similar collection of essays were published by our own Sir Thomas Browne of 17th C. Norwich, a famous physician of his time, who dared to question the holy bible by pointing out that from his research, men and women had the same number of ribs and therefore it was highly unlikely that the first man lost his twelfth rib on the left hand side in order to produce the first woman 1 However, the greatest richness in the history of science and philosophy emerges from the British School of thought which illustrated the poverty of Aristotelian inductivism. This can be attributed largely to the writings of Hume, the Scottish 18th century philosopher, and developed further in the 20th century by Sir Bertrand Russell and Sir Carl Popper.

Evidence-based medicine

It is accepted that the gold standard for evidence-based medicine is the results from reproducible randomised controlled trials (RCTs). The philosophical underpinning of the RCT approach was codified by Popper's *Logic of Scientific Discovery*. But some of the most important

developments in the history of medicine, such as the discovery of penicillin or insulin, were not dependent on the conventional standards now required for evidence based medicine. Medical students need to appreciate the poverty of inductivism and the fertility of deductivism whilst seeing the history of medicine as a series of paradigm shifts as described by the late Thomas Kuhn.

Perhaps the most dramatic paradigm shift was the demonstration of the circulation of the blood by William Harvey who predicted the existence of invisible channels linking arterial and venous systems 100 years before this was confirmed by Antoni van Leeuwenhoek, with his invention of the microscope. It ultimately led to the death of Galenic doctrine.

An intelligent medical student armed with the knowledge of the history and philosophy of science should be able to make the demarcation between scientific (rational) medicine versus unscientific irrational or alternative medicine.

Holistic medicine

There are many lessons to be learnt from the growing enthusiasm for alternative medicine amongst the lay public. The holistic model of the human being is a valuable concept but naive ideas expressed as the three-legged stool (mind, body and spirit) are insufficient to take account of the modern understanding of biology and physiology. It is indeed possible to reconstruct the whole person upwards through a hierarchical system exactly as described in Robert Pirsig's cult book *Zen and the Art of Motorcycle Maintenance,* or taking this to a more sophisticated level using the notion of the holon as described by Arthur

Koestler in *The Ghost in the Machine* - viz- "Organisms and societies are multileveled hierarchies of semi-autonomous sub-wholes branching into sub-wholes of a lower order and so on. The term 'holon' has been introduced to refer to these intermediary entities which, relative to their subordinates in the hierarchy, function as self-contained wholes; relative to their superordinates as dependent parts. This dichotomy of 'wholeness' and 'partness', of autonomy and dependence, is inherent in the concept of hierarchic order." Using this model we can reconstruct the human being from autonomous sub-cellular components such as mitochondria, to the single cell, to cells acting in concert within an organ, for organs co-operating together orchestrated via circulating hormones and lymphocytes, to the psyche situated somewhere in the brain, acting on the soma through cortico-hypothalamic pathways, to the highest level of them all where groups of individuals act as social beings at harmony within their cultural domain.

In order to understand and study this highest level of activity of the human subject in sickness and health, students need to understand the value of qualitative research. Subjective outcome measures such as social adjustment and quality of life are equally important as length of life and we need to acknowledge the contributions of alternative medicine in reminding us of this. Yet we must not court popularity with unquestioning acceptance of bizarre health belief systems as a result of the post-modern pressures of cultural and scientific relativism. Any intervention has the capacity for benefit and for harm. The scientific method is sufficiently robust to study subjective outcomes and quality of life in trials of any intervention whether it originates from the main stream or the fringe.

4. WORKING GROUP I:
HUMANITIES IN MEDICAL UNDERGRADUATE EDUCATION

Philosophy and theology in relation to the understanding and teaching of medical ethics

Medical ethics are not absolute codes of conduct and demonstrate an uncomfortable plasticity with subtle variations emerging between different ages in history and between different ethnic and cultural groups. Medical ethics may be driven by the law of the land or by medical technology, but more often than not medical technology runs in advance of our capacity for ethical control,- the law is a blunt instrument which may belatedly react to medical abuses or public outcry. Traditionally ethical codes of conduct for the practice of medicine have had their bedrock in philosophy and theology. For example, the Hippocratic oath, which is seldom recited today, probably emerged as a result of the teaching of respect for human rights and dignity at the time of the birth of democracy in Athens 400/500 years before the common era. Much of the teaching of Plato and Socrates can be seen reflected in the teachings of Hippocrates. In contrast, contemporary medical ethics is heavily dependent on the teachings of Immanual Kant (18thC.) which have contributed to the four principles:

Autonomy:
Beneficence;
Non-maleficence;
Justice.

However, many tensions arise in contemporary life when these categorical imperatives clash, for example the right to self determination and distributive justice or religious teachings, in issues such as suicide, euthanasia or abortion. For example, an absolute belief in the right to self-determination would encourage suicide and euthanasia which would be an anathema to orthodox Jewish teaching.

The Jewish faith believes that life is of infinite value and you cannot split infinity. Therefore every moment of life is of infinite value, and therefore the individual or the doctor working on the individual's instruction must not do anything to shorten life. In a similar way, witness the current furore regarding the debate between the anti-abortionists (who describe themselves as pro-lifers) and those demanding the freedom of the individual to control their families by the use of abortion where necessary (pro-choice). According to Roman Catholic doctrine, life begins at conception and the individual does not have sufficient autonomy to end the life of the unborn child. Thus, even within our narrow Western world of Judeo-Christian belief system, there are many tensions. Yet when we recognise that our society exhibits an enormous range of cultural and religious diversity, the problems are magnified. For example, how do we accommodate the shariah law of Islam and the Hindu systems of caste and belief in reincarnation. Once again we are in danger of losing respect for minorities within our pluralistic society, whilst on the other hand drifting guiltily into a post-modern relativism of "anything goes". Our young doctors must learn to respect and celebrate the ethnic and cultural diversity of the society in which they work and therefore need to study the fundamentals of theological belief shared by large numbers of their prospective patients.

Theology plays a much more important role in society than merely underpinning the code of medical ethics. Theology is the basis of faith and faith provides spiritual solace for patients at times of suffering or when confronting the inevitability of death. The practice of religion can contribute to the healing of the spirit, but a clear demarcation has to be made from spiritual healing and healing of the body, although one might speculate on the possible links between a spirit at peace with

itself and a body best equipped to heal itself. Students should be warned of the quackery which finds fertile soil in filling the gaps vacated by faith in an essentially secular society, "New age" belief systems have led to a return to animism, idolatry, witchcraft, astrology and the magic bough, mistletoe, which has been reincarnated as Iscador, the most popular unproven remedy for advanced cancer.

Literature and theatre

The study of literature and the theatre has three possible roles in the education of medical undergraduates:

- rebuilding medical idealism;
- deflating medical pomposity,
- providing a window into personal suffering.

In the past many doctors entered medical school fuelled with idealism from stories such as Axel Munthc's *The Story of San Michel* or A.J. Cronin's *The Citadel,* which are not widely read these days. All medical students could usefully read the preface to *The Doctor's Dilemma* as well as the play itself. The works of Voltaire or George Bernard Shaw satirised beautifully the inhumane pompous or arrogant doctor who still exists in the higher echelons of the medical establishment. Sadly these attitudes are also seen amongst young doctors who know all about molecular biology or managing a fund-holding practice, but little about the feelings of patients.

One of the best lessons in medical humility is to study the history of medicine and recognise that improved life expectancy and reduced infant mortality are due to improvements in public health and the relief of poverty, rather than medicine.

In the 19th century, the novels of Charles Dickens aroused righteous indignation in idealistic politicians and therefore contributed as much to infant welfare as any medical achievement of the time. This same sense of indignation should be experienced by medical students reading some of the wonderful contemporary novels from the Indian sub-continent, or gaining first-hand experience from electives in the developing world. Recognising the impact of social injustice on health would educate the undergraduate in the true meaning of the ethics of distributive justice, health economics and the inevitability of rationing. In a just and humane society we must decide how to allocate scarce resources, of which the most precious is skilled manpower, between pursuits such as organ transplants and the less glamorous care of the elderly, the chronically infirm or the mentally ill.

Literature and the theatre also provide us with a window on personal suffering. Talk of empathising with patients is meaningless without a genuine understanding of their fears and sufferings. Good communication skills, which are dependent on genuine empathy and the gift of listening, are a pre-requisite for sensitive doctoring. Students should be taught to respect the patient's natural gift for story telling and exploit it to enhance the conventional medical history. Taken to extreme, an individual's experience of disease and suffering linked with a lyrical gift of poetry, literature and the transcendental, can produce the most beautiful and moving prose.

When proposing literature, theatre and poetry as a component of the study of medicine, we have a powerful ally in the UK's most influential medical journal, *The Lancet.* This has been an important feature of recent issues.

The history and execution of fine art

Many doctors, including high ranking surgeons, are gifted amateur artists and find art therapeutic in releasing the frustrations, tensions and anxieties of their daily work. Art therapy provides a catharsis for even the least gifted patients, who can express themselves through images which provide an insight or window into their fear and suffering.

The traditional link between art and medicine has been in the illustration of anatomy texts, or more recently, to illustrate the techniques of complex surgical procedures. Perhaps the most famous text book of anatomy of all time was published by Versalius in the 16th century and illustrated by some of the leading Florentine artists of the day. Art, Like literature, has often satirized the pomposity and pretensions of medical doctors and quack charlatons (viz: *From Hogarth to Rowlandson. Medicine in Ait in 18th C. Britain.* Fiona Haslaim, Liverpool Univ. Press 1996). It is also a powerful-teaching medium. Great artists of the past have skilfully illustrated the ravages of disease and deformity, possibly unwittingly as in the illustration of breast cancer in Rembrandt's painting of Bathsheva at her toilet, in the Louvre Museum. The model for this painting died nine years later with symptoms typical of untreated, advanced breast cancer. Other examples are Masaccio's Cripple illustrated in one of his frescoes of the Brancacci chapel in Florence, or the goitre of Dante Gabriel Rossetti's favourite model.

A

Another direction which might be pursued is the way in which physical handicap might impact on artists and their creativity. This has been covered in a beautiful short monograph by Professor Philip Sandblom of Gotenberg University, Sweden. Examples might be: Monet's cataracts; El Greco's astigmata; Renoir's rheumatoid arthritis; Aubrey Beardsley's tuberculosis.

Musical performance and appreciation

As with painting, music can be therapy for the doctor as well as for the patient, either in its performance or in its appreciation.

There is a fascinating linkage between the appreciation of music and of speech, and yet there are paradoxical relationships between aphasia and amusia. Several examples are described by Oliver Sacks in his book The *Man who Mistook his Wife for a Hat.* There are patients with severe mental or neurological disabilities who are capable of appreciating or performing music at the highest levels. As with art, many great composers have suffered disease that has affected their physical and mental well-being and inevitably influenced their creativity (covered for example in Anton Neumayr's book *Music and Medicine).* Beethoven's deafness also impacted on his work.

Opera is a remarkable amalgam of theatre, design, spectacle and music; in scenes such as the deaths of Mimi or Violetta in La Boheme and La Traviata, the delicate balance between pathos and bathos depends heavily on the sensitivity of the Director, which is another aspect of the performing arts. The Doctor as Director has a fine tradition, the leading contemporary exponent being Jonathan Miller.

How can we make all this happen?

In order to introduce Arts and Humanities into the undergraduate curriculum we need:

the political will of the medical estabhshment at the highest level;
adequate funding;
space within an overcrowded curriculum.

The first has been achieved unequivocally. Seed funding has already been provided in University College, London by the Heller Foundation, but to develop things further major funding will be needed, possibly from the Lottery Commission or the Millennium Fund. The most difficult to achieve will be finding space in the curriculum, which is already overcrowded and is undergoing an upheaval with the implementation of the new GMC recommendations. At the same time, the recommendations on the undergraduate medical education published by the General Medical Council (GMC, 1993), has given a green light: "As medical research advances it will inevitably become increasingly dependent on the ideas and techniques of other disciplines. On mathematics and physics in the elucidation of complex biomedical phenomena, on the social sciences and philosophy in confronting the wide range of cultural, environmental and ethical issues that will increasingly impinge on the problems of health. It is hoped that the student of tomorrow may be drawn towards some of these other disciplines and that opportunities to study for example a language, or to undertake a project related to literature or the history of medicine, may be offered".

Potential gaps within the undergraduate curriculum for the teaching of medical humanities

Wide consultation produced the following suggestions:

1 *The elective period.* This proved unpopular with some of the undergraduate representatives and the sub-Deans, who feel that this time has been set aside for travel to study medicine in other countries, or for an in-depth study of a subject related to medical science. It could remain a possibility for a few well-motivated students with a particular interest.

2 *First-year special studies module.*

3 *A combined evening "club" for Arts and Science students.* Worth encouraging but would probably appeal only to a self-selected sub-group already interested in the Arts. Not going to achieve the serious ambition of shaping knowledge, attitudes and behaviour of future doctors.

4 *Mapping Arts Faculty input onto the standard curriculum.* This would lend itself well to the teaching of medical ethics, the history of medicine and communication skills.

5 *Intercollated year.* One of the most popular recommendations; ideally all undergraduates should complete a six year course in medicine. The Provost of the combined medical schools of University College, London and the Royal Free Hospital, has agreed to look into the implications of studying arts subjects. Senior academics do not feel that gaining a BA rather than a BSc would be an impediment to the development of a successful medical career.

6 *Summer school.* Professor Bernard Cohen already runs a summer school at the Slade School of Art. This would ideally lend itself to the long summer vacation between the first and second pre-clinical years; possibly part of the Heller Foundation money should provide two or three bursaries for this. Other vacation study modules might be developed but some undergraduates need to work during this time to support themselves through their studies.

7 *Afternoon sports session.* According to the student body, only a small minority of students are actively involved in sports. Therefore the time might equally be used for those who wished to develop skills of an artistic nature. Equal weighting should then be given to those who have excelled in sports or excelled in the arts when deciding on the more prestigious house officer appointments.

8 *The American model.* The Institute of Medical Humanities at the University of Texas, Galveston, has been teaching medical humanities for the last 15 years. Professor Anne Hudson Jones has sent some exciting literature and a prospectus and a visit by representatives of a Faculty of Medicine and undergraduates could be very worthwhile.

In conclusion

Experiencing the music and poetry of a work such as Verdi's Requiem, might be compared to spiritual healing for the terminally ill or, at a more mundane level, anxiolytic therapy for doctors facing the stresses of the week ahead.

Examples of medical student projects and study modules in the arts and health that are available for medical students at University College, London, are shown in Appendix IV.

THE HUMANITIES IN POSTGRADUATE MEDICAL EDUCATION
WRITING AS A REFLECTIVE PRACTITIONER
(A background paper for Working Group 1)

GILLIE BOLTON

Writing is not just a tool - to persuade and inform others, an aide-memoire; writing is not just an art - to transport readers out of their habitual world; writing is also a route to learning about oneself, one's practice, one's thoughts, fears, ideas, skills, experiences '. Writing is an illuminative way of examining practice - viewing it through different lenses, and sharing doubts and knowledge with peers [2].

Reflective practice has been around for some time - a great idea with clear value - but one which few have known how to implement successfully and simply [1.] Yoked alongside both the theory and practice of creative writing, and facilitative group work, reflective practice can plough deep furrows - turning up fresh insights, and rooting out weeds of anxiety, frustration, lack of clarity. Much of our knowledge is embedded in practice: it is the role of reflective practice to uncover this - enable it to be thought about, understood better, and communicated.

Medicine and nursing are tough jobs. Stress levels run inevitably high: snap decisions have to be made, decisions which involve life, death, deformity (both physical and mental). Patients are often at critical turning points in their lives. The stress of dealing with all this can be tackled by writing as a reflective practitioner [2].

Practitioners who have no prior interest in writing, and do not intend to develop creative writing, benefit from this approach. Many, in fact, are very nervous at the thought of writing before they start: but this soon evaporates.

