The Carer's Role in Recovery

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A Stroke of Misfortune

By

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Edited by Chris Newton

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PREFACE

This book is written from our lived experience as carer and 'client' following a disabling stroke. We hope to contribute to the current debate about the future of social care and the need for statutory career structures for carers, and above all to highlight our belief that person-centred approaches, and the healing power of the carer/client relationship, are fundamental to recovery and to cost effectiveness. As a family carer John has had four years' experience of personal care, whilst Karin continues to show a remarkable resilience to cope with her new world.

The ups and downs of these lived experiences are described in Part One. In Part Two we conclude that the pioneers of Person-Centred Medicine, such as Paul Tournier's Médecine de la Personne, are as central to social care as they are to health care. Suggestions as to how to water the roots of compassion and to consider the spirit of man within a relational body/mind/spirit approach to care delivery are made. In Part Three, the educational and research implications of these holistic approaches are considered.

We conclude with a reference to Van Gogh's painting of the 'Good Samaritan', and with a reference list to remind our readers of other writers in this vital field who have influenced us as we travel onwards on our journey.

ACKNOWLEDGMENTS

Our children have contributed, often indirectly, to this text. Our thanks to them for their love, patience, and care.

Cambridge Scholars Publishing have been true to their word. They have challenged and incentivised us. Thank you Alison Duffy. Chris Newton has helped us greatly with the copy editing and formatting of the manuscript, with much attention to detail.

We wish to acknowledge also, quite specifically, the assistance from Dr Hans-Rudolf Pfeiffer for his advocacy of Tournier's ideas at the meetings of the International College of Person Centered Medicine in Geneva, and the Reverend Dr Alison Gray, who has co-authored several papers and chapters which have underpinned parts of our book.

Finally, without the help we have received from carers, and particularly from Celia Jack and other health professionals, and from our General Practitioners, there would have been no book to write.

This book could not have happened without the support, skills, prayers and encouragement of many people who have shared our motivation and seen this opportunity to pass on our experiences to unknown others.

We take responsibility for the final manuscript and apologise for any unnoticed and unforced errors.

The photograph of us was taken by Chris Newton.

INTRODUCTION

Life is a journey from beginning to end. The route taken is an adventure with risks and challenges, and with the excitement of new discoveries. John is an adult psychiatrist with a background in general medicine, and spent much of his professional life carrying out perinatal research and clinical work in the UK – and abroad. He had only limited experience of the rehabilitation that Karin required after the stroke. Although this was not an immediate 'end of life' situation, the threat of disability to the *modus vivendi* was considerable. We had more living and more work to do – and more family stories to tell.

When John was a student in Oxford, encouraged by the John Wesley Society and the Student Christian Movement, the Wholeness approach to medical practice was a prominent theme at that time. The Conference that John and Karin both attended in 1965 asked the question: what do the psychological, theological, and sociological understandings of Man have in common? What were the issues to consider that could lead to shared understandings?

The speakers included Cicely Saunders (then a researcher in Palliative Care), the phosphor Professor Ian Ramsay (later Archbishop of Canterbury) and Robert Lambourne (psychiatrist and author). John's brother Murray, then a General Practitioner in London, led a seminar in the afternoon on medical ethics.

Missionary work, education, medicine and music were in our family bloodstream – John's father was a Methodist minister, his grandfather a missionary in Cuzco (where his mother was born), and his aunt a medical missionary in India. Karin's family in Sweden was also musical and churchgoing. Her father was a deputy head teacher and organist in the large central Baptist Church in Gothenburg, her elder brother Bertil was Chorus Master of Stockholm Opera, and Leif was a dentist in Stockholm and a keen flautist.

We give our readers this family information to explain, at least in part, why music and the writings of Paul Tournier feature prominently in our book – and why the concept of *Médecine de la Personne* (healing of persons) has remained so influential to our present-day thinking about the nature of health and social care.

