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Forgiveness and Reconciliation in Clinical General Practice

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PERSONAL INTRODUCTION

I'm now in my 70th year – I'm horrified how age creeps up on you, so I frequently have to recount my life to remind myself how good God has been down the years (Slide 2). I qualified in 1964 in London, and immediately ran away to sea because of an un-fulfilled childish ambition to join the Navy. Fortunately I had already met this beautiful nurse (slide 3), who brought me back to earth after just six months going around the world. It wasn't long before we had four of these (slide 4 – our children) and now we have nine of these (slide 5 – our grandchildren)

Most of my life has been spent as a General Practitioner, (slide 6) and a significant part of my career has been as an academic, attempting to teach the next generation of doctors and also research into audit and computers in primary care (slide 7). It is interesting that my wife has taken a completely different path (slide 8), and in the auto-biography we are writing as a family, I recount that I married a nurse, she soon became a mother and responsible for a 7 acre smallholding, but in our third age she has become a priest. I am fortunate to have had three wives, but only married once.

But some 25 years ago I had a mid-life crisis, caused by an accident on my motor bike which caused us as a family to re-evaluate our lives. As a result we joined a Christian mission organisation Youth With A Mission (slide 9 The Kings Lodge) and I was taken on a learning exercise in counselling and spiritual ministry to complement my medical training, so, almost by accident, I eventually found myself as a physician of the body, mind and spirit.

At this time I "had a word from God" in an extremely important time personally which gave me my "calling" for life (slide 10). I realised that in order to bring health to people I needed to treat the whole person and not just the physical or psychological aspects of the patient. (Slide 11) After discovering my Spiritual Inheritance this has taken me on a journey of exploration into what is ill-health and how to bring healing and wholeness to people with sickness which reaches beyond the physical. As often happens we "add" to what God says, and for me it was the conviction that I was to open a Christian Hospital. But that is another very long story. Of course the works of Paul Tournier were a significant mile-stone in that journey (Slide 12 Paul Tournier).

WHERE WE ARE GOING IN THIS TALK

As a GP we see a wide variety of people who are "ill". It is our job to understand what that illness is, how it happened, and how it can be improved or defeated.

We have been brought up in a scientific humanistic model of medicine (slide 13) where man is just an evolved animal, so all of our diagnoses are made in patho-physiological terms. Psychiatrists may use slightly different models of behaviours and symptoms to diagnose what is going on in the mind. As a general practitioner I was then taught about making problem lists and so concentrating on the patient experience and involving the social aspects of the patient's life as well as the psycho-somatic. But there still seemed to be something missing. Then along comes EBM with the emphasis on scientific evidence for treatments (slide 14). But still the picture is incomplete, and Sackett pointed out that the research evidence can only be half of the picture. The other half of the picture is made up by the patient themselves (slide 15). For me this missing link was developed as I ministered to people through prayer and counselling and realised that the human spirit played a much bigger part in health that we had realised. And so I began to explore what we now call the whole person approach to health care.

So I want to explore this whole person approach to medicine which recognises the equal importance of spiritual and psychological conditions in the person rather than just concentrating on the physical problems. Within this model we recognise a different set of causes of ill-health. We can begin to talk of broken hearts, loneliness, broken relationships, guilt and fear, and recognise that the patho-physiological framework is insufficient for dealing with these causes of ill-health within the person.

A whole person approach is nothing new. Good doctors have been practicing it for years. Paul Tournier was one of the fore-runners of this person centred approach which recognises the interaction of the physical, psychological and spiritual dimensions of mankind (slide 16).

So in this talk I want to take us on a journey around the person and begin to explore how concepts with which we as Christians are familiar, such as guilt, sin and broken relationships, and how these can be integrated into our medical models so that the cures for these causes of ill-health may be tackled through such means as forgiveness and reconciliation within our health care settings.

WHAT THEN IS HEALTH?

We first need to agree what we mean by health and ill-health (slide 17). Health is not static, but more a reflection of the functional ability of the person. Surely a new definition is needed for our whole person approach. However we cannot define health along the lines of the WHO definition (slide 18 – WHO definition) –

> **Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.**

- but it has historically formed a debatable dividing line. Is health just about curing diseases, or does it involve all of life, health and happiness? One good aspect of this definition is that we have been encouraged to embrace the concept of well-being. This forces us to look beyond the purely physical and look at the social, psychological and spiritual aspects of health.