Principles and Practice

Writing as a Reflective Practitioner groups, whether doctors, nurses, or multi-disciplinary (including counsellors and support staff), are always small (8-12 participants), closed, and create their own set of ground rules which always include elements such as confidentiality. The course may be a module on a postgraduate degree, or other postgraduate requirement.

Practitioners write accounts (generally narratives or stories) based on experience; these usually take the form of *a time when...* (eg *...Ilearned something vital),* or from an open title created by the group (eg *the time the pressure valve blew).* On one occasion a group of doctors wrote about the showing of emotion. One wrote an account of when he cried with the parents of a child who had just died; another wrote about when she knew she was a real doctor the first time she fought back her tears and managed to conceal her emotions from her patient and their relatives. The group had an intense discussion which ranged over ethics, further examples of experience, psychology, and so on [4] \

The writing method used is extremely simple, and easily grasped and practised. Group members quickly find a facility with written words to express thoughts, feelings, theories, and to communicate actions. A far greater facility with writing - whether for reports or case-studies, or academic articles - is a spin-off from these courses.

Master in Medical Science

Writing as a Reflective Practitioner has been delivered successfully in the Education Methods module of an MMedSci in a university Institute of General Practice &. Primary Care, for several years ". The pedagogical ethos of the whole masters degree is of self-directed, student centred,

non-competitive learning[7,8] and the student group is multi-disciplinary (GPs, health visitors, etc.).

Two of the four elements of the summative assessment portfolio are: a learning log or diary; a set of reflective narratives. The diary consists of reflections on the whole module: teaching, learning, the creation of formative and summative assessment materials. The reflective narratives are a series of connected stories concerning a professional incident. Fiction is used here - to allow the student access to points of view, or vantage points other than their own, or the purely factual. Rewriting the core story from the point of view of the patient, for example, putting themselves in their position, enables empathy with the patient. Or the writer may experiment with seeing how the situation would have been altered if the genders of the main characters were switched, or if the conclusion of the event had been felt to be satisfactory. As students write and reflect, more and more aspects of the situation emerge which can be explored through further linked narratives. These stories are accompanied by reflective passages on the writing process and insights gained. They are read and discussed in the group. All these rewritings and discussions invite deep reflection on the incident[2].

Peer-mentoring is a vital formative element of the module. The group meet each week without their tutors: as a whole, and/or in pairs and threes. Specific pairs / threes are organised at the start of the module: they read each other's portfolios and discuss them constructively.

Continuing Medical Education for GPs

Postgraduate-education-allowance credited courses are run on similar lines to that described above for the reflective narrative element of the

MMedSci. GPs have to do thirty hours of continuing medical education (CME) each year; these courses offer effective professional development, as well as support (perhaps similar to Balint groups) [9].

A computer-based Writing as a Reflective Practitioner module is run as part of a CME portfolio. Eighteen GPs are members of a closed email group: writing narratives and commenting on each others' writing. They practise in different parts of the UK, and abroad, and are only in email contact. This is an innovative pilot research project, and is generating a great deal of interest and involvement in the members so far, and is intended to develop towards multi-disciplinary groups. Group members can write and contribute to the group in whatever time suits them - at night / early in the morning / Sunday afternoon. This approach could have great impact on CME for GPs who work very long hours.

Courses have also effectively been run for trainee (Vocational Training Scheme: VTS) GPs, and for VTS trainers. This allows both trainees and trainers to reflect on the process of becoming a GP after their arduous medical training and hospital posts.

In-service Training for Multi-Disciplinary Health Care Teams

Similar courses have been run for full primary health care practice teams, and for nurses and for other groups such as: child care specialists (psychiatrists, paediatricians etc.), gypsy support group health workers. These courses have been found to have a powerful team building element. Team members learn to know each other more deeply, and to trust each other more fully. They feel more able to ask advice and be open about problems and uncertainties after such a course.

The Future

Writing as a Reflective Practitioner courses have been running for the last ten years in these fora. Each course is carefully evaluated in order to develop and refine the principles and practice. This method has proved to be successful with these groups; it could therefore be extended to further health care staff or students. Writing uses our main everyday communicating tool - words, unlike most of the other arts; it is therefore accessible. Humanities in medicine and nursing are set to become a major influence into the millenium; writing has a vital part to play.

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NOTES FROM PROFESSOR MICHAEL BAUM'S INTRODUCTORY CONFERENCE PRESENTATION

The theme of the session on medical education emphasises that art and science are complementary but dichotomy is entirely fallacious. Western culture is based on two pillars, science and art.

> *"Unlike science which is concerned with the general, the repeatable elements in nature, medicine, albeit using science, is concerned with the uniqueness of the individual patient. In its concern for the particular and the unique, medicine resembles the arts"* (Kenneth Caiman, in: Downie, 1994).

So talk about arts and science in medicine is a false dichotomy; the two should be taught hand in hand, within a common syllabus.

The use **of Humanities in the medical curriculum**

Arts and humanities which may at some time be useful in the undergraduate or postgraduate curriculum include:

philosophy,
theology,
literature and poetry,
history and practice of fine art,
music.

Science as a philosophy is particularly relevant today. At the very least, medical undergraduates must be able to distinguish inductive logic from deductive logic before they can begin to grasp what is meant by evidence-based medicine, and attempt to understand the demarcation between modern scientific medicine and alternative medicine, which has such a hold on the popular imagination at the present time.

Science has two steps - hypothesis generation and hypothesis testing. The generation of a hypothesis is an act of creativity - hypotheses are beautiful. A scientist though, does not believe his hypotheses and that is what students have to be taught - the creativity of building a beautiful hypothesis from discordant facts and observations and then the intellectual integrity and modesty of not believing it and testing it.

Medical ethics is determined by philosophy and culture and it differs according to the period in history and the country one is living in. Four categorical imperatives, autonomy, beneficence, non-maleficence and justice, underpin most of our contemporary attitudes to medical ethics, but in ethical dilemmas there is a clash of these categorical imperatives, and so there are no answers. Often deeper models, other ethical treatises or even the Bible are needed.

Literature and theatre are wonderful for building up medical idealism, and at the same time, for destroying medical pomposity and arrogance. Sadly students seem to read less today and few enter medicine fired with enthusiasm from books they have read. But idealism is important and we should not be embarrassed by wanting to do good and help people. As a window on the soul, the literary arts allow us to learn about empathy through beautiful narrative descriptions of the experience of disease. Examples of inspirational stories of triumph over adversity are those of the blind and deaf American writer, Helen Keller; Alexander Solzhenitsyn's *Cancer Ward;* and Bertolt Brecht's play. *The Life of Galileo.*

Fine art is relevant to many areas of medicine. It can give insight into the experience of patients, or provide satirical comment on the profession. It is used to illustrate anatomy and pathology and there are

fascinating treatises on visual pathology in art, such as that on Monet's cataracts (McLellan, 1996). Axt can have a tremendous impact and produce powerful responses. The most important discovery in medicine, in the next millennium, would be the understanding of art.

Music may be of some interest in neurology and there is an association with empathy through music's powerful capacity for expressing strong emotions. Probably the role of music in undergraduate education is best left to the undergraduates themselves to develop their own performing talents. Many of the best A-grade students are also very fine musicians, or performing artists in other ways. Music as therapy for the doctor cannot be recommended too strongly.

It is necessary to discuss prioritisation of the various subjects under the broad headings of Arts and Humanities, viz:

- Sociology
- Scientific and Ethical Philosophy
- Comparative religions
- Visual/Performing Arts

Consideration also needs to be given to any examples of the successful integration of such subjects into curricula in this country or abroad. This Working Group therefore includes doctors, artists, thinkers, writers, a classicist and leaders of religion.

Two concluding quotations:

"Beauty is truth, truth is beauty"

John Keats, 1817, one of the few English poets who knew about science, having trained as a surgeon.

"Science is the disciplined search for truth"
Sir Alan Cottrell, FRS (The Times, 1996)

So if truth is beauty, and science is the disciplined search for truth, then once again, the dichotomy between arts and science is entirely fallacious.

CONCLUSIONS AND RECOMMENDATIONS FROM GROUP I
The Humanities in Medical Undergraduate Education

There was unanimous agreement on the value of the humanities, although there was some discussion about what exactly was meant by "the humanities". Generally, it was agreed that we were essentially concerned with moral philosophy (ethics), literature, classics, history and theology - as well as with fine art and the performing arts. It was repeatedly stressed that a training in the humanities leads to different ways of thinking: not necessarily better (or worse) ways of thinking, but different.

Problems/ailments:

Certain problematic features identified in the current medical undergraduate training were:

- danger of a lack of compassion in young doctors; during the course of the session "lack of compassion" was modified to "lack of empathy" and finally - and most appropriately - to "failure of empathy", since they are not without empathy, but simply have lost touch with its importance and how to experience and use it:

CONCLUSIONS & RECOMMENDATIONS FROM GROUP 1

- doctors are increasingly becoming specialists, "technicians"; there is thus a crucial need for them to develop judgement - which is learned, not taught,-

- there is an urgent need to expand the experience of life and not just the knowledge of the students;

- medical schools suffer from insularity, with students rarely experiencing the full rich range of experience that a multi-faculty environment should offer;

- medical students all too often suffer from tunnel vision, when they should be thinking more widely and laterally;

- there is a real lack of student leadership;

- the culture of Medical Schools is at present not very sympathetic to the notion of embedding the humanities in the curriculum; there is a need for culture-change not only of role-models but also of institutions (the role of Deans will be crucial here);

- there are few opportunities for education "time out" from medical curriculum;

- due to the pressures of A-levels and the demands of university admission officers, students often lose the natural interest in the arts that they had at school;

- there is a lack of mature students (not in the UCAS sense of those who are merely over 21, but students who have come to study

medicine after other experience, be it of work or of other degrees or training).

Learning from others:

After establishing our list of ailments, the Working Group set about considering how best to remedy them by learning from the experience of colleagues who already have a great deal of experience in the field. We first of all heard from colleagues at Glasgow University who have developed a Special Subject Module in Philosophy, as well as embedding the study of literature not only in the undergraduate curriculum but also in seminar groups for staff.

We then heard from colleagues from the Institute for the Medical Humanities at the University of Texas (Galveston), where they have twenty years of experience in the field. The experience at the Galveston campus was compared and contrasted with that at the Hershey campus (also part of the University of Texas Medical Schools). This information was enormously helpful in that it provided us with two different models of how to go about it, whilst also warning that neither solution is a hard and fast solution! Indeed, one of the most important and useful pieces of advice that Professor Anne Hudson Jones of Galveston gave us was that although we are twenty years behind them, they are still grappling with some of the issues that are troubling us. However, their experience will prove invaluable as we move forward in the UK.

We finally heard of Professor John Martin's experience in Australia - one further, different perspective, again reminding us to beware of assuming that solutions can simply be transferred from one environment to another.

In further discussion, it was recognised that

a while there is a need to change the culture, much is already happening that should be welcomed and applauded, and

b while it is essential to keep our idealism, it is crucial also that we retain a sense of realism and propose solutions or actions that are realisable.

Our over-riding aims were identified as:

- to change the student intellectually and emotionally,-
- to change the student's interactions with the patient;
- to develop an evidence base that this approach leads to the production of better doctors.

Actions proposed are:

- we should work to introduce humanities into the 5-year programme, rather than alongside it; here the consensus was that the main need is to embed humanities into the curriculum through Special Study Modules, rather than simply offering the possibility of using the intercalated year;
- there is a need to know what's going on - and where; we suggest the setting up of a national database - and perhaps also an electronic mailbase for discussion and information;
- their is clearly a need for much more active dialogue with schools about curriculum issues - and about expectations (of students, their teachers at school, admissions officers at university, etc.); we also echoed Sir David Weatheral's endorsement of the recommendations of the recent Dearing Report on education for 14-17 year olds;
- there is a need to encourage role-models: senior medical teachers should be actively encouraged to take part in the project and ultimately perhaps even to pubhsh in the field of the medical humanities;

- extremely strong support was given throughout our discussions to the importance of maintaining the first MB;
- there is a need to embed medical humanities not only in the undergraduate curriculum, but also in continuing medical Education, in order to ensure that lifelong learning becomes a reality and not just a catch-phrase;
- we live in a multi-ethnic, multi-cultural, and multi-faith society; this needs to be recognised and, if possible, reflected in the humanities courses we offer;
- there is a great enthusiasm for the initiative amongst individuals; we need to try to establish the sense of a consensual national movement - as well as working to influence individual Deans and the heads of institutions to change their policies and become more flexible,-
- Sir Kenneth Caiman's notion of an Institute of Medical Humanities, based somewhere (possibly in Durham) and with "spokes" in other cities is an excellent one; this would rapidly become a valuable national resource, and could become the centre for the creation of open and distance teaching and learning packages available to all Medical Schools.

Conclusions:

In the modern world, during the course of an average clinical career, a doctor needs not only to learn a great deal of knowledge, but also to unlearn up to 50% of this knowledge in the light of new discoveries,- the humanities offer a training in flexibility and this alone is one of the greatest benefits of embedding them in the undergraduate curriculum.

Disciplines such as the social sciences are extremely useful and important in the medical curriculum, but they focus on the **group.** This

tends to compound the worrying neglect of the **unique person** perspective. There is a need to put the concept of the unique person at the very heart of medical activity - and in this, the humanities will prove invaluable, since their focus is always the **individual.**

The medical undergraduate curriculum will always include - indeed, it must always include - a great deal of *training.* However, we must strive also to ensure that our students receive an education as well as training, so that as doctors they can be both critical and humane. In order to achieve this, we believe, there is a need for students to experience - and to be examined in - the humanities during their medical studies.

We concluded with the following tripartite definition of the well-trained and well-educated doctor:

a doctor who thinks for him/herself;
a doctor who thinks from the point of view of the patient;
a doctor who thinks critically - and consistently.

5. WORKING GROUP II: HUMANITIES IN COMMUNITY DEVELOPMENT AND HEALTH

KEY POINTS FROM THE BACKGROUND WORKING PAPER PREPARED BY GROUP CHAIRMAN:
REVEREND ANDREW MAWSON

AGENDA

1 The context

What is the current situation?:
current activities /perceptions /beliefs /models of effective practice
What are the problems?
What are the opportunities?

2 Ways forward

Which specific issues need to be addressed?
Who are the key players?
What mechanisms are there to move from discussion to action?

3 Developing a specific action plan

This might include:
Establishing some practical pilot demonstration projects across the nation
International networking, strategic research, exchange and funding
Qualitative evaluation

Important points to agree:
A specific agenda for Windsor II
Indications of progress

5. WORKING GROUP II: HUMANITIES IN COMMUNITY DEVELOPMENT AND HEALTH

Some controversial thoughts to stimulate discussion:

- Is the commitment of almost 100% of government resources for health to the NHS compatible with the NHS track record in addressing health needs in poor communities? In Tower Hamlets 18% of the population have poor health. Is the only issue one of resources, or is there a more profound disconnection? In short, is the present approach healthy, or is a treatment required?

- Would it make sense over time for some of that resource (1-5%) to go to community initiatives that find appropriate responses to health needs that draw on many health traditions from around the world, but also from Britain. (Although some funding does go via health authorities to the voluntary sector it is mostly for very specific activity, e.g. which is not community related.)

- If so, what sort of initiatives should be supported? Is there a need to experiment? Could creative projects be supported? Could we learn from successful primary care projects in developing nations?

- What mechanisms will be needed to ensure that funding goes to high quality, innovative, entrepreneurial projects which are genuinely responding to needs of their communities. (In affluent areas this may well be about counselling and aromatherapy; it is likely that something additional will be needed on Merseyside.)

- Part of this might be to "de-professionahse" health, so that people and communities take active ownership of their health, rather than simply being passive patients and victims, complaining that they would be healthy if only this treatment were available or that hospital hadn't closed.