The book is written for health professionals and carers across the world, and for people who suffer with long-term disabilities who require long term care in their home, or in hospital. We hope they will find our lived experiences helpful, and learn from our mistakes. We hope too that the book is relevant to the work of teachers and researchers in this field – as well as their students.

The book has three parts:

Part One tells our stories, and informs readers of the care world in which we live.

Part Two describes the body, mind and spirit Tournier approach to person centredness, the roots of compassion, the nature of personhood and the power of music.

Part Three includes our tips for carers and care organisations, as well as suggested research and audit programmes.

John and Karin Cox
Cheltenham, October 2024

PART ONE

LIVED EXPERIENCE

1.1 Our story: the stroke of misfortune

In the summer of 2020, we were at our holiday home in Ambleside to celebrate John's brother's Diamond Wedding anniversary. In the middle of a very dark night a few days after the celebrations, John found Karin slumped in our small toilet and unable to move. This was totally unexpected. He had to think quickly of possible causes and consequences. Yet with uncanny accuracy, Karin told him in a faltering voice that she thought she had had a stroke.

John hurriedly searched for a torch, for his hand magnifier (he has visual difficulties), for the aspirin tablets and for our postcode – and then waited impatiently for the ambulance to locate our Lake District home, near the top of a steep incline.

Karin's medical history (osteoarthritis and neuro-sarcoid) was hastily written down for the paramedics and her medication listed. 'Do not delay us' they urged, 'We're in a hurry'. John was worried. 'Shall I sit in the front with you, or at the back with Karin?' he asked. 'Neither' came the devastating reply. 'Covid restrictions, you know'.

John shouted out in rage at this sudden loss as the ambulance sped off. No time to say goodbye after fifty-five years of marriage. No time even to 'hang up our boots' in our own home. It was a traumatic experience, with the possibility of imminent death, which he was not prepared for.

The following morning the phone rang. John was perturbed by its ominous ringing tone, but then he heard: 'Hello dear, it's Karin. They did a scan. You should speak to the staff. Please bring me some tissues.'

The Ward Sister on the Stroke Unit in Lancaster told John of the initial assessment. Karin had had a right middle cerebral artery ischaemic stroke of moderate severity, which had affected the left side of her body. The cause was not obvious, other than her age, raised blood pressure and extent of atherosclerosis. Thrombus blasting medical intervention would have been too risky.

1.2 Covid lockdown, and a new world

John could not visit Karin because of Covid restrictions. He did not drive, but miraculously it seemed Susanne, one of our three daughters, could drive from Cheltenham to Ambleside to help us. John talked with Karin on the phone and tried to sort out immediate family affairs and make sense of this unrehearsed happening. We remained hopeful that we could finish 'unfinished business,' known and to be known, and hoped that the quality of life would be good enough.

Karin wished to remain at home. The family also wished her to be at home – and the care system made this possible. We prayed, as did others, for healing. Good can come out of suffering, the Bible had asserted.

After two weeks Karin was moved back to Cheltenham Hospital Acute Stroke Unit, where the community services were more accessible and Covid restrictions less stringent. She was later transferred to the specialist rehabilitation hospital near Gloucester, three quarters of an hour's drive from Cheltenham, but with visiting twice a week – strictly policed due to Covid concerns.

1.3 Questions answered: the search for meaning

The adjustment to this new life was a challenge, especially during the Covid lockdown. Karin was a walker, a hill climber who would have followed in Wainwright's footsteps in the Lake District if she could, but she could no longer be at the helm of domestic and financial affairs. John was troubled by bowel and urinary symptoms, which worried him a little, and the family a lot.

As the immediate threat to Karin's life receded, the possibility of recovery was realised. The hospital chaplain had brought the sacrament, which opened spiritual connectedness, and our family were loving and helpful. Then followed weeks of personal adjustment – for both of us. It was, and continues to be, a slow recovery, a time for loving and a time for touching, a time for thankfulness and for renewed faith. A time for growth and for growing up. And a time of remembered sorrow, and of more recent loss. John's mother had died from a stroke many years ago, and his sister-in-law had a pulmonary embolus just a few weeks after Karin's transfer back to Cheltenham. We were face to face with our own, and others', mortality in a way that changed our perspective on recovery and rehabilitation.