It is not enough to define health as the absence of disease (slide 19) – as we all have diseases (I think I have around 16 at the last count). Nor can it be the absence of symptoms as most people have some symptoms every day. Likewise it cannot equate to happiness and fulfilment, although this does provide us with a challenge to consider a "whole person" definition of health. In 1986 the WHO Ottawa Charter reviewed this definition, and produced (slide 20) –

- **"Health is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."**

A good definition of health was developed by a group of Christian doctors in the CMF a couple of decades back (slide 21) which concentrated on the adaptation and coping strategies which we need to develop to cope with the pain, suffering and sickness which we all experience.

Summed up in the phrase "**The strength to be human**" (slide 22)

A "whole person" definition of Health

- Strength to be human – to live and die
- Minimising morbidity and then -
- Adapting to residual pathology
- Coping with pain and suffering
- Growing through difficulties
- Learning compassion and kindness
- Coming closer to "inner peace" - Shalom

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The strength to be human

- To be human –
  - In relationship with self
  - In relationship with others
  - Free to mature and grow
  - Fulfil the purpose of our life
- Health is not a state but a journey
- Health is relative and not absolute
- We become the people we are through our relationships with others

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WHAT IS A WHOLE PERSON?

We have begun defining health in whole person terms, now we need to agree on our understanding of a "Whole Person". There are several important aspects to the person. Clearly we are a body and a mind (slide 23), and the majority of people would agree that we are also social beings with a human spirit (slide 24). What do we mean when we talk of the human spirit? Can we produce one agreed understanding or does every religion and culture decide for itself the spiritual nature of men and women?

Starting from the Christian theological point of view we have a chequered history in defining the person in monistic, dualistic and Trinitarian terms (slide 25). I was brought up with an old Trinitarian model which talks about the spirit of God coming down to the physical man, and where the two meet the soul is formed (slide 26). This divided the person up into three parts where the soul was the "old sinful man" and the spirit was the "new creation in Christ". This is a helpful distinction, but introduced harmful consequences, basically leading to a dualistic picture of mankind – the mortal body and the immortal soul (which is un-biblical and historically has had many harmful consequences).

The Biblical view of man is much more monistic – we are an indivisible whole and all of my actions, thoughts and attitudes involve all of me – body, mind and spirit (slide 27 – the golf ball model). However we view the various constituent parts of the human, we must recognise that we are indivisible persons (slide 28) with a variety of functions and aspects, but in everyday life it is recognised that in order to understand this "undivided whole" we need to look into the person through three windows (slide 29). This is still an artificial division, but does allow us to see the whole person within.

In the Whole Person clinic we ran based in general practice, the person needed to be assessed in these three areas in order to be able to make a diagnosis in whole person terms. The physical

assessment is usually carried out by the doctor – although it could be a nurse – (slide 30). The counselling professional usually performs the psychological and social assessment (slide 31), and lastly a Spiritual Care Advisor looks in through the spiritual window (slide 32). All of these roles could be undertaken by the same professional, but there is an advantage of having more than one person interacting with the patient as they are encouraged to tell their "health care story". There isn't time to go into this today, but of course the practical outworking of this approach is very important.

I've been asked to concentrate in this talk on forgiveness and reconciliation, but we do need to place it within the whole context of spirituality and health (slide 33).

THE HUMAN SPIRIT AND HEALTH

The working party developing the Whole Person Clinic in our practice have developed a map of the human spirit which we believe can be accepted by all people – of all faiths and none. This seven stage model covers much that a secular psychologist would claim is their own territory (slide 34), but we do believe that the spirit's working can be recognised in all of these areas – not solely, but in partnership with the mind, heart, will and body.

The advantage of this approach is that it separates spirituality from religion, and enables us to open up the spiritual area in a non-threatening way to all people. In the NHS practices where we have Spiritual Care Advisors working (they used to be called chaplains), they are able to help Christian, Muslims, Sikhs, Jews and people with no faith.