- Could this also relate to the move towards "evidence based medicine", which is showing just how significant the placebo is, especially for chronic conditions. This shows that often if you think you are going to get better you generally do, the actual treatment is secondary. Rather than see this as a negative, see it as a way of enabling communities and individuals to generate their own methodologies for promoting health (or indeed for allowing death to take its natural course for the terminally ill).

A new publication: *FrontLine*

Members of Working Group II received with their background material, copies of the pilot issue of a new magazine *FrontLine* (FrontLine Publishing, PO Box 16529, London SW6 2WQ), described in its promotional material as *"a fresh approach to social issues which reflects Britain's changing priorities".* The aims of this publication are:

- to provide a lively forum for social policy debate, for the widest possible audience
- to provide practical help such as the *Drugs Guide for Parents and Professionals* which comes with this first issue.

As Editor Alain Cass, ex news editor of the Financial Times, explains: *"The front line in our lives is the place where we engage and make choices. But first we genuinely need to listen. Fostering the self-confidence which leads to enterprise and innovation hinges on real dialogue. As the state withdraws from more areas of our life - and it will - we need to be more self-reliant, not least to help those who most need our help. We need new 'ways of tackling the issues we face - as professionals, parents and communities. FrontLine is a window, a way into that process."*

WORKING GROUP II:
HUMANITIES IN COMMUNITY DEVELOPMENT AND HEALTH

Many of the articles in this Spring, 1998 issue of *FrontLine* focus on the Bromley by Bow Healthy Living Centre in Tower Hamlets, of which Reverend Andrew Mawson is the founder and chair. They show how an integrated project involving the arts in a community setting to achieve the key aims of:

- increasing self-confidence and self-esteem;
- promoting self-reliance;
- unlocking creativity and imagination.

This not only enhances the well-being of individuals, but, by helping them to achieve unrealised potential, may mobilise the inner city's greatest resource, its *"social capital"* of *"energy and goodwill"* (Greer, 1998).

"Social Capital"

Germaine Greer *{FrontLine,* Spring 1998 Issue) describes Bromley by Bow as the poorest parish in England with the biggest welfare bill, but it also has the highest population density of any urban area of similar size, and that means huge resources of "social capital". What is needed she believes is a new kind of welfare provision, which is about empowerment, not control, and which will create a whole new industry of "mining" people for their energy and goodwill, the "inner city gold". This is what is happening at the Bromley by Bow Centre. *"The experiment that began in Bow 15 years ago, when a church climbed down from its eminence to become a centre run by local people, has generated, and continues to generate, incalculable riches"* (Greer, 1998).

This re-integration of church and community has been described by the Centre's Chief Executive, Allison Trimble: *"Like the medieval*

cathedral, the church sits amidst the market place of everyday activity, allowing the vibrancy and diversity of life to surround it and enabling a mutual crossover of influence between the secular and sacred. . . . It is here at this interplay....between those who traditionally receive change and those who traditionally control change that the creative tensions which lead to transformation are to be found. We have discovered a deep well of energy at the heart of this interplay; a source of renewal which is borne out of the willingness to celebrate our differences and find the common ground to move forward" (Trimble, 1996).

Social Entrepreneuring

Social entrepreneurs are the agents for change in community environments. They help people to take charge of their own lives, by identifying under-used resources - people, buildings, equipment, and employing them to satisfy unmet social need (Community Action Network promotional leaflet). Using skills most commonly seen in the business world (Leadbetter, 1998) they create **social capital** by combining the powerful resources of big companies and enterprising local people, to their mutual benefit. Projects such as the Bromley by Bow Centre train local people to become social entrepreneurs, giving them the opportunity to experiment and "run with their ideas", to make good things happen for themselves (Trimble, 1996).

Whilst local people are given the opportunity to make the best of themselves, involvement in community projects has had *"unquantifiable and unexpected repercussions"* for big business, the principle benefit being an insight into an environment that is *"tougher, more fast moving and more committed than big business itself"* (Kelly, 1998). The culture of community projects, and the shared beliefs and

values, has led to increasing recognition in private industry of the value of people and the kind of skills which promote co-operation. Examples of big organisations working with community projects are:

- Multinational insurers Royal &. SunAlliance, sponsors of the Bromley by Bow youth project. SunAlliance is a service organisation, i.e. about people, and the project is about backing local young people to make a difference in their community. The culture of the project seeps back into the organisation through regular visits and discussion of the different values seen in operation (Kelly, 1998).

- The Atomic Weapons Establishment (AWRE) at Aldermaston, Berkshire is collaborating with East End teenagers and research scientists from Great Ormond Street Hospital to design an ultra-safe, vandal-proof playground (Julien, 1998). For AWRE, working with communities is part of a public relations campaign to improve their public image. The opinion of one of the teenagers, after a meeting at Aldermaston, was that "it made you feel you could achieve anything you wanted" (Julien, 1998). The designs, which are based on different parts of the human body and include a climbing frame shaped like a rib-cage and ladders modelled on a DNA chain or helix, will be exhibited at the Science Museum and, it is hoped, used by other playgrounds around the country.

Community Action Network

The Community Action Network (CAN) is a network of "social entrepreneurs" which has been formed to provide both Internet and face to face links to help members share best practice, inspiration and encouragement (Baird, 1998). Social entrepreneurs in this context can be individuals who run organisations in the not-for-profit sector and who

find innovative solutions to society's most pressing problems. It is hoped that the network will help to reduce the isolation which may be experienced by busy people committed to transforming communities. CAN has been provided with office space in the Royal & SunAlliance's building on Haymarket for its office space and a Community Action Centre where members from around the world can meet and swap ideas. The network's entire first year funding has come from the private sector, other corporate supporters including GTECH, the Coca Cola Foundation, the BG foundation, BNFL, Whitbread and Arthur Anderson. Other supporters include Business in the Community, the National Council for Voluntary Organisations, several Christian denominations, Lord Young of Dartington and the Fermanagh district council. Statutory funding has come from the Home Office. Interested parties from both public and business sectors are welcome to join the Network. It is envisaged that by the end of the year 2000, CAN will have 2000 members, linked in mini-networks of 10-11 (Baird 1998).

Community Action Network is based at the Community Action Centre, Panton House, 25 Haymarket, London SW1Y 4EN tel: 0171 321 2244. Its aims are to:

- identify high potential social entrepreneurs in the UK;
- link these individuals and organisations in a network, both electronically and through direct personal contact;
- disseminate best practice;
- provide useful training (e.g. on legal, training and funding issues);
- raise the profile of social entrepreneurs;
- improve the volume and quality of work performed in communities by CAN member organisations.

The role of the Arts in Inner City regeneration

According to Allison Trimble (1996) of the Bromley by Bow Centre, the arts have a critical role to play in making impossible dreams become reality: *"The emphasis on the arts is based on the view that if you resign from your creativity you resign from your humanity. Artists therefore play a key role in the project, providing the vehicle which enables people to discover new things about themselves and thus restore their human potential to create change. At the heart of any artistic activity is the process of transformation and it is through the experience of taking part in these art sessions that many local people have found the tools to engage with regeneration programmes rather than remain the passive recipients of change. The role of professional artists has ensured that high standards of attainment are both set and achieved"* (Trimble, 1996).

Art projects can break the patterns of failure with which the inner city is associated, by raising expectations and encouraging people to look at situations with fresh eyes (Trimble, 1996). So local people become confident partners in the ensuing process of change. In the many art classes offered, distinctions between givers and beneficiaries are blurred. The objective is that with art as the medium everyone can realise unfulfilled potential through contact with other people and other cultures. Many people come to escape social isolation: art in the various forms in which it is practised at the centre, offers a way in for people which transcends age, race, gender, disability, formal education and quite a lot of cultural hostility.

Many works of art have been used in the project buildings and gardens to instil a sense of beauty and inspiration in stark contrast to the cheap, degenerate environment of the surrounding area which reinforces the

endemic sense of failure. The physical and emotional environment of the Centre has been designed to reflect the high value placed on the people who use it and is based on integration, creativity and excellence.

Integrating community and health services

The Bromley by Bow Centre grew in an inner city community beset with problems of unemployment, neglect, racial tension and NHS cuts. One of the victims of this environment was "Betty", a single mother who died aged 35, failed by both health and welfare services. *"The last months of her life were a horror story of incompetence, lack of communication, lost letters, missed appointments, indifference and broken promises by doctors, hospital staff, social workers, health visitors and government ministers",* a story which provides *"valuable insights into a system of care under intolerable pressure which is in danger of losing its way and its humanity"* (Cass, 1998). However, the manner of Betty's death inspired the local community to raise funds for a new medical centre. In contrast to the completely fragmented care which Betty received, the new centre is committed to a truly integrated care system whose team approach will involve not only health professionals, social workers, education experts, project staff and volunteers but also artists and musicians. It has been recognised as a model for the Government's new initiative of Healthy Living Centres (Our Healthier Nation, 1998).

Concept of a Healthy Living Centre

The vision for Healthy Living Centres needs to grow from within people and communities in the same way that local families in Peckham discovered how to use the new centre which appeared in their neighbourhood in 1935. When the Pioneer Health Centre in Peckham closed in 1950 a community lost a resource which they had helped to

create. Today it has been replaced by its similarly named successor, the Pioneer Health Centre (PHC) which works to foster and promote the values and practices which led to the building of the original Centre and the research and activity which flowed from it. PHC is arguing for a continuation of the work of The Peckham Experiment. The need for understanding health and for providing people with the opportunity to explore how they achieve it is as radical today as it was when the Centre closed in 1950. As PHC has reported (Editorial, 1997a) we live in a world of different technologies, cultures and beliefs today, but the process of achieving physical and emotional health through growth and development is the same. A Healthy Living Centre can provide space and opportunities for activities which are impossible in a domestic environment but which can be equally free. Some strands which PHC has identified which may prove important include:

- art activity which is fully participative, avoids judgement and an over emphasis on the production of an "art object or performance";
- opportunities for physical exercise which draw on our capacity for play and spontaneous action;
- the importance of creating a space where everyone within a local community feels welcome and able to explore how they can achieve the best quality of life given their particular circumstances;
- providing child care resources so that parents can balance their own needs with those of their children;
- many good links with other agencies to ensure that people can get information, advice or services outside the centre,-
- some form of family or individual monitoring and review process which establishes the whole picture of a person's life as part of a wider community. This might be a Quality of Life Audit which draws together information including health, housing, income and social contacts.

There are now around 70 contacts across the UK who have expressed interest in developing closer working links under the broad theme of improving quality of life locally. They form a network which has the potential to grow into a dynamic and sustainable means for local projects to share good practice and mutual support.

Today there is an increasing reliance on new partnerships with the voluntary sector to provide essential health and social services in the community. There is also a growth in private business involvement in creating local leisure and sporting opportunities. These present an exciting opportunity for partnerships at a local and national level.

People involved with these projects are moving into an innovatory field which is challenging the separate disciplines and sectors which provide services for local communities. The aim of the now-established Quality of Life Network is to ensure that people can make contact to grow and develop together and benefit from different views and experiences. The end result is intended not as a formula or a blueprint, but a pool of information and inspiration which can be shared.

As PHC has reported, the shared values under the Quality of Life banner include:

Health is more than absence of disease, it is concerned with personal growth and development in a full relationship with the physical and social environment.

Participation in decision making and action is a vital part of achieving health. Participation by local people is essential in the planning and development of health, social and leisure facilities.

Inclusion - personal and community health relies on a balance between privacy and opportunities for involvement. People should not be excluded from local health, social or leisure opportunities.

Sustainability - the network will only survive in the long term if members contribute as well as consume shared resources.

Personal growth - given an appropriate physical and social environment, people have an innate capacity to grow, develop their abilities and meet their own physical, emotional and spiritual needs, in co-operation with others.

Quality of Life - quality of individual and community life is achieved by creating space and opportunity for spontaneous physical and social growth and development to occur, complemented by medical and other forms of intervention.

Co-operation - network members will need to co-operate to provide shared information resources, training and development opportunities coordinated by PHC.

Use of modern technology - to create a "virtual community" where the pool of information available is contributed to and shared by network members.

PHC works in co-operation with individuals and organisations to promote these values and to ensure that resources are made available to research into the nature of human health and provide space and facilities for people and communities to grow and develop from within.

PHC can be contacted at:
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Tel/fax 01705 755540
Email dplloyd@dial.pipex.com

The Bromley by Bow Centre

In its green paper on public health *Our Healthier Nation* the Government proposed a network of Healthy Living Centres aimed at improving health amongst poorer communities. According to Minister for Public Health, Tessa Jowell, these community projects, partly funded by the National Lottery, must *"belong to the, communities that they serve and not be parachuted in from Whitehall"* (Jowell, 1998).

Bromley by Bow is a prototype for such a centre. *"Health is about living, it's not about ill-health"* (Allison Trimble, quoted by Summers 1998). The Bromley by Bow Centre has grown to include community care services, education activities, arts projects, ethnic minority programmes, health projects and community regeneration schemes.

Many GP consultations are about non-medical problems and often poor health is a result of stress and inadequate support. The concept of a Healthy Living Centre sets health in an integrated social context where a holistic attitude to clinical services means that a whole range of services or activities can be offered. The broad primary care team at the Bromley by Bow Centre allows GPs to concentrate on clinical issues and patients to take art classes rather than anti-depressants (Ramm, 1998).

The centre is founded on the pillars of health and social care, education and training, employment and enterprise, the environment and the arts. Its aim is to empower local people to make choices and ultimately take

responsibility for their own lives (Ramm, 1998). In addition to the art classes, nursery, cafe and care facilities, other activities now include:

Health promotion initiatives including:

- the setting up of a food co-op, jointly funded by health and local authorities, where people can purchase fresh fruit and vegetables more cheaply than in the shops;
- a welfare and benefits advice shop offering help with problems related to housing, money and bills;

Training for volunteers including:

- Computer and groupwork skills;
- Stress management;
- First aid;
- Health promotion topics such as diet and nutrition,-
- Opportunity to progress to NVQ level 2 in health and social care.

Health Connections: a lottery funded project offering complementary therapy classes including:

- Homeopathy;
- Massage;
- Reflexology;
- Yoga,-
- Aromatherapy;
- Alexander Technique;
- Tai Chi.

and exercise classes including:

- Aerobics;
- Dance classes for children;
- Exercise classes for Bengali women;
- Individually tailored exercise programmes for older people with arthritis or heart or respiratory problems;

- Circuit training for boys.

Talking Art, a King's Fund funded project using visual and performing arts to help local people to gain a better understanding of health issues in order to support personal change. This will include:

- Birthday cards for children, including "vaccination party" invitations to improve the uptake of immunisation - intended outcomes are to promote awareness about child health, facilitate preventative health care by increase of take up of immunisation, and to create an accessible and friendly profile for the Health Centre in the local community across all cultural boundaries;
- A weekly group run by a professional story teller, a health promotion worker and an interpreter to explore themes such as the history of health care and to help adults aged 60+ share their life stories; - it helps to deliver health promotion material;
- Workshops for primary health care workers to explore the use of art to communicate health information, demystify it and make it more accessible;
- A singing course for young asthma sufferers to help their breathing techniques, alleviate symptoms and cut reliance on drugs;
- A dancing and movement course for those with weight problems who experience depression and low self esteem;
- A programme for people with eating disorders.

Bromley by Bow Centre is being recognised in some circles as a pathfinder scheme that could provide the model of inner-city regeneration (Greer, 1997).

NOTES FROM REVEREND ANDREW MAWSON'S INTRODUCTORY CONFERENCE PRESENTATION

Andrew Mawson is a practising clergyman who has spent the last 15 years working in the middle of a group of run-down estates in Tower Hamlets, London, where fifty languages and dialects are spoken within ten minutes walk of the Bromley by Bow Centre. When he first came he found 12 elderly people sitting in a 200 seater church. Slowly he gained a pastoral insight into the complicated realities of people's lives in that community, trapped by unemployment, mental ill health, financial problems or old age.

