

# **Packaged Mindfulness?**

## **Some unpackaged pieces of mind**

**David Zigmond**

**© 2014**

Our increasing push-buttoned and systems-managed world has produced myriad losses of human relationship and personal sentience. Can this then be countered by modern packaging of ancient wisdom and practices? Is this our wisest approach?



*The worse the economy, the better the economists*

– Alfred Zauberman, Economist 1903-84

*Our truest wisdom must be sought and grown, slowly and with difficulty, by each individual afresh. Humanity's tragedy is that our follies are so directly and easily transmitted, and on a massive scale*

Now that we have severely imperilled the heart, soul and intellect of healthcare we scramble to stem the destruction. Management reorganisations and revisionings have been rapidly conjured. Alongside these some resuscitatory words and phrases have been rapidly mobilised and conscripted, like a national recruitment for armed forces at a time of imminent collapse or invasion. Here are a few that peppered a morning's volley of communiqués I received from assorted managers and commissioners: *compassion, Integrated Care, holism, multidisciplinary perspectives, continuity of care, mindfulness.*<sup>1</sup>

I balk at their attempts to galvanise me. For, at the beginning of my career, most of my professional mentors and milieux were good models for such humanistic principles of care. What now seems remarkable about that earlier time is that we then had little need of, and hardly used, such words: for when things are deeply, naturally and seamlessly embedded they require far less language to anchor or designate. Our current pressure to propagate such vocabulary is thus an alarmed signal: that we must rapidly drive in stakes, to arrest our slippage and disintegration.

Our repeated use of these words is like a mantra: we encourage faith that they will consolidate and rejuvenate our vanishing spirit of welfare. But can such mantra-words and their kindred, rallying slogans themselves, directly, fare better our ill-faring welfare? Should we not, first, understand how we have come to lose those human aspects and values we are now attempting to name and to capture? As with animals imperilled by a hostile environment, if we wish our captive species to survive and then thrive, we cannot merely keep them in a zoo: we have to thoroughly understand, and then safeguard, their natural history and eco-systems.

These tasks are not easy to understand and they are even harder to implement. Worse, specious remedies merely add to our problems. The following loose assortment of notions and vignettes indicate how institutionally packaged remedies – creating zoos – may merely add to our follies. Even our best principles still need much discrimination.

\*

*Mindfulness*<sup>1</sup> is a word currently in vogue in healthcare. But although the terminology and packaging may be new, its roots and equivalents are ancient and wide. Our current culture – increasingly predicated on industrialised manufacture and commercialised consumerism – is now sharply juxtaposed to these roots. Almost everything we use and do becomes coded, branded, packaged, automated and marketed. All of these reduce the individual's need for effort, patience, attention and sentience. It is to be expected, then, that our attempts to access wisdom should suffer the same fate. *Mindfulness*<sup>TM</sup> would consummate the coup.

Likewise, many people like the reassuring notions of specialists, experts and procedures in matters of human wisdom and complexity. We like to think that there is someone who *knows* and will prescribe how we may find connection, peace, meaning, forgiveness or fulfilment. Such guidance may sometimes have real substance. But can we mass-produce it? What kind of mind will endure in *NICE Endorsed Mindfulness*?

\*

I have another cautionary view: that any attempt to officially define, prescribe, package or proceduralise such wisdom and guidance tends rapidly to become *unmindful*.

\*

As neither the Market nor academic authorities have (yet) occupied legally fortified territory, there is still time and room for feral and non-specialist offerings. This may be opportune, for our most intelligent use of the term mindfulness is often best derived from unsystematised associations and examples.

Herewith.

\*

Mindfulness has both the rich meaning and elusiveness of kindred words like religion, philosophy, holism and transcendence. In all of these we may seek and cherish the kernel, but the attempt by others to define or organise this for us is likely to yield merely its empty shell. Religion, philosophy and personal psychology (and thus therapeutic influence) are best served by small-scale dialogues in vernacular settings. Such dialogues require a willing autonomy of the participants, a culture of mutuality, and a creative cooperation for learning by enquiry. These are complex and delicate dances. Our attempts to define, control or hegemonise such important fluid fragility may be understandable, but are liable to paradoxical consequences. These range from the clumsily banal to the horrifically sinister. Our current healthcare abounds in the former; for the latter we need only look at World history – its theocracies and dictatorships.