The seven area of spiritual activity cab be divided into -

a) **Self Image** (slide 35)
    a. Awareness of self, and self-understanding
    b. Ability to "love oneself"
    c. Able to handle constructive criticism
    d. Growth and maturity through experience leading to wisdom
b) **Relationship with others** (slide 36)
    a. Healthy relationships with family, friends and neighbours
    b. Ability to confront and to reconcile and so mend broken relationships
    c. Able to distinguish the different types of relationships and act appropriately
c) **Relationship to the world around** (slide 37)
    a. Attitudes to society, culture, work and environment
    b. How much control I have over the external world
    c. Where is my locus of control?
    d. Able to be creative.
d) **Morality and ethical practice** (slide 38)
    a. Knowing what is right and wrong
    b. Able to judge the morality of their own actions
    c. No dissonance between what they believe and what they practice
e) **Purpose, meaning and hope for the future** (slide 39)
    a. Having purpose and meaning in life
    b. Having a hope for the future
    c. Understanding the "desires of the heart" (or the deepest desires)
    d. Positive attitude to the future

f) **Decisions, choice and will power** (slide 40)
   a. Understands the process of decision making
   b. Able to work out the consequences of choices
   c. Able to exercise will power
   d. Having perseverance and courage in the face of adversity

g) **Belief and faith** (Slide 41)
   a. Faith is belief in action
   b. Having an ability to examine and change their beliefs
   c. View of the spiritual world and God
   d. How they exercise their faith
   e. Highs and lows of religious life

So is this understanding of spirituality of any importance in health care? (slide 42) There are three responses – and we believe the correct one is the third (slide 43).

Is spirituality part of a medical model?

- Three responses –
- 1 Not at all, it may be important, but like the need for sewers and clean water, not part of a medical model. (Dualism)
- 2 Yes it is an important part of the delivery of health care, involving equality, respect of patient's beliefs, compassion etc.

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The third option

- The spirit plays an important part in both becoming ill and then in overcoming sickness, so it is an integral part of any successful model of care.
- BUT this presents the big challenge
  - How do we integrate spiritual diagnosis, treatment and care into a whole person model which is practical and achievable?

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FORGIVENESS and RECONCILIATION

In any health issue where mental and spiritual aspects are playing a significant part in producing ill-health, a whole person approach is necessary to recognise the nature of the problems and help in providing healing.

What sort of problems arise in this spiritual area? (Slide 44). Three main ones involve relationships, shame and guilt. This is in addition to many other issues such as mental health problems, anger, loneliness, wounds following abuse, anxieties and sorrow.

1 We see many people with **broken relationships,** sometimes through no known fault of their own, sometimes after wrong actions they have taken. Virtually all relationships are vulnerable and fragile, especially those with those closest to us.

2 We see many patients who admit to a **sense of shame and guilt** over actions and situations in the person's past. This is sometimes due to the person's own actions, but of course can be as a result of abuse which the person was unable to avoid. Many children will feel that the arguments of their parents is somehow their own fault as a naughty child, and so shame and a sense of guilt can develop early in childhood (Freud called this infantile guilt as it is undeserved and an emotional reaction to events beyond the child's control)

3 Many patients will express **feelings of guilt**. (Slide 45) There have been many ways of describing and dividing up guilt. Tournier spends chapters talking about false guilt and true guilt. More recently Gordon (2000) has described three types of guilt –
   a. Transgression guilt (where the person's actions and behaviour are responsible for wrong doing for which they feel sorrow and guilt).
   b. Perfection guilt (which comes from a falling short of one's own standards and expectations – a failure to achieve idealistic standards).
   c. Rejection guilt (follows rejection by others – not necessarily deserved, so may be true guilt or false guilt).

Gordon argues that forgiveness is only an appropriate response in transgression guilt, and the other two forms of guilt don't need forgiveness but need only affirmation and acceptance. (Gordon, H., 2000 "Guilt: Why is it such a burden?" Bishop John Robinson Fellowship Newsletter 9, pp 4-6)

I take a slightly different view of the way to view and treat guilt as I think that forgiveness works in all cases of guilt feelings, and I think Paul Tournier agrees with me! Guilt is always an internal emotional response to events in life. Some of these events are the responsibility of the person (transgressions against the accepted norms of behaviour in the religion or culture of the patient). Some are due to an inappropriate level of standards and expectations which are often set as the person develops, and largely beyond their control – or at least so it seems). Lastly some guilt feelings are fuelled by a feeling of unworthiness and failure to stop others from abusing them.