The church's elderly caretaker suffered from kleptomania but despite endless bottles of pills and endless trips to the doctor she never got any better. One local GP, aged 70, didn't put heating on in his waiting room in case his patients wanted to stay. The area also had one of the largest artistic communities outside America but it was massively unconnected with ordinary people's lives. The question was, what did it mean to be there as a clergyman in such surroundings?

In Bromley by Bow, it was decided that the old church buildings should be given away to the community. The interior of the church was ripped out, and a canopy put in defining a church for 40, leaving room for an integrated children's nursery, a toy library, an art gallery round it, and a canopy that lifts up to create a theatre in the middle of this human activity. Artists were given rent-free space for workshops in exchange for running art classes for local people.

A community care facility was developed for a lot of very vulnerable people who had been dependent on a culture of doctors and social workers from Essex, coming to solve their problems in the mornings and disappearing at night. Gradually local people, often those who had needed to be cared for themselves, were enabled to become the carers;

like Karen, an agoraphobic who four years ago never came out of her flat but who now runs the community care group.

Some of the most vulnerable people in the community were falling through all the safety-nets of so-called health and care. One young woman died of cancer in appalling circumstances and after her death an enquiry was held and very difficult questions were asked. As a result a group of local people determined that the community should take responsibility for health for itself. The first integrated health centre has now been built, bringing together GPs, nurses, health in arts, education, a three acre park, sheltered housing and support and care, in a fully integrated project.

Experience has shown that life is integrated, and to be effective in our inner cities it is necessary to deal with everything at once, the whole person, the whole situation. Also, GPs working in very difficult circumstances, often quite isolated or under pressure, need to be connected with other people, other carers, other artists.

This week (i.e. in March 1998) the Bromley by Bow centre was opened by Tessa Jowell as the first Healthy Living Centre of its kind in Britain. It exemplifies this integrated approach to the whole person, offering local people access not only to the the doctor, but to 125 activities going on each week, to do with the arts, the environment, the caring, of which they can become a part. The next generation are going to demand an integrated view of the world, in which art and health and quality of community are all profoundly interconnected.

Fifteen years ago real disconnection was apparent between the many different bodies, health authorities, trusts, local authorities, central

government and many different departments operating in the East End. This is beginning to change and there are now many possibilities. This conference (Windsor I) is one of the occasions when some of the foundation stones of this more integrated way of thinking about health and art and our humanity will be placed on the ground.

CONCLUSIONS AND RECOMMENDATIONS FROM GROUP II

Humanities in Community Development and Health

Some initial thoughts from group members:

- This area is concerned with broad "quality of life" issues covering health and social policy.
- It goes beyond the medical profession to include the whole health/social team and the whole person.
- Visible examples are needed. (Should Health Action Zones include arts based activity?)
- Healthy Living Centres could provide an important opportunity to weave arts into the health agenda.
- A national network of five year projects would have the potential to make international links.
- There is a need for training and induction of artists to work in this emerging field.
- Information technology can provide an area where health, education

and arts can work together and have fun!

- It is essential that the public can participate in a friendly and welcoming environment.

- If additional money is limited a real shift in this direction will mean that something else will need to go.

- Evidence based interventions and a range of methodologies are needed in this field.

- This will require research, evaluation and better co-ordination. At present there is a lack of information about current activity.

- A focus of some kind is needed. This could be in the form of an office, published information (including research), an electronic journal, peer review process. This information needs to be widely available.

The discussion opened up to cover a wide range of topics:

- The development of a market place for trading or bartering information with IT providing the way of sending and receiving information.

- The importance of local action working with ordinary people. Existing bureaucratic and voluntary structures do not understand the process. Young people and Local Exchange Trading Schemes (LETS) are alternative models.

- There is a need for professionals and the public to share expertise.

CONCLUSIONS AND RECOMMENDATIONS FROM GROUP II

- It was suggested that vested interest is natural and should be accepted and used to develop the work.

- The process is emergent and relies on flexibility and responsiveness.

- It involves risk but requires consideration about how this can be balanced with safety. Criteria are needed to establish what is good practice.

- The final product may be less important than the process. How do you prove the quality of the process? The outcome is the person and their experience, development and achievement.

- Responsibility of health as part of broader quality of life/well-being rests with local authorities, business and the voluntary sector (who often find it hard to share resources). A body of testimony is required to celebrate the links between health and culture.

- The new British government provides an opportunity to develop this area of work.

- There are links between creativity and local entrepreneurs. Self help and mutual support grow from a creative response to situations.

- There is a need to link this grass roots activity to bigger gallery/prestige projects.

- A4E (Arts for Everyone funded by the Lottery) projects can link health and youth policy. Grants of less that £5000 can make a big impact locally.

- Local Agenda 21 could provide a way in for local authorities to explore quality of life/health and well-being issues. Arts are an ideal catalyst for change.

There is a need for the NHS and Arts Council to work together and a cross departmental lobbying to draw together Public Health, Culture Media and Sport and Education policy.

Arts can act as oil or connections which make other activity more effective eg. linking health and environment or health and personal growth and development / lifelong learning.

- Arts can be practical and develop into ways of making money through providing services, developing business.

- Evaluation is about stories - we all have stories to tell. All art forms tell stories. It is not an academic analysis.

A short statement is required - a cue for action?

A loose organisation / community to share information.

Support for innovation/leadership to provide education for the voluntary sector and health professionals.

Support or permission is needed from a wide range of stakeholders.

- Relief of suffering - bringing health into being has strong links with creativity. There is potential for arts on prescription.

- People can learn from illness and disease can be managed creatively. There is room for service development and use of new technology by the community.

The discussion continued:

- The importance of partnership. The DoH/ Arts Council/ DTI/ local government could all benefit from supporting health/community arts activity. There is opportunity to draw together threads which include:
    - well being
    - equity
    - broad quality of life issues
    - social exclusion
    - environmental /Agenda 21
    - housing
    - healthier nation targets
    - lifelong learning

Health Action Zones and Healthy Living Centres could embrace these concerns:

- The process involves harnessing available resources and energies to encourage a range of opportunities for dialogue. It is a long term process of many small steps. All sectors can take part and become active in social change.

- This forum has encouraged an emergent process which is already happening - a process which makes a clear connection between arts and health/well being.

- This process can be seen as contagious. People can become infected by what they see and experience going on around them.

- The importance of television - it is a powerful medium which is popular, has credibility and can provide opportunities for education. BUT - the medium may also be important as a way of offering a way into "real world action", with full physical action and involvement at a local level.

- NHS Direct is a new service which can provide advice and link to other services. This may provide a way of encouraging self help/mutual support. Information can create choice and empower people to make sense of connections.

Need for a clear agenda for 12 months time.

Emphasis on artohealth link for Health Action Zones and Healthy Living Centres.

Funders can stimulate action through co-ordinated small grants programmes.

The development of a community that learns by doing and develops mutual trust.

The need for a long term programme which makes connections, develops research and carries out experimental action research.

The need for integrated voluntary/statutory/commercial activity which is not service delivery but enables emergent sustainable action.

Summary of action points

The new government provides an opportunity for real innovation in the field of arts and the broad field of health and well being for individuals and communities.

New information technology and the popularity, credibility and educational potential of television can both provide many opportunities for using arts to achieve health and well-being for local communities.

The maintenance and improvement of health and well-being/quality of life of local people requires a cross departmental and cross sector approach.

Arts activity can perform an important role in linking health, social, education and environmental departments and policies. It requires the full ownership of local people to ensure access to relevant information, a range of opportunities and the potential for an emergent process of change and development.

Funders can support improvements in health and well-being by offering small, medium and long term grants for local action, combined with supportive co-ordination, information, research and evaluation.

All sectors need to share resources to develop skills which encourage the creativity and trust required for a "learning by doing" development process.

A clear agenda needs to be agreed for a Windsor II event in 12 months time.

Participants at Windsor 1 event need to develop into a supportive community rather than a formal organisation.

An overview of the Conclusions of Working Group II has been published (Turner, 1998):

- We need to capture the energy we have, and the resources that are already there, and use them better. But there is a need to develop a new range of skills, expertise and capacity which may need new resources.
- We need a mechanism of coordinating and connecting. Need to keep a register / journal / electronic database.
- We need an assessment of what is already there - though it is important to assess the added value to the community and the participants rather than the quality of the finished product.
- Projects need to be intersectoral for strength to survive the vicissitudes of departmental policy.
- We need to encourage the approach of the social entrepreneur.
- We do not want citadels of art - a millennium dome in every region. The £8m Hall for Cornwall has taken the lion's share of resources in Truro, Cornwall, for example. Nearby, shabby establishments enjoyed by the poor are to be flattened for a massive Marks and Spencer. We need excellent projects like the cafe for teenage mums and their toddlers, run by teenage mums, not more opera and shopping halls for the wealthy.
- We need small grants for small projects, which are simple to apply for. Gradually, trust will be built up between donor and recipient. But we also need development resources - a developments programme of catalytic funding for each region to develop arts in centres of necessity.

- The group was uncertain whether we need a national organisation to coordinate all this activity. It was certain that we need to build an active community. The group did not want a separate governmental organisation - the arts need to permeate government policy, to be the grass that grows up between the paving-slabs, rather than to be another paving-slab.

For example:

- The arts should be incorporated into Health Action Zones and Healthy Living Centres being developed by the Department of Health.
- The arts projects should be linked in with education action zones, early years centres, and latch-key projects being developed by the Department of Education.
- The Arts Council should stop turning down grants for being "too socially worthy".
- Television - the culture that reaches most people - should be involved to progress the movement.
- The importance of IT skills, like literacy, in empowering people should not be forgotten. There are exciting developments in IT that should be used. We also need to develop story- and joke-telling skills.
- Immediately, participants should go back and organise Community Action Network "CAN-do" lunches.

"Only connect".

6. WORKING GROUP III: THE ARTS IN THERAPY AND HEALTHCARE SETTINGS

KEY POINTS FROM THE BACKGROUND WORKING PAPER PREPARED BY GROUP CHAIRMAN:

DR ROBIN PHILIPP

AN OVERVIEW

Topics that the group could usefully address include:

A. The arts in health:

1. how art can benefit levels of personal and community well-being;
2. what arts administrators and artists-in-residence are employed to do and what contractual issues, including professionalism, need to be addressed;
3. the range of ways in which art and artworks can be used in the health care environment to help enhance health;
4. the documented ways in which art and artworks in the health care environment benefit health;
5. what published frameworks of aesthetic principles of quality and beauty exist to guide health care planners, architects and designers of health care environments?;
6. should art works be purchased for display or created for this purpose by patients, visitors and/or staff?;
7. is art in the general built and/or natural environment beyond the health care environment beneficial to health and well-being?

B. The arts in health care:

1. the range of arts activities for which therapies exist;
2. indications (and contraindications) for art therapy interventions,-
3. the known and published scientific basis for each type of arts intervention including evidence for its effectiveness;
4. types of training courses and qualifications for practitioners of each intervention (e.g. art, dance, drama, music and creative writing);
5. input, process, output and especially outcome indicators of the

effects, effectiveness, benefits, side-effects, indications and contraindications of each therapy;

6. is there any need for art therapists in each major grouping (q.v. point 4 above) to integrate with, or work in closer collaboration with occupational therapists, physiotherapists, counsellors, speech therapists, GPs, psychiatrists, psychologists or rehabilitation physicians?;
7. the development needs for education, information, research, policy and service delivery.

Many of these topics were discussed at an international multidisciplinary conference, "The Arts in Health Care: Learning from Experience", held at the Roehampton Institute, London, in September 1997 (q.v. Section 2: General Background).

It is hoped that the debate of this working group will now help lead to:

(a) interdisciplinary clarification among different health professionals of the points covered in A & B 1-7, above;
(b) wider appreciation of:
- the emotional and spiritual dimensions of health and the importance of aesthetic qualities of the external environment in enhancing them;
- the benefits to health and well-being of art and art works in the health care environment;
- the role of creativity in personal health and well-being;
- appropriate referrals for art therapy;
- when to intervene, for which patients and what conditions, and with which intervention,-
- what to do with uncovered psychological problems during the therapy or as a consequence of it, and whom to refer patients on to or to

collaborate with in on-going help for them;

(c) identification of ways forward for developing training standards and competencies where/if needed for any/some of the different art therapies (e.g. for poetry and other forms of creative writing interventions);

(d) preparation of professional codes of ethics where they are not yet developed for different art therapies.

Professionalism

Professionalism is essential to help the arts in health and health care to move ahead. 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 cooperate with others (Philipp et al, 1997).

Professionals also have:

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

To progress the development of arts in health and health care, there are several interdependent, inter-professional needs for education, information, research, policy and service delivery projects. Improved

teamworking is needed between artists, artists-in-residence, arts administrators, health care planners, architects, art therapists, occupational therapists, doctors, nurses, psychologists, psychotherapists and counsellors.

Creativity

Art is part of the basis of creativity and has a role both in the promotion of health and in health care. The WHO has defined health promotion as *"the process of enabling people to increase control over and thereby improve their health"* (WHO, 1986; DoH, 1995). Intriguingly, the Creative Director, Millenium Dome, London, has suggested that creative people do things with courage, conviction and vision and do not need focus groups or discussion (Today programme, Radio 4, BBC, 15 January 1998). As Isaiah Berlin has reminded us in *Personal Impressions* (Hogarth Press, London, 1980; pp219), the creativity of individuals can also leave us with *"priceless reminders of the importance of individual freedom and variety, of vitality and warmth and exuberance of spirit"*. At a practical level, the arts are, for example, recognised as an effective means of providing health education messages to people and obtaining feedback from service users (Ejidokun et al, 1998).

Creativity involves stimulation and uses of the bodily senses (sight, sound, smell, touch and taste) to absorb and interpret experience, express and impart the understanding gained, and to derive and give a sense of emotional pleasure and personal meaning.

It is hoped that the Working Group will be able to discuss the topics suggested above, elaborate the points noted and help develop them for the arts in health and health care. To help foster the possibilities, as Sir

Kenneth Caiman, Chief Medical Officer noted, paraphrasing Victor Hugo (q.v. Editorial, Occupational Medicine, 1998): *"there are few things more powerful in the world than an idea when its time has come".*

But what is creativity?

If creativity is important what is it, how can it be recognised, can it be nurtured/taught, what factors does it need for its encouragement, why should its encouragement be fostered, who will gain from developing it and in what way are these gains beneficial?

Who should be influenced to encourage creative endeavour to improve/sustain the aesthetic quality of the built /natural environment?

General questions the Working Group could consider include:

Is art important? If so, for whom? Why?

What would we do if art was not readily available, and what environments should it be included in?

Is the art of the natural environment important and how does its "importance" differ from that of the built environment? Is the natural environment an art form? Can it and should it be included in the health care environment?

Can art (natural/art work) be used to help people identify with a place, becoming receptive to what is there, and resonating with it to help give a sense of belonging, identity and purpose for enjoying being at one with it or part of it?

Does/can art education awaken people's souls to be receptive of their artistic experience?

6. WORKING GROUP III:
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The Universal Declaration of Human Rights and long term strategic aims for public health:

In attempting to set a contextual framework for the discussions of Working Group III, it may be helpful to link the Universal Declaration of Human Rights (1948) to a viewpoint on public health from the Department of Health for England. Thus:

Following adoption of the Declaration, the General Assembly of the United Nations called on all member countries to publicise its text and cause it to be disseminated, displayed, read, and expounded principally in schools and other educational institutions, without distinction based on the political status of countries or territories.

Article 27-(l) states that: "Everyone has the right to freely participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary, or artistic production of which he is the author" (Editorial, 1997b).

The long term strategic aims for public health of the Department of Health, England, are (Caiman, 1997a):

- to promote efforts to ensure health for all;
- to achieve the targets in a strategy for public health;
- to involve patients and the public in choices and decision-making;
- to establish an effective intelligence and information system for public health and clinical practice;
- to ensure a health service based on an assessment of health needs, quality of care and effectiveness of outcomes; and

- to provide a highly professional team of staff with strong education, research and ethical standards.