The learning curve on this journey was steep and painful, but there were stopping places, with time to reflect, ask questions and search for answers.

Can your anchor hold in the storms of life?

Many world faiths had provided helpful anchoring points with a sense of awe before a God who is compassionate and gave explanations at times of suffering. We dug deep into our Christian faith that a creator God had become man. These were anchoring points that helped us through. The Christian faith, as with other Abrahamic faiths, has a long tradition of providing health care, and of motivating health workers. They encouraged adherents to consider a range of spiritual practices relevant to health, such as prayer and penance, taking part in group worship and healing rituals, whether in a mosque, temple, synagogue, or church. Such religiosity can be both intrinsic (personal, subjective) and extrinsic (rules and regulations, creeds, and disciplines). Spiritual practices included searching for answers to existential questions. such as the meaning of life, the relationship with the sacred or with a transcendental Being. Health, we rapidly realised, was more than the absence of illness, and as the WHO definition summarised, is a state of wellbeing when an individual is in harmony with themselves, with society and the environment. The healthy person may be able to cope with the day-to-day stresses and become a more reflective and creative person. Religions are concerned with how the physical/biological body – an 'embodied being' – relates to the spiritual, divine God.

A greater understanding of how these religious traditions, and their spirituality, can complement the natural sciences was needed for the present time. Keith Ward, Professor of Theology and Philosophy at Oxford, in his 2009 Roy Niblett Lecture *Christianity among the World Religions,* had suggested that each faith tradition's core beliefs were a metaphor of the relationship between an Almighty God and humanity, and that these could converge, but were unlikely to merge[1]. Similarly, Paul Tournier[2] in his lecture 'The Enigma of Suffering,' given to an audience of Catholics and Protestants in Switzerland, recognised the possibility of uniting not only Christians but also Moslems and Jews in a shared spiritual view of man. Ecumenism and inter-faith dialogue was to be found throughout his writings.

Keith Ward also reminded his audience that Christianity was itself influenced not only by Judaism but also by Greek philosophy. Christians believed that Jesus was the incarnated God in the world – and that after the resurrection he remained present as the Holy Spirit. Teilhard de Chardin[3], Catholic priest, theologian, and palaeontologist, regarded this Holy Spirit not as a meta- or epi-phenomenon, but rather the very Spirit of Man – the stuff of the Universe. John Mbiti,[4] Professor of Theology and Comparative Realign at Makerere University, described how in many African religions there was an awareness of the spirit world, which was generally benign but could be harmful.

Although Tournier himself stood firmly on his Christian roots, he was open to dialogue with doctors from other faiths, including atheists, Buddhists and Muslims. His own understanding of personhood, and of Medicine of the Person, however, came from this belief in a creator God, and in the power of sacrificial love shown by Jesus' suffering. He regarded these beliefs and the nature of human growth and development as being complementary, and not contradictory – a breadth of theology that helped us anchor in a new and turbulent secular world.

There were several other questions to be answered:

Can you cope with emotional turbulence in yourself and in loved ones?

Whilst there were occasions when John was overwhelmed by exhaustion and on the burn-out continuum, self-reflection and additional assistance reduced the duration of these times. Karin's lack of reactive facial expression was initially one of the social handicaps that we learned to overcome. Communication with carers, especially when face masks were worn, was another difficulty that impaired daily relationships. Cultural and linguistic misunderstandings had to be recognised, and then overcome. Karin is Swedish. Most of our carers were African. John is English and alas familiar only with the English language.

Can you manage at home in a two-bedroom apartment with carers working in your private spaces and carrying out personal care in private areas of the body? Can you pay for this care?