Another way of looking at guilt is the concept of "outward" guilt and "inward" guilt, and I suspect that it is a continuum where in real life there is usually a mixture of the two in any situation (Slide 46). Paul Tournier examines the guilt often felt by doctors when a patient dies. In the self-examination the feeling often arises "I should have done more – I should have referred or taken some action". Tournier after describing how Jesus dealt with the women caught in adultery points out that all men are equally burdened with guilt. Those who call themselves righteous are not free from guilt, but have repressed it. Those called sinners are aware of the nature of their guilt and so are open to receive pardon through grace.

However we analyse or divide up guilt I feel that all these types of **guilt need similar treatments**.

1 The first element of help is to offer **personal empathy** (Slide 47). Within a healing relationship with openness, truth, love and acceptance there is empathy and understanding as the foundation of the therapeutic relationship. Slide 48 concerns a study of 800 patients where a quarter of them admitted that they had not shared their greatest concern with the doctor. Patient satisfaction is affected by non-verbal communication (slide 49). If we find common ground with the patient we will get a better result (slide 50).

Here is a story from Annie, one of our SCAs in Birmingham

I think of 'B', a woman from Zimbabwe who came to see me, referred by her doctor. She had been beaten up before fleeing her country. She had spent two nights on the toilet floor of New Street Station in Birmingham, with nowhere to go. Her daughter had been raped, her husband taken away and she feared for the lives of her other children. She had been an influential businesswoman but as she sat with me, overwhelmed with grief and loss, all she possessed were the clothes she was wearing. Initially few words were exchanged between us – but she found comfort in being prayed for as she wept. Through

the help of many different resources, she now is an influential member of an organisation helping other victims of torture and campaigns for justice.

2 **Affirmation** of the good elements of the person's experience, even if this is only an insight into the problem in the early stages. (Slide 51) Get them to understand that all of us are guilty and fall short, what Tournier describes as the journey from "the guilt of doing to the guilt of being"

3 **Education to develop insight**, to understand the aspects of the problem due to the sins of others, the problems due to one's own sins, and problems brought on by the person's own responses when they are sinned against, so that the process of confession and forgiveness may be "real". (Slide 52)

4 **Build up hope** in the patient that they will not receive judgement but mercy. (Slide 53) The person is able to make choices which can lead to freedom from guilt through God's **grac**e. Hopelessness is a vital factor in increasing poor health (slides 54 and 55)

5 Learning how to **express sorrow and enter into repentance**. At this point I want to refer to some real patients seeing a Spiritual Care Advisor in Birmingham. (Slide 56) Annie writes:

It seems to me that I often stand in "Easter Saturday", a place that appears hopeless, without future, only blackness, fear and uncertainty. I believe in the resurrection and new life but it is important not to rush people before time into that place of acceptance and renewed hope. The stories of people that I hear are often of terror, abandonment and unutterable despair. A faith that cannot cry out to God in anger and confusion can only stifle growth and does not allow for healing. (Slide 57)

A nun I visit, once remarked to me that, "God can take the 'shit' of our lives and turn it into manure!" I quoted this to a lady I had seen on a number of occasions. She had suffered bitter betrayal and felt unable to move on. She thought for a moment and then said, "You mean the roses can grow again." It became her experience that out of the dark soil of despair grew beautiful shoots of forgiveness, acceptance and joy. (Slide 58)

6 Learning how to **give and receive forgiveness**. (Slide 59) Both need grace, and repentance is the door to grace. Forgiveness has health benefits. There is a cycle of forgiveness, it is not just a quick fix. We also may need to practice "naked forgiveness" where the other person is dead or unavailable (here we may encourage the patient to write letters to the person who sinned against them or whom they hurt). If penance from the abuser is not forthcoming you have to practice this "naked" forgiveness, for your own peace of mind and well-being. Of course there will not be reconciliation in this situation.

(Slide 60) This is just one study – there is an increasing literature around the health benefits of forgiveness, especially in the area of relationships and good social support.

7 Education about the dynamics and process of reconciliation. (Slide 61)These stories also illustrate the process of reconciliation. How does Paul Tournier (and me) look at the process of reconciliation?