The values and principles which underpin this approach are (Caiman, 1997a):

Health for all: This principle involves the whole population, not just as empty rhetoric, but implying the need to ensure that the whole population - no matter where they live, who they are, their age, gender, lifestyle, or what they believe in - should not be disadvantaged. As a key principle of social justice, everyone should have the opportunity to realise their potential for health, and they need to be involved in the process.

The value of people: Resources, enthusiasm, energy and skills must be focused on individuals; services to improve health do not exist to please doctors, managers, or politicians, but for the public, and involve a wide range of contributors, including voluntary agencies. The involvement of patients and the public in this process is essential. Self care and care by relatives and friends should not be overlooked or unacknowledged: it forms the greatest proportion of overall health care.

Intelligence and surveillance: Changes in health and the outcome of health care should be identified early and acted upon, which requires an effective system of monitoring and surveillance and must incorporate continual evaluation of the results of the interventions.

Evidence-based decision-making: A scientific approach and recognition of the importance of the knowledge base are essential to make rational decisions about health and health care - although the limits of scientific knowledge, and the need to deal in some circumstances with uncertainty, should be recognised.

Education and research: A knowledge base continually revised and updated by research represents the bedrock of information for professionals, patients and the public alike.

Ethics and moral issues: At the heart of the effective and equitable delivery of health care services, these provide the framework within which decisions should be made. Informed principles of equity, human rights, social justice and concern for the individual should be held by all those involved in making decisions about health and health care.

These six key principles 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).

Questions associated with this policy for public health and the Universal Declaration of Human Rights and linking them to the arts in health and health care are:

- What are the requirements of health care purchasers?
- How can competencies for health care staff holding art workshops such as creative writing workshops be developed and who should establish them?
- What are the criteria of professionalism?
- How can we establish standards?

Research and the need for formal studies:

It has been reasoned that *"values permeate everything"* and that *"it is mistaken to believe that one human being - for instance, a doctor, a health educator, or a nurse - can ever be fully detached from a human being - for instance, a patient or a client.... The view that any inquiry, even 'scientific inquiry', can be detached, impartial and objective is incorrect. In all inquiry the unquantifiable, human, creative, emotional, intuitive, caring, egoistic, competitive element is indispensable"* (Seedhouse, 1986).

The above quotation can be illustrated. For example, in 1996, a study of patient-focused architecture rightly noted that: *"The general value and importance of views and access to outdoors and of the enhancement of the environment with the arts and crafts and with other activities is self-evident"* (Scher, 1996). Moreover, it pointed out that: *"Florence Nightingale's direct and extensive observation* (in: Nightingale, F. *Notes on Nursing;* Harrison and Sons, 1860), *accords variety of positive experience a high value in the 'relief of suffering' and for facilitating recovery".* As far back as 1859, Florence Nightingale observed that: *"variety of form and brilliance of colour in the objects presented to patients have a powerful effect"* and are *"actual means of recovery"* (Sosinowicz B., 1998, personal communication). Somewhat wryly, but perhaps rightly, the study in 1996 added that: *"Over a century later we seem to need elaborate medical research to persuade ourselves that 'sensory deprivation' and 'low levels of environmental stimulation' are damaging"* (Scher, 1996). So, if evidence is needed, how can it be collected and evaluated?

A framework has been prepared to help evaluate the effectiveness of the arts in health care (Philipp, 1997a), as have more general conceptual

frameworks for setting environmental standards (Philipp, 1996a). They do have a rationale. The frameworks have, for example, been applied to help evaluate the role of poetry in healing. One study identified that 75% of 196 respondents perceived personal benefits from reading and/or writing poetry; 17 respondents were able to be weaned off tranquillisers or antidepressives, and benefits were reported amongst persons with chronic anxiety states, reactive depressions, post traumatic stress, eating disorders, bereavement reactions, those suffering from sexual or childhood abuse or HIV infection, or experiencing marital problems or difficulties associated with lesbian and gay issues (Philipp and Robertson, 1996). Debate is though needed to determine what, if any, next steps should be taken to develop the frameworks needed for rigorous evaluation of the effectiveness of the arts in health care.

Methodological issues in the relevant research questions are important. Traditionally, the sciences have been used to study environmental values and their association with well-being, and as a basis for setting standards and guidelines of environmental quality. However, the way we look outwards at our world influences our perception of it and our values of what is "truly" important in it. Increasingly, therefore, the arts are being used to identify and express what we seek and consider worthwhile in both our surrounding, external, and in our personal, internal, environments. An arts-science gradient is recognised which spans the artistic, intuitive, inspirational and subjective personal viewpoints, and the measurable, objective, deductive, logical and scientific perspective (Philipp, 1998a; 1998b). Both approaches are informative, expressive, and each has its evidence base. But whereas the scientist believes that if some activity or other intervention "does something" the effect or outcome must be measurable, artists are often content to have expressed their creativity and hope that a completed

endeavour evokes pleasure when being experienced by others. A dichotomy is not intended and it has been suggested that: "in the medical professional framework that links epidemiological and clinical strategies for public health, the scientific and artistic aspects of inquiry and expression can be combined" (Philipp, 1994). A doctor working with individual patients, using evidence, intuition and empathy, must combine 'knowledge' with 'knowing' (Philipp et al, 1999).

Qualitative studies are valuable for two reasons. Firstly, it has been reported that their benefits are greatest when the subject of study cannot be controlled and is poorly defined (Black, 1994). Secondly, they can be usefully applied to investigate the functioning of a professional body and its code of ethics (Ryan, 1996). Such methods are appropriate to open up a new area of study or to identify and conceptualise salient issues,- they depend not upon numerical but conceptual analysis and interpretation (Fitzpatrick and Boulton, 1994). Most qualitative studies are restricted to a small sample size because qualitative data are more cumbersome to manipulate and analyse than quantitative data (Fitzpatrick and Boulton, 1994). The focus group method (a form of face to face group interview that capitalises on communication between research participants to generate data (Fitzpatrick and Boulton, 1994; Kitzinger, 1995), is particularly useful as the issues can be explored in dialogue and the method can "generate a significant body of rich textual data" (Editorial, Riskom, 1995). It is commonly regarded as an exploratory method and considered particularly useful where investigators wish to establish quickly the range of perspectives on an issue of importance among different groups (Fitzpatrick and Boulton, 1994).

Quantitative research may well follow or precede qualitative evidence (Philipp, 1996b; 1997b).

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Possible topics for formal study that are being explored at present include:

- Why do hospitals borrow on the Paintings in Hospitals Loan Scheme, and the perceived benefits amongst viewers;
- The effect of "stress arousal" and "calming" poetry on immunoglobulin A levels and/or cerebral activity;
- The use of textual data from children's poems to explore environmental values,-
- The role of creative writing programmes in improving emotional resilience and reducing stress;
- How the aesthetic quality of an environment contributes to health and well-being;
- Attitudes to art in the health care environment.

Attitudes to art in the health care environment:

It has been reported that art in the health care environment benefits health by:

- enriching the lives of patients, visitors and staff by improving the quality of health care environments;
- improved staff morale;
- demonstrating care and reassuring patients and visitors;
- assisting recovery and restoration of health (e.g. post operative recovery times, patterns of urinary incontinence and host immunity to infection);
- alleviating stress and boredom;
- encouraging well-being;
- providing reassurance, comfort, humour and motivation;
- giving purpose and dignity to people's lives;
- developing closer links between the health service and the community;

- improving direction signs and landmarks within and around the hospital (Senior and Croall, 1993).

But, what are the attitudes to art in the hospital/other health care environment amongst staff, patients, and their visitors?

This question is thought particularly worthy of further consideration as for example, some 1.4 million people are employed by the U.K. National Health Service (NHS), and the quality of their working environment can have an important role in their health. The European Charter on Environment and Health draws attention to this point (WHO, 1989). Furthermore, WHO has defined occupational health services as existing to promote and maintain the physical, mental and social well-being of all staff.

As an inquiry into the mental health of the workforce in NHS Trusts noted, *"the majority work within NHS Trusts and are responsible for meeting the physical and mental health needs of the population. Working with those who are ill and in pain, as well as with anxious relatives, is demanding and potentially stressful"* (Borrill et al, 1996). The report continued by noting: *"Such stressors can be detrimental to the well-being and effectiveness of employees, as can a wide range of other work demands and pressures. ...research suggests that such stressful working conditions can have an impact on the effectiveness of people at work, reducing their efficiency and contribution* (Warr, 1990). *Stress can affect people physiologically, reducing resistance to illness and increasing levels of sickness absence* (Maier, Watkins, and Fleshner, 1994). *Exhaustion at work can also lead to prolonged periods of mental ill-health, with associated absenteeism* (Elkin and Rosch, 1990; Cooper, 1994). *In many cases, highly trained professionals will leave their work, rather than jeopardise their quality of life by*

remaining in work situations they find stressful and damaging. The human and economic costs of work-related stress, aggregated across a very large workforce, can therefore be very high indeed" (Borrill et al, 1996).

It therefore seems worth asking: **Could art in the occupational environment be beneficial to health? Should we, and can we, design a study amongst staff, patients and their visitors to help develop evidence-based practice?**

Other points for possible consideration by the working group included:

1. the interdependence of "community" and "personal" development, and ways of using the arts to help foster "constructive citizenship";

2. how the arts can contribute to the teaching of undergraduate medical students and other health professionals;

3. can definitions be agreed for the following words and terms:
   humanity (having looked at the Shorter Oxford Dictionary, I suggest: "the study of human nature and the practice of compassionate concern for the advancement of mankind's welfare";
   humane;
   humanities (the Concise Oxford Dictionary defines this as "polite scholarship, csp. of Latin and Greek classics" - for the present Conference, do we really mean this!) - (The New Encyclopaedia Britannica, 15th Edition, 1993, reports the humanities 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");
community development (as it relates to the arts);
art;
aesthetics;
beauty.

4. who in the health professions, apart from medical practitioners and medical students, might equally be interested in the arts as they pertain to the humanities for health care, health promotion, personal and community well-being? (Those who have expressed interest to date include psychologists, psychotherapists, counsellors, general and specialist nurses such as stoma therapists and breast care staff, occupational, speech and drama therapists, health promotion specialists, hospice and elderly home care workers, art therapists and arts co-ordinators, health care building architects, social workers and complementary therapists).

Aesthetic values and art in the general built or natural environment

The psychological impact of environmental factors on personal well-being is well-known. For example, the WHO definition of health represents *"a balanced relationship of the body and mind and complete adjustment to the external environment"* (Howe and Lorraine, 1973). The European Charter on Environment and Health also states that *"good health and well-being require a clean and harmonious environment in which physical, psychological, social and aesthetic factors are all given their due importance"* (WHO, 1989). A new discipline, "aesthetic medicine", has even been proposed to address the interdependence of these factors (Kovacevic-Cabrijan, 1988). But, what is intended by "aesthetic factors"?

Nature as art, architecture, the built environment, and art works of the

visual and performing arts all help to show us that retaining our sensitivity to all that impinges on us from the external world, and using to the full our senses of sight, hearing, taste, smell and touch, can foster feelings of wonderment and enjoyment and considerably enhance our emotional well-being (Philipp, 1997b; 1998a; 1998b). 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, and to help determine aesthetic standards of environmental quality (WHO, 1998).

Initial studies of using the arts to explore environmental values suggest that people react negatively to some external environmental factors, retreating from the impact on their senses (sight, sound, smell, touch and taste). In contrast, they respond positively and resonate with others,- personal well-being is associated with a positive response (Philipp et al, 1998b). It seems that the different sensory inputs stimulate the building of images in the mind and the associations, connections and interpretations that give meaning, understanding and purpose to living (WHO, 1998). Moreover, as noted earlier, 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.

As Epictetus noted in the 4th century BC, *"men are disturbed not by things but by the views they take of them".*

To help derive environmental quality guidelines and improve the quality of life, more studies are however needed on:

- the understanding of aesthetics, defined as *"having an appreciation of the sense of beauty in accordance with the principles of good*

taste" (Onions, 1973);

- the association of sensory inputs with mental health and well-being (Philipp et al, 1998a);
- ways of improving "the quality of life".

"Quality of life" is too, *"a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationships to the salient features of their environment"* (WHOQOL Group, 1993). Nevertheless, it has been considered a somewhat amorphous concept (Bowling, 1995). Market measures of health benefits and aesthetic improvements from environmental control programmes are also not readily available (Cropper and Oates, 1992). Such observations reinforce the need for further research.

The research evidence to justify establishing guideline aesthetic values for human well-being is, however, often not available. Although aesthetic appreciation and the quality of art in the environment and quality of the natural and built environment as art are at the basis of environmental values, their contribution to health is not understood. Improved understanding of what determines our human environmental values is needed (Philipp et al, 1998a; 1998b; WHO, 1998). This understanding is needed because, as reported elsewhere, *"true knowledge cannot be divorced from wonder, and wonder cannot be divorced from life"* (Skolnik, 1988). As noted elsewhere, (Philipp, 1998a), 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:*

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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?

Interested persons may find some helpful additional background reading within publications cited in the References, and in the extra Bibliography section, Appendix III.

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The arts in health, and in health care, cover a broader area than arts therapy alone. Other people apart from therapists are also using the arts, for example artists-in-residence in hospitals, in general practice surgeries, and now in workplaces and other healthy settings. So, we are exploring the role of arts in improving people's levels of health, as well as participation in the arts as a way of helping with one's health problems.

Working Group III has been convened on the basis of available but 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 is a recognised treatment and undertaken by qualified art therapists.

The workshop seeks to explore:

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

and to develop an action plan beyond the Windsor I conference to be followed through and audited as indicators of progress.

This is a huge area and what is really needed now is a **taxonomy** of what we are actually talking about. We need a **credible scientific base** in order to promote what is available in the way of interventions, because health care purchasers need evidence that different arts actually benefit people. There is already some limited evidence that such health care interventions are cost-effective. However, we also need to explore the inter-relationship between qualitative and quantitative research methodologies and ways of improving the quality of research and its information yield.

The background.

Studies in the late 1980s, for example of children's paintings of their family doctor (Leech and St. George, 1982; Philipp, 1983; Philipp, 1987; Philipp et al, 1984; Philipp et al, 1986), not only gave insight into the ways in which patients perceive medical practitioners but highlighted the play between the written or spoken word and the actual visual portrayal of events in the clinical environment. The children's spontaneity, enthusiasm, imagination and creativity and their poetic way of putting things, were

striking. For example, one child provided the following caption to his painting of a doctor holding a hypodermic syringe behind his back:
"Our doctor says this won't hurt while it's hurting."

A five-year old girl wrote on her painting:
"This is my doctor. He always tickles me sometimes."

Similar patterns of imagery are used in the adult world, and perhaps paintings such as Susan Macfarlane's work on the experience of breast cancer (Macfarlane 1995), could be used in our teaching of communication to undergraduate medical students. The imagery and power of expression in her paintings are incredibly evocative. For example, one of her paintings depicts the doctor and his office desk as large and intimidating to the patient. Children's paintings have expressed identical viewpoints.

"Inner" and "outer" reality are important concepts. For example Dannie Abse, a chest physician who became a full-time poet, speaking at the Cheltenham Festival of Literature in 1993, raised John Keats' question, *"do we retreat from the reality of the outer world into ourselves at times, or, do we retreat from the pressures of the outside world into the reality of our inner selves?"* He commented that: *"imaginative daydreaming is an escape from the precipitous pessimism of living or dealing with problems and the sphere of sorrow, and it is used to restore balance"* (personal communication, 1993). Professor Anthony Storr, in his book, "The Dynamics of Creation", talks about "creative apperception" where he notes that: *"Creative imagination suggests a healing function .... people who realise their creative potential are constantly bridging the gap between the world of external reality and the inner world of the psyche .... 'creative*

apperception' is what individuals feel makes life worth living" (Storr, 1972). Dame Cecily Saunders, from her enormous experience with the hospice movement, reported that the search for meaning and for something in which to trust may be expressed in many ways, *"perhaps most of all, in art and the unexpected potential for creativity at the end of life .... It has been suggested that much personal talent has never been stimulated and that awakening this hidden capacity through art can be beneficial to health"* (Saunders, 1996). Given such comments, it seems that these concepts could be usefully employed to explore more about roles of the arts in health.