These practical questions we are still answering, yet at the time of writing the provisional answer is implicit (and to an extent explicit) in the pages of this book.

1.4 The Caregivers

After the stroke, we were immediately immersed in this new world of care - and we needed help to know where and how to seek assistance in answering our questions. Care agencies were located from the internet by our daughters, spreadsheets of comparative costs scrutinised, and the ward staff also helped us. We were novices, despite our professional backgrounds, and were vulnerable in a costly and seemingly hazardous situation.

Karin, despite her difficulty concentrating, made her preferences clear enough. At the discharge meeting she made it clear that she wished to go home, and not to consider a care home. This was John's definite preference too – and that of our daughters.

The senior nurse asked John via Zoom if he was aware that looking after Karin would be like looking after a baby. John replied that he had been married for over fifty years and we had always looked after each other. He did not say that he had never been a prolific nappy changer!

Of similar importance was whether he would assist, or hinder, the care workers with their complex work of carrying out personal care, such as hoisting for transfer from bed to wheelchair. The tasks for family carers were demanding and there was a need to learn new skills that we had never considered before. Later the occupational therapists and physiotherapists made their assessments, and the social worker from Gloucestershire County Council signed off the initial home care arrangements. A ripple bed and a wheelchair were soon delivered, and later a commode, and John hastily prepared our bedroom. The NSF Care Agency would provide personal care, initially five times a day, and a sleep-in carer completed the package. Only two years later did we acquire a live-in carer. John continued to be a husband looking after his wife but became also an informal family carer, often at the interface of care agencies, and sometimes providing feedback to the agency when there were problems – or when the care was of a particularly high order. Some carers were not used to this input, but at times it was very necessary. John had to learn to be firm, to accept criticism when justified and know when it was a way of coping for carers and the family. His medical and psychiatric training and the practice of meditation (prayers, holy books, mindfulness) helped when the going was tough. Some aspects of his specific training helped when carers were burnt out, or when Karin had a seizure in her chair. We had to clarify the Powers of Attorneys for Health and Welfare, which gave Attorneys power to act in the best interests of the person, and if necessary to override paramedics' decisions about hospitalisation or treatment in an emergency, if Karin had lost capacity. Karin did not wish to be resuscitated (DNR) nor be hospitalised, unless for a short-term emergency.

Carers

There have been over seventeen carers through our front door since the stroke, mostly from Central and Southern Africa: Zimbabwe, Namibia, South Africa, Botswana, Nigeria, and Mozambique. We have welcomed this cultural and linguistic diversity, which has been reminiscent of our time in Uganda (1972-74). The sleep-in carers were mostly from Gloucestershire or South Wales, and arrived at 9.30 p.m. A live-in carer – via the Country Cousins Introductory Agency – is now with us, working about ten hours a day. She works with an NSF carer to carry out personal care and hoisting,

and to give attention to Karin's other immediate needs and prepare food. She has assisted John to take exercise, go shopping, resume some reading and make music. Celia, our present live-in carer, occupies our second bedroom. We are fortunate to have a large hallway with space for a desk and a piano in a modest sized two-bedroom apartment in a retirement complex with community facilities.

We have received advice and practical assistance from over 12 community-based health professionals within the new NHS Community Stroke service, approaching that recommended in the 2018 NICE Guidelines for Stroke Rehabilitation[5].

This team also included community and wheelchair occupational therapists. The NHS was at its best. District nurses, a physiotherapist and a sensory loss team, as well as a community stroke coordinator, were also on hand. Certainly, this new community service gave us confidence to manage at home – and to see the NICE guidelines being implemented was impressive and much welcomed.

Our General Practitioner and a consultant neurologist were both helpful with telephone advice about medication, the need for additional tests, and to discuss the likelihood of further seizures. We were fortunate in accessing this range of care on the NHS. Our experience was that recovery and improvement in quality of life can indeed occur many years after a stroke, although Karin is unable to move her left arm or leg, and requires a wheelchair and other forms of assistance every day. We are companionable most of the day with a shared 'language' and we generally sleep well in the same bedroom.