\*

So, some examples of mindfulness: the cave paintings of our ancient forebears, yoga, meditation, chess, Japanese Tea Ceremonies, the rapt musician, bird watcher, Tai Chi supplicant or fly fisher. It is the attuned mother of her infant, the freshly attentive gaze of lovers, the moment of compassionate understanding, the percipience of the environmentalist.

\*

Many years ago I asked an artist friend, Tiffany, what gratified her about painting. I expected her to say something about expression, or communication, or mastery of form or medium. What she said was something quite different. Her answer was both simpler and more profound, and much more interesting: I remember it freshly. She said: 'It helps me really see'.

I remember thinking how important this was to me as an example of sentient holism, of conscious connectedness and less conscious receptivity. The power of her insight into seeing rapidly replicated its effect in me. Mindfulness can ripple benignly between us.

\*

To pursue our optical analogy: being mindful is mastering the use of our zoom lens to both our internal and external realities. We see the small detail, now the bigger picture. We see the thing-alone, now with depth of field: its history, its interconnections. We see the moving image of the process, and the still image of the state. In mindfulness we learn both to freeze our frame and move our image. Propulsive and receptive; systole and diastole.

\*

But while mindfulness may be facilitated by techniques, procedures and rituals, it should never be in thrall to them. Its essences must remain those of ethos, aspiration and attitude. Its conundrum – of autonomy within structure – is shared by the kindred journeys of philosophy, meditation and religion.

And if we hurriedly attempt to assimilate these wisdoms into our institutional protocols: what then?

\*

I receive an email from Dr F<sup>2</sup> informing me about a short course in Mindfulness. He expresses a friendly interest in my participation. The email, though, is an untidy stream of consciousness with many casual and erroneous

elisions, collisions and confluences of phrases and words. This is compounded by a lack of guiding punctuation or paragraphs. As I read it I imagine being a strapped-in passenger in a speeding car. It is slewing on wet roads and driven by an impatient and inattentive driver who is heedless of my experience.

Both his email and my evoked image seem to me far from mindful. And this from a herald of our new Mindfulness. How does this happen? And where does it lead?

\*

Dr F is a senior practitioner and manager. He is an intelligent, courteous man whose warm style of engagement harbours both personal conscientiousness and conventional ambition. Bringing this mixture into a current edgily competitive NHS is bound to be a difficult mixture. Now mantled with managerial power and responsibility, he struggles with a dilemma: having to create discrete paths between his own values and the directives of greater institutional powers which he perceives as often betraying those values. He is also subject to the strains of multiple roles, meetings, goals, deadlines and an endless ocean of emails. Despite his considerable personal resources, these irresolvable conflicts and pressures cause him stress. He has himself been introduced to mindfulness and describes to me how he can cope better through the peace and equanimity it brings. He wants to share this sanctuary with others.

I am certainly interested in the values and ethos of mindfulness as I understand it, but express my reservations about structured and didactic approaches: I prefer informal dialogue and dialectic. While Dr F wants to disseminate structured courses and documents into the NHS, I instead wish to challenge and dismantle many of the cumulative *modae operandi* that have so enervated any spirit and mindfulness of healthcare.

Dr F's official office now empowers him to more direct leverage to our ever-reconfiguring NHS. I want to share and explore with him some seminal notions about how insidious yet radical changes in our healthcare practice

and economy have unmindfully impoverished our mindfulness. What, in outline, are these ideas?

\*

Our first surge of Industrial Revolution depended on the combustion engine and gathered force about one hundred and fifty years ago. Our second, and current, surge has come from digital electronics and computers. Through this time and these processes, we have become vastly better at systems design and management and then automation: 'efficiency'.

These components are often synonymous and convergent. They then become equated with an overriding explanation, excuse and prophecy: 'progress'. Together these constitute a phalanx, like an Advance Guard, making way for our cultural evolution with its bright triumphs and shadowed follies.

The triumphs are easy to see and understand: more, better, quicker, cleaner, clearer, safer ... what can the problem be? The follies are more difficult to discern and understand, though we are now awakening to how important they are. This is, and will become increasingly, a global problem. But let us return to the still enormous territory of healthcare.

\*

First, two cardinal words and their human implications.