In 1994 the British Medical Journal published a letter in which we asked the question *"could or does poetry have a role in medicine and should, or do, we ask our patients to perhaps produce pieces of work which might be helpful to them in terms of some emotional release!"* (Philipp et al, 1994). To our surprise, it produced a large and unexpectedly serious response from the news media who took up the theme of *"ways in which poetry might be used in the art of medicine"*, and with headings such as:

"Poems or pills?"
"Let iambics take the measure of your stress"
"GPs to be versed in therapy".

This in turn produced an enormous response from the public, and a powerful personal testimony from patients and health professionals saying there really is something in this. A small percentage of people were actually able, as a result of finding poetry for themselves, to be weaned off benzodiazepine tranquillisers or anti-depressants (Philipp and Robertson, 1996). Taking 1992 costings in the UK, we spend 81

million pounds a year on anti-depressants, making the cost for one patient around £300. So there may be a role for some creative therapies if they could wean just a few people off such psychotropic medications. Poetry can too help medical students to understand ethical concepts (Philipp and Hart, 1998).

Other groups have also been taking an interest in this whole area. For example, the Wellcome Foundation organised a seminar on the arts in health in 1993, and in 1994 there was a conference in Wellington, New Zealand, organised by the Royal New Zealand and Australian Colleges of General Practitioners on the science and art of medicine. The Royal Society of Medicine, Section of the History of Medicine, held a Symposium on 1 March 1995, entitled "Art in hospitals: past, present and future". In 1996, the University of Auckland, New Zealand, organised an international conference "Narrative and Metaphor Across the Disciplines", and the University of Otago, New Zealand, held an associated conference "Health in the Writer's Hand" on literature and the humanities in the work and education of health professionals. Such stimuli have helped to provide a tremendously powerful impulse for this area to move forward. However, in all the activity and interest, an apparent dichotomy has emerged between the health care providers and purchasers. The providers of some of the arts therapies have been saying "this is what we've got, this is what we can do - it's tremendous, it's exciting" and the health care purchasers have been saying "we hear you, it is exciting but where is the evidence?"

Some of that evidence is beginning to emerge through the work of groups such as Celebratory Arts for Primary Health Care and the Arts in Hospitals Forum of the Kings Fund.

In addition to present areas being developed for roles of the arts in health care we could also think about their role in:

- interventions for specific clinical problems,-
- the development of clinical student teaching from paintings, sculture, music, drama and literature that show different pathologies in the art works or of the artists;
- the power of art in imparting health education and health promotion messages such as in advertising campaigns.

For example, it has been reasoned that the "non-biological arts" could be taught at medical school as they have the following roles in the practice of medicine as well as in education.
The arts:

- can form a vehicle on which experience may be enriched or learned;
- can be useful in therapy;
- are important in developing the quality of leisure time,-
- can be a tool in teaching (Smith and Taylor, 1996).

Lastly, there is the role of the aesthetics of art in helping to determine the quality of some of our environments (WHO, 1998). Some very interesting work has been done, for example, on the quality of hospital entrances and how the aesthetics of the built and of the natural environment can impact on our health (Critchlow and Allen, 1994).

There is too, a long-standing tradition of links between disciplines to help justify ways in which the ideas could be progressed. For example, again from antiquity, the Greek god Apollo presided over both the arts and humanities. His son, Asclepius, was the god of medicine. He in turn had two daughters, Hygiea, the goddess of health, and Panacea, the goddess who restored health and provided medicines. Today, the British

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Medical Association logo of a snake entwined around a stick is a stylised version of the rod and staff of Asclepius (BMA, 1997). Busts of Asclepius and Hygiea can be found in the Royal College of Physicians, London.

The motto of the Royal College of General Practitioners, UK, and of the Royal New Zealand College of General Practitioners is "cum scientia caritas" - science with humanity and feeling (Wright-St Clair, 1989). It epitomizes what we are hoping to achieve with all of this interest and activity, that is to help put a smile back into living for a lot of people who have sadly lost it. What is now needed is the input and involvement of all participants in this conference, rather than just the background views of the Working Group Chairmen. After all, as Aristotle noted all those years ago:

"You get a better notion of the dinner from the dinner guests than you do from the cook!"

CONCLUSIONS AND RECOMMENDATIONS FROM GROUP III

The Arts in Therapy and Healthcare Settings

The issue addressed by Working Group III was:
how, throughout the U.K., and in the multi-cultural context of our nation, can we influence those responsible for budgets, staffing and policy to understand that using the arts in health and health care is a valid field of activity?

This question was addressed by the Group in the context of the World Health Organisation *Health for All* programme, reports within the UK for the *Health of the Nation,* and *Our Healthier Nation,* and increasing awareness that art for contemplation and art as creative endeavour, in the health care and general environments, can be spiritually uplifting and help to restore health and improve emotional well-being.

It was agreed that there is a need to:

1. establish a taxonomy of the field for:
   - organisations and what they do;
   - the different types of arts for health and art therapy activities;
   - the roles and remits of health professionals working in the different arts for health and art therapy activities;
   - a catalogue of research in progress;
   - standards in artistic expression and the fine arts;

and to consider making all this information available as a website.

2. collate a bibliography under headings such as:
   - descriptive case studies;
   - advocacy by individual activists, their interests, expertise and personal experiences of art and art therapy with patients, and of

well-being associated with placements of art work and creative endeavour;
- theory and history;
- manuals of good practice including principal books, reports, (e.g. the Attenborough and Carnegie reports), journals and pamphlets,-
- peer reviewed and other published evidence of benefits, (including the effectiveness and efficiency of art interventions and of improvements in health and well-being from the placements of art work and creative endeavour).

Preparation of such a bibliography involves consideration of different activities such as:
- purchased work;
- commissioned work;
- artists in residence working with patients and staff and producing work in the health care environment;
- ways of improving the quality of the environment (including the building and social and professional interaction within it);
- personal endeavour as creative expression;
- art works as health promotion and educational material;
- the arts as therapies.

3. describe the different groups of professionals working for the arts in health (including codes of ethics, accountability and training);

4. clarify the constitution, composition and ways of working of arts committees in hospital and other health care environments and in the general environment, and determine if a " template/proforma" of suggested good practice is already available/can be produced and become more widely available,-

5. prepare and publish a "Beginners Guide" (of items listed in Points 1-4 above, and including summaries of Points (a)-(f) below) for health service managers and other purchasers in the NHS. This Guide should be brought to the attention of Parliamentarians, journalists, opinion formers, decision makers, educationalists, the Higher Education Funding Council, funding bodies, researchers, and the international community through WHO and UNESCO;

6. avoid creating any new comprehensive body of the published literature but rather to spread awareness of existing bibliographies for such materials, and to spread this awareness to:
   - professional associations, colleges, councils and other professional registration and educational bodies in medicine and other health care professions;
   - relevant voluntary bodies for health and patient care;
   - the media;
   - persons responsible for introducing relevant "taster" courses at undergraduate level for the arts, design, architecture and medicine;

7. seek ways of raising funds with the NHS, Health Care Trusts, the New Opportunities Fund of the National Lottery and other groups and organisations to enable the Points 1-5 to happen.

Working Group III also identified that:

There is a need for a comprehensive, fully referenced book of some 5-6 chapters, each of about 5000-6000 words to present detailed informed viewpoints, of the key points covered in Points 1 & 2, above. Its preparation could benefit from additional contributions beyond membership of the present Working Group. The book should include the following chapters:

(a) Introduction: the contribution of arts and design to public health in the widest parameters, including the "rights" and "expectations" of patients, their visitors and staff;
(Action: Jon Allen and Robin Philipp)

(b) An outline of the ways of working of:

- arts in the health care environment;
- the art therapies,-
- the commissioning and purchasing of art work

and of what they do and what to expect of the work for health and well-being;
(Action: Adrienne Brown, Helen Payne, John Plant and Peter Senior).

(c) Information as to ways that the arts benefit people, not necessarily always to prove, but also, where appropriate, to show how and that the question has, or is, being addressed in the following ways:
- economically;
- in making people better;
- in improving the quality of life for people in care, as in-patients and out-patients, and in the community, and for their visitors and staff;

but, where research has been undertaken, to show the following evidence:

- anecdotal;
- qualitative,-
- quantitative;
- a mixture of the above three types,-

(Action: Gillie Bolton, Angela Fenwick, Linda Moss, Helen Payne, Robin Philipp, Diane Waller)

(d) Milestones in the development of the field during the last 25 years;
(Action: Linda Moss, John Plant and Peter Senior)

(e) A model for uses of the arts to help improve the quality of life in terms of health, well-being and happiness in the wider environmental context and not just as restricted to health care settings.
(Action: Robin Philipp)

(f) An outline of what issues need to be addressed for the future to change public health policy, clinical practice and/or patients' lifestyles and to help influence developments in professional organisations and registration bodies (i.e. the range of issues, scope and foci);
(Action: Alison Combes, Linda Moss, Robin Philipp and John Plant)

7. THE CONCLUDING PANEL REVIEW

Following presentations by the Working Group rapporteurs to the final conference plenary session, a Concluding Panel, led by the Reverend Dr Kenneth Boyd and Professor Frank Harris, reviewed the underlying themes:

RE GROUP I: This Group has identified the principal training needs in the humanities as fitness for purpose (particularly as the majority of medical students will go into practice to help patients). There are outcomes of medical education for both patients and doctors. The needs are to improve the delivery of care to patients and to improve the person delivering that care. It is important to appreciate what is happening currently. Thus, we should not attempt to re-invent the wheel through pushing an emphasis on the humanities. There is a need to collate what information there is. The social sciences already have and fulfil an important role - avoid possible sibling squabble - don't try and displace any elements of what already exists. It is important to emphasise again that we are speaking of medical education and not just training - for this knowledge, skills, attitudes and values are all interwoven. The humanities can introduce an added value to the practice of skills and the formation of values and attitudes.

Sir Kenneth Caiman added that all this is also useful in Continuing Medical Education where there is a huge opportunity to change and use this thinking in several different areas such as: - social exclusion, Health Action Zones, Healthy Living Centres, the use of information technology, entropy (the study of how we use energy and the need to now not let all that has been achieved for the humanities in medicine "fall down"), how people (and health professionals) learn by telling stories, the fact that people "infect" you with new ideas and different ways of looking at issues. (He illustrated this with the example of

applying dance and movement work and suggested the UK Government Department of Health could be more appropriately renamed the Department of Health and Happiness.) The three elements to all this are: "health", "well-being" and "happiness". There is a need now to find our own hearts, minds and souls to just "get on with it" within the whole group of conference participants. Sacrifice, sacrilege, and suffering are, however, needed to overcome apathy and indifference. After all, the importance and privilege of being able to "give" and contribute to public service is because we should, and presumably all in this room do feel that it is worthwhile.

RE GROUP II: Art can be counterproductive if it is done for the wrong reasons. The typical artist is for example, not a good health role model! However, clinic clowns are used in Germany to cheer people up whilst they are waiting for health care. In a housing estate in Leicester, England, where 70% of people are single parent families, the value they felt of being a stakeholder in the education of young medical students who were attached to their neighbourhood has been shown. Perhaps surprisingly, the medical students were not perceived by the local population as being privileged outsiders who had no place there. We must not force the issue of the humanities in medicine. Personal examples can illustrate most poignantly some of the points at issue - e.g. as he told us, Sir Kenneth Caiman's mother achieved for herself as a very ill patient in hospital, by taking great pride and pleasure whilst there in completing paintings for her grandchildren before she died.

RE GROUP III: In addition to the relevance of points noted above for Working Groups I and II, and the fact that they equally apply, there is also a need to know much more about the range of what is going on and for this information to be more widely disseminated.

OTHER POINTS FROM THE FINAL PLENARY SESSION: In schools education, the national arts curriculum is under review. There are also current changes in the General Medical Council undergraduate medical curriculum requirements, in which 10 weeks can be taken out of a 5 year course for the humanities. This is not a large proportion of the time but could yield worthwhile benefits for suitable students. Local people should be involved in the choice of medical graduates being considered for GP training.

A Virtual Centre could be produced. A follow-up conference, Windsor II, is proposed and could become a reality. John Wyn Owen, Secretary, The Nuffield Trust, suggested the conference participants should become a recognised Group as product champions of the ideas discussed and agreed. Andrew Mawson suggested we draw together as a community of interest that could be based on the Planning Group for the first and now just completed conference - Windsor **I.**

SUMMING UP: SIR WILLIAM REID:

There is a massive variety of experience at this conference but there has been excellent bonding. Three hours more discussion time is really needed to develop and consolidate what has been discussed. I am now racking my brains to report what I think should be reported from what people think they thought about what was discussed!

We should all build on the action points in the draft Windsor Declaration. This Declaration will be finalised and disseminated. The New Opportunities Fund of the National Lottery may be a source of possible funding to help develop some of the work.

8. DECLARATION OF WINDSOR
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 lesson 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.

8. DECLARATION OF WINDSOR

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.

9. THE 12-POINT ACTION PLAN

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.

For further information please contact:

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10. INFORMATION RELEASED TO THE MEDIA

On 17th March 1998, a synopsis of the conference entitled: *"Arts **on prescription. Campaign to improve the Nation's Health"*** was released to the news media.

The Declaration of Windsor and 12-point action plan were made available at a press conference. Briefing material for the news media included the following written comments from conference participants:

"The well trained doctor thinks for himself or herself, thinks away from another person's point of view, and thinks in a critical, consistent and humane way".

Professor Michael Worton, Professor of French and Dean, Faculty of Arts, University College, London.

"At 1992 costings we spend £81 million a year in Britain on anti-depressants, and the cost per patient can be as high as £300 a year. If we can wean just a few of these patients off such drugs (through the use of arts in healthcare), it will be worth it."

Dr Robin Philipp, Consultant Occupational Physician, Bristol Royal Infirmary and Senior Clinical Lecturer in Occupational Health and Public Health Medicine, University of Bristol.

"I need no persuading that there is a role for humanities in medical education to improve the delivery of care to the patient and improve in some ways the person delivering that care. There is now nothing that can be blamed on the GMC that stops medical schools getting humanities onto the curriculum. "

Professor Frank Harris, Dean of Medicine, University of Leicester Medical School, Member of the General Medical Council's education committee.

Also released were three case studies, one illustrating each of the themes covered:

1 *Mark Harris,* a fourth year medical undergraduate student at the University of Bristol who feels that he benefited greatly from a "Society and Medicine" course in his first year; and time spent in his fourth working year in arts, music and dance therapies with mental health patients.

2 *Mandy Hogger* who became a volunteer at Bromley by Bow Community Centre after joining a women's group there, working with the disabled and those with learning disabilities. Whilst working as a volunteer on a one to one basis, she learned new skills, often from the group members, and has had the opportunity to attend courses to train as a Welfare Benefits Advisor and she has gained an NVQ in Care of Members.

3 *Peter Senior* who helped to set up Arts for Health as a result of the terrific response by the health service to his work in Manchester Hospitals. Arts for Health is a national resource to advocate the use of arts in all places of health care. The centre provides advice, gives practical help to a wide range of individuals and organisations, initiates projects, manages an affiliation scheme and publishes an arts and health magazine called *Artery.*

Known responses of the news media to this information can be found in Appendix V.

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APPENDIX I

CONTENTS OF THE DELEGATES PACK

(a) An Introductory Letter to Delegates from Sir Kenneth Caiman

February 1998

Dear Colleague,

There is an increasing interest in the use of the arts and the humanities in medicine and health. Humanities in this context is defined broadly to include literature, the visual arts, drama, ethics and philosophy. They bring a different dimension to clinical practice, that of the art of healing, and are complementary to the science base.