Some of the most normal times of day are when we watch quality TV in the evenings or in reclining chairs in the afternoons. Certainly, we enjoy getting to the local church and occasionally to a concert or local park, but recently John's mobility and stamina have been more limiting. Our family are very helpful and visit us when their work and family commitments allow. Christina, our eldest daughter, in Salisbury, is an anaesthetist and helps us with our home management, including cooking. Ann-Marie is a local

General Practitioner, and Susanne works as an international human resources manager.

The family has grown in knowledge of each other as we have come to terms with what has happened to Karin, and we marvel at her resilience. Karin speaks quietly and is sometimes hard to understand, but remains alert and appropriately conversational, most of the time. The loss of autonomous dignity is however galling, and at times the future can seem bleak. Symptoms of clinical depression for either of us have rarely lasted more than a few days, but if they had continued, general practice therapy would have been necessary.

Cross-cultural communication issues with carers, which have been a bedrock of our international marriage, still require great sensitivity, patience – and a sense of humour. There are cultural differences about body language (use of touch and eye contact) and a need for consensus about forms of greeting, of thanking, about the use of local banter, and how much to talk about the weather – the Swedes rarely do!

We have been fortunate in the family support and the NHS care we have received – the stroke could have been more damaging – but we share these stories with you in our book not because doing so helps us (which it does), but because we believe it may encourage readers to know that there can be light at the end of a dark tunnel, that human resources from within the self and within the care system can assist in the darkness, and that sometimes there can be a coming together, which is unexpected, and which enables others' needs to be considered, and hope and faith to be restored.

Writing this book is not a late-life vanity project but rather a re-living, a bringing together of our pasts, our values, and our writings to tell a story to explore the way in which person-centred relational approaches are applicable in the care world.

PART TWO

BODY, MIND AND SPIRIT: WHOLE PERSON CARE

2.1 Paul Tournier: the man and the message

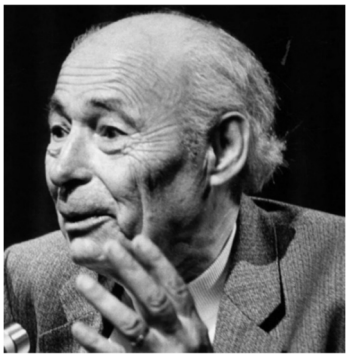
For many years John was an advocate for Paul Tournier's body mind and spirit approach to health care delivery. Tournier's first book, *Médecine de la Personne*[6], as well as *Doctor's Casebook in the Light of the Bible*[7] and *A Listening Ear,* were all influential in shaping his attitude to his work as a consultant psychiatrist and his choice of research methods in the perinatal and transcultural studies.

In the weeks after Karin's stroke, as a family carer and husband looking after his wife, John was uncertain whether a person-centred relationship-based approach was possible in the delivery of the social care that Karin was receiving each day. It was nevertheless apparent when such care was person centred, and when the transfers with a hoist were carried out in an impersonal way. We also knew when carers were preoccupied with their next client, or behind with their schedule of visits. We knew when health and safety issues were important.

We knew also of the demands on care agencies to provide care with an intermittent workforce, especially during Covid, with abbreviated time schedules, lack of national standards for guidance and without the support of occupational health assistance for the carers. We did not know whether a collaborative person-centred relational approach is possible when intimate body washing and personal hygiene are being undertaken. There were indeed a lot of unknowns, and we had to dig deep into the way we had managed in previous adverse life circumstances, as when Karin had neurosarcoidosis in the brain stem, or we had experienced a serious road traffic accident.

We revisited again what Tournier had been saying in his writings about the ‘Adventure of Living’ and its meaning, as well as the use of the Bible as a resource and the value of meditation. To do this we had first to reconsider the essence of Tournier’s own life story with his own experiences of loss and personal tragedies –he lived his message, and his message was indeed the man.