RECONCILIATION

Two people can be pushed apart by injury. Reconciliation works to bring them together. Reconciliation may be considered to have two parts – forgiveness and penance. (Slide 62)

If reconciliation is not practised it produces grudges which lead to separation, loneliness and anger (slide 63). The person can develop a victim mentality as they seek to justify themselves. If they respond actively it may lead to anger – either external of internalised. If they react passively it may lead to melancholy, depression and addictions.

Penance involves confession, penalty and repentance. (Slide 64) There is a cycle or repentance, we often need t o re-visit our guilt and take it to a deeper level of understanding. It is not a quick and easy saying "sorry", but rather an exploration of the hurt and its consequences to allow a complete healing through God's grace. Penance and forgiveness are therefore inter-woven, "you can't one without the other".

In starting the process of reconciliation the golden rules are – a) Use "I" messages, b)take the first step yourself, and c) practice humility (Slide 65). Too often we wait for the other person who has hurt us to apologise first. 43 years of married life teaches you to be the first to break the ice, offer an apology, and start the dialogue to discover what exactly happened, and thus explore the hurts of both parties.

Through our marriage Jenny and I would have frequent arguments, but in the early years neither would take that first step. Often we "suffered" in silence for several days. As we matured we understood the importance of "I" messages, apologising for the hurts I must have caused you, and asking for forgiveness, even when at the stage of not understanding what exactly you were asking forgiveness for. Reconciliation then requires an on-going dialogue to work through the hurts and mis-understandings.

There is a danger to entering into forgiveness too lightly as this cab lead to incomplete forgiveness.

You cannot forgive someone until you have fully felt the pain they caused you. (Slide 66) This can leave inner anger and resentment if forgiveness is "too quick". It is of importance of allowing each person to "fully tell the story" of the pain. There is a need to change the painful story into one of acceptance. This activity includes and covers the concept of penalty, without which forgiveness may not be complete. You cannot forgive and forget without going through the whole process, and it is not about forgetting, but rather understanding and accepting.

At the heart of forgiveness is sorrow – for the fact that evil exists both in other people, and also in me. Many people who have been abused become abusers themselves. If the victim cannot embrace the whole process of forgiveness they cannot heal the inner wound, which can fester and come out in a variety of ways, including by the abuse of others.

Paul Tournier's solution for all this – the oil that makes it work - is of course God's Grace – linked with His Mercy and Forgiveness (Slide 67).

True forgiveness has two directions – towards the abuser and also towards yourself. It can be a completely internal process if the other person is dead or refuses to cooperate.

MAKING A WHOLE PERSON DIAGNOSIS and TREATMENT

To summarise and bring the practical aspects to the fore. (Slide 68) How does the GP – recognise, assess, diagnose, involve the patient and institute therapy in these situations? (Slide 69)

1. Being **open to recognise** when a deeper problem is involved – only by active listening can you discern that deeper problems exist which the patient will not share at early encounters until trust is built.
2. Able to conduct **an assessment of physical, psychological, social and spirit**ual elements of the patient's health problems. This of course takes time, and is best done using other professionals in an integrated team.
3. Able to make **a diagnosis in whole person terms**, adding psychological and spiritual understandings to the patho-physiological diagnoses.
4. How **to agree with the patient** what is wrong and what to do – joint understanding and decision making. It is the patient's understanding which is the important aspect as they have to do all of the surgery and hard work.
5. How to use an **integrated team** to treat the whole person.
6. Finally keeping an overview of the whole process and making a **dynamic assessment**.
7. How to measure a **successful outcome**

SPIRITUAL CARE ADVISOR of Fascilitator

Finally a few words about the Spiritual Care Advisor. (Slide 70) For many years now we have been experimenting with using chaplains in General Practice settings. This has been very successful and is now spreading. In order to get away from the religious associations of the word chaplain, we are calling them SCAs and training them to be spiritual advisors at a general level, able to refer on to a secondary level specific chaplain as the patient needs and desires. They are this able to enter the patient's spiritual domain whatever belief system the patient has. They talk of God, but don't specify their understanding of God unless asked to by the patient. We believe they should become full members of an integrated primary health care team, able to assess and treat all patients in the whole person approach to health problems.

Final slide 71 – contact details

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