The objective of including the humanities is to assist in improving the quality of life of patients and the communities in which they live and work. They should help the professional to be more compassionate and have a greater understanding of the patient perspective. But how sure can we be that such statements can be justified? Does an interest in the arts really make for a better doctor or nurse? Can we really persuade those in authority that it is worth investing in the arts to improve health and quality of life? These are some of the questions which need to be answered and will be tackled in this Windsor meeting.

The purpose of this seminar, therefore, is to explore three related topics. The first is that of the education of the professions and the role that literature and the arts may have. The second is to review the role of the arts in therapy, and in particular assess the evidence base supporting such activities. This will include newer developments such as creative writing. The final section will be to consider a number of issues around

the arts in the community and how these might be used to improve health and quality of life.

It is an ambitious programme, which will provide time for sharing ideas and for reflection on some of the issues which will need further discussion. It will help to develop an agenda for the future and identify research questions for further work.

This is the first of the Windsor Seminars on the humanities and health. I am delighted that you are able to come and take part, and I look forward to welcoming you.

KENNETH CALMAN
Chief Medical Officer
Department of Health
London

APPENDIX I

(b) The Conference Programme

Thursday 12th March

4.p.m.	Tea and welcome
4.45.p.m. - 5.p.m.	Scene setting: Sir Kenneth Caiman
5.p.m. - 5.30.p.m.	The Art of the Practice of the Science of Medicine: Professor Sir David Weatherall
5.30.p.m. - 6.p.m.	Presentation - Plenary Professor Michael Baum Rev Andrew Mawson Dr Robin Philipp
6.p.m. - 7.p.m.	First group sessions
7.p.m.	Pre-dinner reception
7.45.p.m.	Dinner after dinner musical recital: Emer McGilloway (Professional Opera Singer and Medical Practitioner)

Friday 13th March

8.a.m.	Breakfast
9.a.m. - 12.30.p.m.	Group sessions (30 minute coffee break @ 10.30.a.m.)
12.30.p.m. - 1.30.p.m.	Buffet lunch
1.30.p.m. - 2.15.p.m.	Feedback from groups to Panel
2.15.p.m. - 3.p.m.	Panel Review John Wyn Owen (Chairman) Sir Kenneth Caiman Rev'd Dr Kenneth Boyd Professor Frank Harris
3.p.m. - 3.30.p.m.	Summing Up Sir William Reid
3.30.p.m.	Tea Depart

APPENDIX I

(c) Roles of Chairmen, Rapporteurs and Panel Members

Chairmen:
Professor Michael Baum, Reverend Andrew Mawson, Dr. Robin Philipp

At the opening session to present, in ten minutes, what will be covered by their group.

Identify the rapporteur who will "feedback" to the panel. (Each group will be allocated 15 minutes for feedback - 5 minutes on what was covered in discussion and 10 minutes to present [up to] 8 action points).

Keep group to allocated timings.

Invite an individual within the group to sketch visual impressions of proceedings.

Ensure practical recommendations are forthcoming in order that the panel can offer comment.

Take responsibility for highlighting topics covered and why these topics were chosen; recommendations of group; to whom the recommendations should be addressed; what needs to be done to take recommendations forward; who will deliver on these recommendations; what is seen as a successful outcome.

Identify one case study for the subsequent press conference.

Ensure a summary of the discussion can be produced as a Nuffield publication. (To be written by Chairman and rapporteur.)

Identify 5 or 6 individuals from group to write c.5000 words each for inclusion in a handbook of guidelines for groups involved in the use of humanities in the health care environment which will be published a year after the conference. The first draft should be completed within four months of the conference.

Rapporteurs
Will report for their respective groups and provide brief examples, including clinical, of instances where the application of humanities has made a measurable difference to an individual's health.

Take responsibility, with their group Chairman, for writing up the summary of the group discussion and recommendations.

Panel:
Sir Kenneth Caiman, Professor F. Harris, Reverend Dr. Kenneth Boyd
Chaired by John Wyn Owen.

Offer comment on feedback from groups and focus on ways in which involvement in arts contributes to health and ways in which artistic expression contribute to well being. Offer practical proposals which will make a difference and suggest a way forward.

Summing-up:
Sir William Reid

Highlight potential of millennium projects which might be informed by this conference. Looking at and beyond the millennium to events around the country which might be informed.

APPENDIX I

Draw attention to the fact that more effective use of current funding could progress this initiative: additional funding is not a requirement.

Identify potential sources of current activity and funding; who is doing what.

Has the meeting produced a clear sense of future direction?

APPENDIX II

BIOGRAPHIES

(a) CHAIRPERSONS AND PANEL DISCUSSANTS

PROFESSOR MICHAEL BAUM has been Professor of Surgery at University College London and Consultant Surgeon at the University College Hospital Trust since June 1996. He is President of the British Oncological Association and Honorary Director of the CRC Clinical Trials Centre.

Previously, Michael was Professor of Surgery at King's College Hospital School of Medicine and Dentistry (1980-1990) and Professor of Surgery at the Royal Marsden Hospital/Institute of Cancer Research (1990-1996). He was also Chairman of the breast cancer sub-committee of the UK Co-ordinating Committee for Cancer Research (1990-1996) and Vice President of the European Society for Mastology.

Michael is a member of the Advisory Committee on Health Technology Assessment to the Director of Research and Development, Department of Health. He is also a specialist advisor on breast cancer services to the House of Commons Select Committee on Health.

Michael's special areas of interest include complementary therapies, quality of life assessments, counselling and scientific philosophy, clinical trials and the ethics of clinical research and endocrine aspects of cancer.

REVEREND ANDREW MAWSON was ordained in 1979 and spent the next five years working at the Kaleidoscope Project in Kingston-upon-Thames running an all-night club and hostel accommodation for young people with drug-related problems, the homeless and young people in care.

Since 1984, Andrew has been Chief Executive and Minister of the

Bromley by Bow Centre in East London.
This church-based project is in the middle of a £6 million community development which brings together health, the arts, environment (a 3 acre park), education and training, community care, housing for single homeless people, a nursery, a church and enterprise initiatives in a fully integrated project - the first of its kind in the UK. The centre has been featured in Charles Leadbeater's book *The Rise of the Social Entrepreneur.*

In 1990 Andrew was appointed a director of the McCabe Educational Trust which takes young people from inner cities across Britain, to the Sinai Desert. He was appointed a Mental Health Act Manager in 1991 and a member of Tower Hamlets Housing Action Trust Board in 1993. Between 1993 and 1995, Andrew was the Director of the Great Banquet, a London-wide event involving 30,000 people taking the partnership agenda into over 200 communities across the capital.

Andrew is at present developing a national Millennium project called '2000 by 2000' which seeks to stimulate the role of social entrepreneurs in developing community projects across the UK. This initiative will promote and support 2000 projects which demonstrate a local 'can do' approach to social regeneration.

DR ROBIN PHILIPP studied medicine in New Zealand. He came to the UK for postgraduate training in epidemiology and preventive medicine and since 1997 has worked as a Consultant Occupational and Public Health Physician in the Department of Occupational Health and Safety, Bristol Royal Infirmary, where in collaboration with the World Health Organisation (WHO), he has established and is a Director of the Centre for Health in Employment and the Environment, and from where he

holds an Honorary Senior Clinical Lectureship with the University of Bristol.

Previously, Robin was a Consultant Senior Lecturer in Ocupational and Public Health Medicine in the Department of Epidemiology and Public Health Medicine, University of Bristol, where in 1989 he established and co-directed a WHO Collaborating Centre for Environmental Health Promotion and Ecology.

Currently he is the South Western Regional Specialty Adviser in Occupational Medicine for the Faculty of Occupational Medicine (FOM), Royal College of Physicians, London; representative of the Regional Specialty Advisers on the FOM Board and a member of the FOM Ethics and Fellowship Committees. He is also a Fellow of the Royal Institute of Public Health and Hygiene, a member of the RIPHH Council and its Membership Committee, the UK representative of the Australasian Faculty of Public Health Medicine and a member of the GP Writers' Association.

Robin is an advocate of sustainable development, has published widely in different environmental health problems and is at present editing the WHO Recreational Water and Bathing Beach Quality Guidelines. His present research interests, in collaboration with the WHO, are in aspects of the arts and mental health, the impact of recreational water environments on public health, the delivery and quality of occupational health care and evaluations of the effectiveness of the arts in health promotion and health care. In the arts, Robin has twice been a finalist in the annual Hansells New Zealand Contemporary Sculpture Competition and some of his poems on aspects of health and the environment have been published.

APPENDIX II

His published research into the role of poetry in health and healing has led to the formation of the interdisciplinary Association of the Literary Arts for Personal Development (LAPIDUS) and he is a member of its organising committee.

PROFESSOR FRANK HARRIS is Dean of Medicine, University of Leicester Medical School.

SIR WILLIAM REID was formerly: Parliamentary Commissioner for Administration and Health Service Commissioner for England, Scotland and Wales,- Chairman, Mental Welfare Commission, Scotland; Chairman, Advisory Committee on Distinction Awards.

JOHN WYN OWEN, CB took up the post of Secretary of The Nuffield Trust on 1 March 1997. Prior to this he was Director-General of New South Wales Health, and until 1994 was Director of the National Health Service in Wales. His career has spanned both public and private sectors and is based on a strong commitment to research, education and training as a foundation for effective management.

His list of achievements includes the establishment of the Welsh Health Planning Forum which developed an innovative strategic framework for health management and protocols of investment for health gain; Chairman of the Welsh Health Development International; Chairman of the Australian Health and Community Services Ministers' Advisory Council; Deputy Chairman of the Strategic Planning and Evaluation Committee - National Health and Medical Research Council; Chairman of the interim Board of the Australian Health Management Network; Member of the Management Committee National Breast Cancer Centre; Chairman of Olympic Health and Medical Working Committee for the Sydney 2000 Games, Convenor of

G10, Council of Australian Governments with responsibility for advising on reforms of health and related community services, aged care, services for children and the disabled.

Recent international commitments have included representation of government interest in Japan, People's Republic of China, Hong Kong, Thailand, Laos, Vietnam, Indonesia and New Zealand.

In recognition of his services to public health, he was elected an Honorary Fellow of the Faculty of Public Health Medicine, Royal College of Physicians (1991); Fellow of the University of Wales Colleges, Aberystwyth (1991) and Bangor (1992); Fellow, Institute of Health Services Management (1992); Fellow of the Australian College of Health Service Executives (1994); CB - Companion of the Order of the Bath, Queen's Birthday Honours (1994).

(b) PARTICIPANTS

WORKING GROUP I:
HUMANITIES IN MEDICAL UNDERGRADUATE EDUCATION
Chairman: Professor Michael Baum

GILLIE BOLTON is Research Fellow at the Institute of General Practice, Sheffield University. Her research is into the role and value of therapeutic writing within the Health Service and writing as a reflective practitioner for health care staff. Her book *The Therapeutic Potential of Creative Writing: Writing Myself* is due out later this year,- and she is working on an edited volume *Stories at Work: Writing as a Reflective Practitioner.* She is also an award winning published poet.

REVEREND DR KENNETH BOYD is Senior Lecturer in Medical Ethics, Edinburgh University Medical School, Research Director,

Institute of Medical Ethics, Chairman of the 'Boyd Group' on the use of animals in science, and the author of numerous publications on medical ethics. From 1989 to 1991 he was Research Fellow in Medicine and Literature, Glasgow University. Dr. Boyd is a minister of the Church of Scotland and associate minister of the Scottish Episcopal Church of St John the Evangelist, Edinburgh.

PROFESSOR ROBIN DOWNIE is Professor of Moral Philosophy, University of Glasgow. Special interests are discussing the humanities and ethics with doctors and medical undergraduates. His publications include *The Healing Arts: An illustrated Oxford Anthology: Why Arts Courses for Medical Curricula* (with KC Caiman); *Humanizing Medicine* (with Jane Macnaughton et al) and the Lancet will shortly publish *Imagines of Health in Literature* (with Jane Macnaughton).

DR RICHARD HORTON qualified in medicine from the University of Birmingham in 1986. In 1990 he joined *The Lancet,* moving to New York in 1993 before becoming Editor of *The Lancet* in 1995.

PROFESSOR ANNE **HUDSON JONES** is Professor of Literature and Medicine in the Institute for the Medical Humanities and the Department of Preventive Medicine and Community Health at the University of Texas Medical Branch at Galveston where she is also on the Faculty of the Graduate School of Biomedical Sciences. A founding editor of *Literature and Medicine,* she was the journal's editor from 1984-93 and continues to serve as Senior Consulting Editor. She is also on the editorial board of *Medical Humanities Review.* During the past twenty years she has served as a visiting professor and curriculum consultant for colleges and medical and nursing schools throughout the United States and in Peurto Rico. She has published and lectured

extensively about literature and medicine, narrative ethics and medical humanities. Recently she was elected to serve a three year term on the Executive Board of the American Society for Bioethics and Humanities, the leading US professional organisation devoted to medical humanities.

DR JANE MACNAUGHTON is a lecturer in general practice at the University of Glasgow and part-time principal in general practice in a deprived area. Before studying medicine she did an MA in history and english and has continued these academic interests in her current post by developing two special study modules in humanities subjects (philosophy and literature) in the new medical curriculum in Glasgow.

PROFESSOR JAMES MCCORMICK is Fellow Emeritus, Trinity College, University of Dublin. Following army service abroad and whole time general practice he was appointed Professor of Community Health and General Practice from 1973-91. Has published widely on general practice and prevention with special emphasis on ethics and screening.

DR FAITH MCLELLAN is Faculty Associate and Director, Manuscript and Grant Preparation Service, Department of Anesthesiology, the University of Texas Medical Branch, Galveston, Texas. An author's editor, she also acts as managing editor of *Problems in Anesthesia.* She holds a BA in English from Wake Forest University, Winston-Salem, North Carolina. In 1997 she took the PhD in Medical Humanities from the University of Texas Medical Branch, where her dissertation was on electronic narratives of illness. Her current research interests are in the ethics of biomedical publication and in literature and medicine. In collaboration with Professor Anne Hudson Jones she has contributed a series of essays on literature and medicine to *The Lancet.*

APPENDIXII

PROFESSOR MARSHALL MARINKER has had a long career in academic general practice and is Visiting Professor at the United Medical and Dental Schools of Guy's and St. Thomas's. He is currently Millennial Festival Adviser to King's College, London. As a major component of this Festival he is attempting to put together a year-long *Medicine and Ait* programme based on an involvement of many of the creative arts, particularly theatre. His major professional interests have been the theory of general practice, the interplay of art and science in clinical thinking, medical education, medical ethics and health care policy.

PROFESSOR JOHN MARTIN is British Heart Foundation Professor of Cardiovascular Medicine at University College, London. He studied philosophy in Spain before entering medical school in Sheffield. Since then he has worked in medicine teaching and research in the University of Melbourne, Australia, Kings College London and University College London. His main research interests are into the cause of heart attack. He is pursuing simultaneously research at a basic level in the laboratory and in patients.

MARY COZENS-WALKER is a professional artist whose work is about personal identity, optimism and the humour of the human condition. She uses papier mache, plaster and paint. She makes sculptures and some of her influences include 17th century English painting and 'raised' work. She studied at the Slade School of Art and then Goldsmith's College, London, has had several one person exhibitions in New York, Tokyo, London, Eastbourne and Stafford and is a joint winner of Tower Art Gallery 'Open', Eastbourne 1993.

PROFESSOR MICHAEL WORTON is Professor of French and Dean, Faculty of Arts, University College London. He is also Chair of the Council of University Deans of Arts and Humanities. He has written

extensively on modern literature and on issues in critical theory and gender issues. One of his current projects is a study of medicine in literature.