Tournier the man



Paul Tournier was an orphan. His father, a pastor at St Peter’s Cathedral in Geneva, died when he was two months old, and his mother died from breast cancer when he was six. With his sister he went to live with his uncle in a less religious household. He was a lonely and withdrawn child and very uncertain in his relationships with others. Only later did he come out of himself through having regular conversations with his Greek teacher, who engaged him in conversation and philosophical debate.

As a young doctor he was also assisted by his contact with the Oxford Group in Geneva, which engaged him in the value of personal disclosure with trusted friends and in the daily practice of meditation. It was at one of these meetings that Tournier for the first time was able to mourn the death of his mother, which had influenced him to study medicine. They taught him also to meditate each day – a practice that he continued for the rest of his life, usually with a mixture of prayer, bible study and thinking about the day ahead.

Tournier studied medicine at Geneva University from 1917-1923, and had his internships in Paris and Geneva. He was a student leader, becoming president of the Swiss Zoflia Student Association, which involved him in much public speaking and debate. After WW1 he worked with the Red Cross in Vienna, assisting with the repatriation of Russian, Austrian and German prisoners of war. Interestingly, as Tournier authority Dr Hans-Rudolf Pfeifer[8] has pointed out, he co-founded a home for mothers with their children who were suffering from tuberculosis; Tournier himself was an orphan.

Although not formally trained in psychiatry, psychology or psychoanalysis, Tournier was well read in these fields and was frequently meeting doctors from all these specialties in Geneva. He once asked the well-known psychoanalysts Alphonse Maeder and Theo Bovet whether he should train as a psychoanalyst, but both gave him the same answer, recognising his counselling potential as a generalist doctor: 'We are not short of good psychoanalysts, there are plenty of them,' he was told, 'but there is only one Paul Tournier'. Tournier responded:[9] 'I had to follow my own personal vocation, and attempt a synthesis between psychology and classical medicine, and even religious belief. The danger for the specialist is that of interpreting everything in accordance with the theory he has received from his teacher. A synthesis will be achieved only if one is free from all dogmatic prejudice. So therefore, I did not become a psychoanalyst. I opted for the medicine of the whole person, the non-specialized attitude par excellence, which works to understand man as a whole – the importance of the body, which the psychologist is in danger of neglecting, the importance of the psyche, which the organicist is in danger of forgetting, and the importance of religious faith, which may escape the doctor who confines himself exclusively to science' (Tournier 1982 pp 35 -36).

Family history

Tournier had two children, Jean-Louis and Gabriel. His grandson Alain, like his father Gabriel, is an architect, and curator of the archives held by the Tournier Association in Geneva. Nelly, Paul's first wife, died in a hotel in Athens, a tragic loss which he has described movingly. They had had had a loving and complementary marriage for many years. He later remarried, to

Corinne O'Rama, a much younger concert pianist from Geneva, whom he had met on a Greek cruise ship, but after several years of happiness, she developed health problems and Paul was alone when he died at his home with a cancer, after a few weeks in Geneva University Hospital, where he was looked after for by a physician and close colleague, Bernard Ruedi.

The inter-war years

The inter-war years were times of considerable personal as well as professional turmoil, which influenced Tournier's decision to change the way in which he practised medicine. He informed all his patients that he would become more open with them and more willing to explore their underlying difficulties. The seeds of his first book, *Médecine de la Personne,* were being sown during these stormy years. The first manuscript for this book was then ground-breaking.

The book was written in 1938-9, but after his call-up as a military doctor, he had more time to reflect on it and take more advice from colleagues, and he then re-wrote much of the text. It was published in 1941, but it was not until 1957 that it was translated into English. This text, however, struck an immediate chord with readers in the aftermath of WW2, and many were listening across the world. Only after the war ended did he receive encouraging letters, especially from Germany and Holland.

In 1946 he had a painful separation from the Oxford Group which had meant so much to his personal development. The Oxford Group was a Christian organisation (Later known as First Century Christian Fellowship and the Moral Re-Armament (MRA), a modern, nondenominational revivalistic movement) founded by American Lutheran minister Frank Buchman in 1921[10]. However, by then they had turned into 'Moral Rearmament', located in Caux near Vevey, Switzerland, and he realised they had taken an ideological moralistic course with which he could not identify any more. He lost many friends. But in 1946 he and his wife were invited to Germany for a conference of medical doctors and counsellors in Bad Boll, Württemberg.

International Group

In 1947 Tournier invited doctors to a one-week retreat at the Ecumenical Institute in Bossey near Geneva for what he called a 'Group for Research into Medicine of the Person' (in French, 'Groupe de la Recherche de la Médecine de la Personne). Ever since then, these meetings have taken place annually in different countries in Europe. Psychotherapist Hans-Rudolf Pfeiffer has described how in 1969 the group published an account of the first twenty years, which included a summary of the core concepts of Medicine of the Person. The 57th meeting took place in Great Britain, and there have been other meetings in the USA.

The participants came from various professional backgrounds and with different views of life, although most had Christian beliefs. Tournier wanted these meetings to be opportunities for personal encounter, for sharing about personal doubts, failures, and joys. Each day there was a bible study class led by Tournier, not as a theological exegesis but with a personal dimension - a highlight for those who attended. Theologians were discouraged from attending because he had noticed that doctors then talked less about their difficulties, spiritual experiences and clinical dilemmas. Family members, because of their influence on the practice of the doctor, were always welcomed – there was no category of 'accompanying persons'. Then, as now, all communications were translated into French, German, and English, usually in advance of the meeting or by a member of the group who translated as the discussions continued.

Tournier wrote over twenty books, many of which were translated into over twenty languages and found a global readership. Towards the end of his life, Tournier continued to write. He published *Learning to Grow Old,*[11] *The Gift of Feeling, (La Mission de la Femme)*[12], *The Meaning of Gifts, Creative Suffering* and a *Listening Ear*, which included interviews with the media, as well as public lectures. These are of relevance to the present-day problems in the practice of medicine in the National Health Service, as well as personally to ourselves in this new world of care. Tournier described on several occasions how much he regretted not being able to help his mother when she was dying of breast cancer, or his sister suffering with influenza, nor his uncle, when he was killed in a car that he was driving. He wrote:

'I think that if I am sensitive to human suffering, I owe it to this experience of suffering, while I was still very young, to become a doctor. It was, without my realizing it, to avenge my mother, to fight against the death that had seized me'[13] (Tournier 1972 pp 240-241).

Tournier was always open to dialogue with doctors from all faiths and none, including atheists, Buddhists, and Muslims. In Isfahan, Iran, he was invited to talk in a mosque. His understanding of personhood, and of a Medicine of the Person, sprang from the biblical concepts of personal growth, as well as the power of sacrificial love.

He had a full understanding of developmental psychology and of psychoanalysis and found few contradictions with his own liberal biblical faith. Indeed, he regarded his Christian beliefs as complementing the understandings of Freudian scientific theories of the structure of mind. Religious belief, spiritual practice (meditation), the biblical record, developmental psychology and scientific exploration were each a part of the tapestry of human beings and their search for the transcendental. So, they were important to health care delivery, to maintaining mental health – and to understanding his vocation as a doctor.

Central to his relational body/mind/spirit approach was an empathic healing dialogue between patient and doctor, which he regarded as spiritual.