WORKING GROUP II:

HUMANITIES IN COMMUNITY DEVELOPMENT AND HEALTH
Chairman: the Reverend Andrew Mawson

PENNY GREENLAND is founder and director of JABADAO, a pioneering organisation which uses movement to address aims not easily met with groups of people for whom the spoken language is not easy. Over the past twelve years the company has developed its unique approach to communication and relationship-building in health and other related fields. The JABADAO approach is increasingly well-known for training, project work and provision of resources for professionals in such areas as learning disability, dementia and challenging behaviour.

DR GRAEME HARPER is co-ordinator, R & D, of the Centre for Creative and Performing Arts at the University of Wales, Bangor, National Director of the research programme 'Pathways: Media Arts and Young Children'. As a writer, his creative work has been awarded the Australian National Book Council award for new fiction and the inaugural Commonwealth Universities Creative Arts scholarship in creative writing. He has been a creative arts fellow of the Australian Literature Board, the NSW Ministry for the Arts, the University of Technology, Sydney and the University of East Anglia and is strongly involved in developing links between practising creative artists, higher education and community health care.

APPENDIX II

CLIVE HOLMWOOD is co-founder Project Manager of Act-up! For Mental Health, one of a very few theatre companies in Britain made up of mental health service users. He has a background in theatre with a degree in drama and an MA in educational theatre; has worked as a freelance consultant in drama and special needs for the past ten years in a wide variety of settings. He holds a postgraduate diploma in dramatherapy and practises in Birmingham as Head of Dramatherapy at the Birmingham Centre of Arts Therapies in addition to working as a freelance actor/director and chairing the Jigsaw Youth Theatre.

ALISON JONES is a self employed artist and founder of Celebratory Arts for Primary Health Care and leads the *Looking Well* project in Bentham, North Yorkshire - a unique, arts-led community centre set up to address local health and social care needs. Since 1988 the company has been working in partnership with members of local communities and a wide variety of health and social care agencies to identify needs and produce artworks and celebrations about health. Through a participatory and communal process, they use the arts to provide a description, exploration, affirmation and promotion of health in the widest sense. They create 'congenial space' which acts as a focus for community development and in which self esteem and purpose can be encouraged and nurtured.

DAVID LLOYD is Development Officer for Pioneer Health Centre, the charity which grew from the Peckham Experiment. He has a background in Fine Art and Art Therapy. Since leaving the NHS in 1985 he has worked in the voluntary sector, including eight years with MIND, the mental health charity.

DR MALCOLM RIGLER is a general practitioner in Dudley, West Midlands. Sixteen years ago he opened a new medical practice on a large estate in Dudley. The list size has grown to 4000 patients and the practice has recently become a pilot site for innovative GP services. The practice has firm links with local community groups - especially the local schools - and has undertaken a wide range of 'Arts in Health' initiatives with funding support from Dudley LEA, West Midlands Arts, The Arts Council of England and the Wellcome Trust. The practice has also built firm links with the University of Central England's Department of Community Care Health and Nursing.

SONIA THOMAS is Assistant Private Secretary to the Chief Medical Officer, Department of Health.

TILL TURNER is Director of *The Health Summary,* a briefing paper read primarily by chairmen and chief executives. Having read English at Cambridge she worked at *Nature* and as Health, Social Services and Home Office Correspondent of *New Society* before being invited to found and edit *The Times Health Supplement.* Fifteen years ago she set up as a private company to publish *The Health Summary.* Independently financed and produced *A Dream of Health,* a documentary on WHO policy, featuring the director-general, Halfdan Mahler, in co-operation with Soviet, Swedish, Danish, Spanish Television and BBC Wales, shown in prime time on BBC2 and in many other countries.

APPENDIX II

MIKE WHITE is Assistant Director, Arts, Gateshead Council. He set up what was probably the first arts in primary care project in 1988 at Dr Rigler's surgery at Brierley Hill. Has developed arts in health in Gateshead since 1989 in a programme including artwork commissions for Gateshead Hospitals Trust, the annual 'Healthy Hearts' sculptural lanterns event, and a long-term arts for older people project, 'Prime Time', which explores connections between creativity and well-being. Is currently doing consultancy work for the West End Health Resource Centre, Newcastle and embarking on a two-year evaluation study of arts in health involving Gateshead and four other projects in the UK.

WORKING GROUP III:

THE ARTS IN THERAPY AND HEALTHCARE SETTINGS
Chairman: Dr Robin Philipp

JON ALLEN is a senior researcher at The Prince of Wales's Institute of Architecture working with the NHS on a programme researching *Environmental Quality in Healthcare Buildings.* He has authored (jointly with Professor Keith Critchlow) *The Whole Question of Health: an enquiry into architectural first principles in the design of healthcare buildings.*

ADRIENNE BROWN is a graduate of St Martin's School of Art and Director of Stockport Arts &. Health. This involves promoting and managing arts activities for Stockport's two NHS Trusts, contracting artists to work with patients, staff and community groups on commissions for health service sites and health promotion projects, of which some are undertaken in liaison with other agencies such as the Borough Council and Voluntary organisations. Stockport Arts & Health

also commissions artists from throughout the UK to make works for specific hospital sites in Stockport and works closely with architects, interior designers and estates management on the integration of art works into all new health services buildings.

ALISON COMBES is the Literature Officer with special responsibility for lifelong learning at the Arts Council of England. Previously Education Development Officer at the Poetry Society, she was the creator of the first National Poetry Day Schools' promotion *Our World Ourselves* and the author of two nationally distributed schools' packs. A qualified English teacher, she has a particular interest in the connections between health and the literary arts, was the organiser of a Poets in Hospitals project sponsored by Glaxo Wellcome, and is an officer on the organising committee for LAPIDUS: the Association for Literary Arts in Personal Development. An occasional poetry critic and journalist, her work for the Arts Council now encompasses research into the role of literature in health promotion.

ANGELA FENWICK is employed on a voluntary basis as Executive Manager of the Birmingham Centre for Arts Therapies, which she was instrumental in founding in 1993. A music graduate from Durham University she taught as a music teacher before establishing music therapy departments at Rubery Hill Psychiatric Hospital, Birmingham and within the Birmingham Education Authority, in which she was senior music therapist for nineteen years. She has published many articles on music therapy and is interested not only in arts therapies on a professional level but in the wider concept of Healthy Living Centres and in the 'Arts in Health/Humanities in Medicine' movements particularly.

APPENDIX II

DR JOHN HORDER was a general practitioner in Hampstead and Kentish Town for thirty years where he helped to create a primary care team in a health centre designed for teaching and closely associated with University College Hospital Medical School. Joining the College of General Practitioners as a foundation associate in 1952, he started its library and archives and edited its earliest reports on vocational training and was elected President in 1979. Since 1982 he has been a Visiting Professor at the Royal Free Hospital of Medicine, founding Chairman of the Centre for the Advancement of Interprofessional Education (now President), Vice-President of the Royal Society of Medicine and an Honorary Fellow of Green College, Oxford. As a painter he has had four one-man shows in London and continues to play music on the piano or organ.

DR LINDA MOSS worked as a hospital artist after gaining a degree in Russian and a PhD in art history before returning to research, now in the field of health care arts. During the 1980s she published a number of articles on the history and philosophy of using the arts in healthcare in medical and arts journals. This work helped to bring the field into greater prominence with the medical profession. She was involved in the establishment of the National Health Care Arts Centre in Dundee and has spoken at many conferences over the last ten years. She is currently researching the impact of vandalism on art in hospitals and teaches health care arts as part of the MA in Cultural Policy and Management which she set up and now runs at Sheffield Hallam University.

DR HELEN PAYNE is senior lecturer in health and social care, University of Hertfordshire and has an extensive background in dance movement, therapy, group analysis and counselling. She is a registered

psychotherapist with the United Kingdom Council for Psychotherapy and a Fellow of the Association for Dance Movement Therapy UK. Author of several books and research studies she has a private practice in psychotherapy. Her research interests include personal development groups in the training of therapists and authentic movement.

JOHN PLANT is Chairman, Art in Hospitals, The King's Fund. He was formerly Chief Executive of the Royal Brompton Hospital Group, associated with the National Heart &. Lung Institute. He has been Secretary of the London Postgraduate Committee and a member of various London and National Committees as well as Chairman of the London and Provincial Nursing Trust.

PETER SENIOR is Director of Arts for Health, a unit within the Faculty of Art and Design at the Manchester Metropolitan University. A lecturer at Manchester Polytechnic, he has over fifteen years' experience as the founder and director of Hospital Arts, Manchester, arts consultant to the DHSS and member of both the Attenborough Committee of Enquiry into Arts and Disabled People and the Carnegie Council (to promote and monitor developments following the Attenborough Report). In 1987 he received a National Art Collections Award for his 'outstanding contribution to the visual arts'. Formerly a member of the Community Arts Panel of North West Arts and Chairman of their Environmental Arts Panel, he is founder director of Partnership Arts Ltd, the environmental art company. He is an adviser to the Arts Council of Great Britain's Per Cent for Art Steering Group.

DR DIANE WALLER is Reader in Art Psychotherapy at the University of London, Goldsmiths' College. She is Chair-Elect of the new Federal Arts Therapists Board at the Council for Professions Supplementary to

Medicine and represents Arts Therapies on the CPSM's Council. She has researched and written extensively on the development of the profession of art therapy in the UK and Europe and has been engaged in consultancy and programme development in Bulgaria, former Jugoslavia, Italy, Switzerland and Germany.

PROFESSOR RICHARD WATSON is Professor of English at the University of Durham.

A Selected Bibliography of Additional Background References

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APPENDIX IV

Examples of Medical Student Projects or Study Modules in the Arts and Health, at University College, London.

ELECTIVE PERIOD IN ARTS AND HUMANITIES FOR MEDICAL STUDENTS

WHY NOT SPEND YOUR ELECTIVE PERIOD STUDYING ARTS AND HUMANITIES AS THEY APPLY TO MEDICINE, IN PREPARATION FOR THE DEMANDS THAT WILL BE MADE UPON YOU AS A NEWLY QUALIFIED DOCTOR}

THANKS TO THE GENEROSITY OF THE HELLER FOUNDATION UP TO 8 BURSARIES WILL BE AVAILABLE FOR APPROVED PROJECTS IN MEDICAL HUMANITIES DURING YOUR ELECTIVE PERIOD.

EXAMPLES OF PROJECTS:

- The philosophical & theological underpinning of medical ethics.
- Art, literature & theatre as a window on physical suffering.
- The performing & visual arts as therapy.
- Psychology, social anthropology & the history of medicine in the understanding of health belief systems.

APPENDIX IV

MOST OF THESE ELECTIVES WILL BE BASED WITHIN THE FACULTY OF ARTS UCL BUT ONE OR TWO, BY NEGOTIATION, MIGHT BE SPENT AT THE INSTITUTE OF MEDICAL HUMANITIES, GALVESTON TEXAS.

(RELEVANT CLINICAL CONTACT WITH PATIENTS DURING THESE PERIODS WILL BE ARRANGED)

IF YOU ARE INTERESTED & HAVE DEVELOPED AN OUTLINE PROPOSAL CONTACT:

Professor Michael Baum
Dept. of Surgery
Charles Bell House
67-73 Riding House Street
London W1P 7LD Telephone: 0171 380 9147

Components of the available options include:

A: PHILOSOPHY

1. The nature of man in Greek, medieval and 20^{tn} century philosophy.
2. Study the use and rationale of folk remedies amongst different ethnic minorities within your catchment area.
3. Study the public understanding of science and their attitude to randomised controlled trials using the techniques of market research.
4. Study the public understanding of risk and risk reduction that may govern their attitudes to public health and recognised health hazards.

B: THEOLOGY AND ETHICS

1. Investigate the belief systems of ethnic and religious minorities in your hospital's catchment area and the possible impact this may have on the practice of medicine and the ethics governing euthanasia and abortion.
2. Carry out a study of the literature of the ethics of randomised controlled trials and the meaning of informed consent. Conduct a survey using market research techniques about the understanding of clinical trials and whether the public accepts or rejects their responsibility for recruitment into clinical trials in return to demanding their rights for improvement in medical treatments.
3. Study the history of the development of medical technologies and how new knowledge has impact on ethical teaching. Conduct a survey of health insurance agencies to determine emerging

attitudes to the disclosure of genetic data about the individual in setting insurance premiums.

C: LITERATURE AND THEATRE

1. With full consent write the biography of an 'interesting character' who is one of your patients. Describe the impact of a chronic disease on his or her life, personality, ambitions and fears.
2. Research the impact of chronic disease or disabilities on famous authors or poets. Try to identify this from original sources and as yet undiscovered links between their illness and creativity. John Keats and his tuberculosis is a good, if over-worked, example of this genre.
3. Write a thesis on doctors as heroes and doctors as self-interested charlatans using as source material the late 19^{tn} century and 20$^{t\cdot1}$ century novel.

D: THE HISTORY AND EXECUTION OF FINE ART

1. Study the concept of beauty in Greek, medieval and 20^{trl} century teachings.
2. Select a common disease and trace its history with illustrations from paintings in the London and provincial art galleries. Discover an as yet undescribed illustration of a physical deformity, deduce its aetiology and trace other possible examples amongst Europe's great art collections.
3. Approach patients with serious illnesses and ask them to describe their innermost feeling using simple art materials. Analyse their imagery and from this paint a composite picture in oils or collage that describes the suffering and hopes of the critically ill.

4. Research failing eye sight and the use of eye glasses by great artists of the past. Is there any relationship between maturation and greatness of the artist with age? If so, explain this paradox.
5. 'Making daily life beautiful' incorporating a visit to the Milan Design School.

E: MUSICAL PERFORMANCE AND APPRECIATION

1. Write a dissertation on musicians and their physical disabilities - are there detectable differences between the early and late works of Beethoven that reflect his increasing deafness?
2. Study the directorial techniques of Jonathan Miller at first hand and analyse the interpretation of pathos through music and opera.
3. Study physiological arousal in relation to the music of different composers. Use as your subjects healthy student volunteers or patients with different degrees of chronic ill health.

APPENDIX V

Response of the news media to Windsor I

Known responses of the news media to the information released are shown in Tables I and II. Reporting was constructive, informative and supportive.

TABLE I:

KNOWN NEWSPAPER REPORTING OF THE WINDSOR I CONFERENCE

NATIONAL NEWSPAPERS

DATE	NEWSPAPER	HEADLINE
24/3/98	The Times	Arts therapy will have role in NHS
30/3/98	The Guardian	Arts plan for medical studies
31/3/98	The Times	Better read than dead?
19/4/98	The Sunday Times	The best medicine
28/4/98	The Times	Beat the high-tech headaches
2/6/98	The Times	Students take a novel approach to medicine
3/6/98	The Scotsman	Doctors to study death and illness in literature
1 10/10/98	The Guardian	Forget Prozac: write a poem instead

REGIONAL NEWSPAPERS

24/3/98	Western Daily Press	The fine art of healing
25/3/98	Bristol Evening Post	Moves to use arts in care of mentally ill
24/3/98	Cardiff Western Mail	Health experts want NHS to use healing power of the arts
8/6/98	Western Daily Press	A poem a day keeps the doctor away

OTHER JOURNALS

March '98	The Health Summary	Only connect: the doctor, the patient and the person
29/5/98	The New Statesman and Society	Take three chords of Bach daily
12/9/98	Classical Music	The arts are good for you says National Campaign for the Arts
10/10/98	Positive Health	Creative writing
October '98	The Leisure Manager	Dobson told of art's vital role in health

APPENDIX V

TABLE II

KNOWN RADIO AND TELEVISION REPORTING OF THE CONFERENCE

DATE	MEDIUM	STATION/PROGRAMME
30/3/98	Regional Radio	BBC Radio Bristol
21/4/98	Regional Radio	BBC Radio Essex
22/6/98	Regional Radio	BBC Radio Bristol
11/8/98	Regional Television	West CountryTV
13/8/98	Regional Radio	BBC Radio Bristol
13/10/98	International Radio	BBC World Service - Outlook programme
15/10/98	Regional Radio	BBC Radio Bristol
16/11/98	Overseas Radio	South African FM Radio