Tournier – the message

Tournier believed that this practice of *Médecine de la Personne* could be taught only by example – not from didactic lectures or from the pulpit. He once reprimanded a chairperson who introduced him as an expert on concepts of person-centred medicine. 'No!' Tournier exclaimed, saying that he was not an expert about concepts, but about the dialogue itself, and that it was the relationship which was at the heart of medical practice. It was his insistence that it was the I-Thou, person to person, relationship (in contrast to the less personal I-It dialogue) that was important. This understanding, which might even seem rather old-fashioned or totally impractical in the fast-moving internet social media-driven world with its less personal hybrid meetings and the limited opportunity for face-to-face dialogue without imposed limits of time, almost seems to be a lost asset. Yet the public in the

UK wish to re-establish this personal relationship with their doctors, who are currently on strike primarily because they wish to be left to work in this way.

Nevertheless, despite the problems that persist at the present time there are changes in health care delivery that are much to be welcomed. Tournier would have welcomed many of the changes in medical practice today, for example more education and training in ethics and in knowledge of counselling psychology across all health professionals, and the extent of present-day multidisciplinary teamwork in multi-faith societies – as well as the user movement.

Tournier believed that that for a whole person understanding, the brain, mind and spirit cannot be separated – they are intrinsically part of the whole person. The mind cannot exist without the brain, and vice versa. Brain and mind were two sides of the same coin. The whole person is primary, the brain mind spirit were 'extricates', and the person becomes a person by relating to others.

Tournier had an anecdotal, intimate, and personal style of writing and summarised these ideas in the following extract from *The Meaning of Persons*:

'Even if I could arrive at knowledge of all the physical, chemical, and biological phenomena of the body, all the psychical phenomena of the mind, and all the spiritual, social, historical, and philosophical factors at work in man, would it make me into a doctor of the person? Would it result in personal contact with my patient? In the end of the day, I would still be in the world of things. Knowledge of things, even of infinity of things, does not bring us to knowledge of the person... Do not misunderstand me; I am not denying the usefulness or interest of the effort to synthesise our scientific knowledge of man. But, however successful, it will reveal only one side of man's nature: that of his mechanisms. It will still be necessary to complete it with a personal knowledge, which is of a different order, the order of the person, not that of things. This knowledge is within the reach of every doctor, be he an ordinary General Practitioner or a learned specialist'[14] (Tournier 1957 p187).

2.2 Medicine of the Person – healing relationships

A Medicine of the Person was thus an integrative (holistic) biosocial/psychospiritual approach to healthcare delivery which encompassed the art and science of health care, and regarded the Self (the Person) as a relational human being. Professor Juan Mezzich, President of the World Psychiatric Association and founder of the International College of Person-Centered Medicine, has summarised Medicine of the Person as a Medicine *of* the Person (of the totality of the person's health, including its positive aspects), *by* the person (with clinicians extending themselves as full human beings with high ethical expectation promoting the fulfilment of the person's life project), and *with* the person (working respectfully in collaboration and in an empowering manner).[15] The World Psychiatric Association programme 'Psychiatry of the Person' was initiated in Geneva, when our book *Medicine of the Person: Faith Science and Values in Health Care Provision*[16] was about to be published by Jessica Kingsley. This juxtaposition of place and ideas was highly motivating. John was then Secretary General of the World Psychiatric Association, which had just moved its secretariat to Geneva. This juxtaposition seemed to be symbolic of a surprising interconnectedness of things.

Medicine of the Person is thus optimally considered as an approach to health care delivery which gives equal attention to the biological, psychological, social and spiritual aspects of health problems. Tournier believed that developing spiritual sensitivities in the doctor was also a central component of its practice, and that a healing relationship was facilitated by limited self-disclosure which could open doors. This personal encounter might be brief – almost gone in a flash – as when greeting someone by name, or sharing a faith background with the anaesthetist when waiting for a serious operation.[17] A more reductionist approach to medicine restricted to biomedicine alone, and without ethics, could be harmful, as it may lack an integration of body, mind and spirit necessary for both health and wholeness.

Tournier anticipated the present-day search for more dialogue in health care provision, and the increased recognition that spirituality cannot be neglected in the training of all health workers, and in their practice. Medicine of the Person was not a specialist technique confined to primary care, nor was it