First, *systems*. Systems in human affairs are executively designed maps and routes for others to follow. Systems are excellent for streaming, eliminating anomalies and working repetitively with boundaried commonalities. They are an essential basis for production and maintenance of all manufactured objects. In healthcare they serve us well in countering the acute biomechanical breakdown of physical illness.

But systems have limitations and contraindications. Systems subsume all aspects of the Universe to themselves. Systems cannot recognise (other)



meaning, ambiguity or multiple designations. Systems say: *This is this and That is that*. Any system can therefore only deal with small aspects of complex humanity and for short periods. To deal longer with complex, real people in complex, real situations we need to transcend systems to holism: *This is That, as well as this*.

In healthcare systems are executive tools: experts have decided what reality is and what should be done. The essential knowledge and procedures of systems thus operate in tamper-proof packages absolving the practitioner of significant personal agency, judgement, investment and responsibility. The practitioners' activities are confined to compliance and obedience. Any 'intelligence' is in the system: individual thought becomes displaced and discouraged. Mindfulness becomes an inimical, loose body. Eventually, it disappears.

\*

Let us now take the second word: *automation*.

As with systems, the positive benefits seem evident and straightforward: speed, mass-production, cutting costs, standardisation, elimination of obstructive anomaly and human error ... all good, surely? Only up to a point, and that point is important. It is about complex human connection and discrimination. Here are three interconnected and seemingly prosaic examples from primary care:

- Ivy is now age 86 years, widowed, alone and largely chairbound from multiple incurable infirmities. Her remaining family are cordial but live far away. She is lonely but circumspect, vulnerable yet stoic, conversational but a bit deaf.

Ivy calls her GP surgery. She is greeted by an automated system whose robotic voice aurally sprays Ivy with a confusing assortment of choice, information, caveats, musak and recommendations. She is required to navigate this automated system by pressing telephone buttons: her

impaired eyesight and finger joints make this difficult. Far worse is the human chasm. The automated system fuels Ivy's sense of isolation, vulnerability and peripherality. There is no mindfulness to greet her.

A few years ago, when Dr V was still working from his smaller practice, it was very different. Ivy, then, felt she 'knew' the 'girls on Reception': they would quickly recognise her voice, and warm the interchange with affectionate banter before guiding her request. She remembers their lightly-touched compassionate support in the bleak months after Samuel, her husband, died suddenly. No-one would officially aggrandise the receptionists' human connections as 'Psychotherapy', yet it was certainly psychotherapeutic. Ivy felt these others 'kept her in mind': she felt her plight was known, cared about and contained. This, to my mind, is personed mindfulness.

- When Dr V worked in his small practice he used to use the old type of sphygmomanometer to measure Ivy's blood pressure. He would carefully place and wrap the cuff around her upper arm before feeling for the best place for him to listen to the changing flows of Ivy's arterial blood. This listening required skilful discernment of different sounds, while simultaneously controlling the air pressure in the system with a small rubber hand-pump. Dr V's attentive gaze had to accurately correlate the depressuring and falling column of mercury with the changing sounds from his stethoscope. His mind had to combine all these activities and perceptions into a single judgement: the blood pressure.

Ivy used to enjoy watching Dr V's care and watchfulness while doing this: she imagined that these both represented and emanated his care for her. The mindfulness here may be instrumental, but its effects are human too.

Dr V had once tried to share this thought with a young practice nurse at the end of a busy morning. 'Good blood pressure measurement is like Tai Chi', he had summarised.

She looked at him askance: an obscure eccentric. 'I really don't know what

you're talking about', she replied with sincerity and a sigh of wearily contained tolerance. 'I have lots more real things to do. I must get on.'

- Ivy's frailty eventually made it difficult for her to easily visit Dr V. Within a few years of this Dr V was moved from his small Family Doctor Surgery and into a much larger purpose-built Primary Care Medical Centre. Ivy is brought to see Dr V by her visiting middle-aged daughter, Margaret.

Ivy does not now know any of the reception staff who, in any case, do not need to be mindful of her: the greeting and shepherding is now guided by a touch-screen computer. Receptionists have become more receivers of data than people.

Margaret tenderly escorts Ivy into the brightly lit, clinically-surfaced consulting room, where Dr V is angled away from them, gazing at a computer screen. Ivy is at first reassured by Dr V's appearance – he has not aged much. This reassuring familiarity soon passes, for she finds that something else has disappeared: Dr V's kindred manner. His greeting is courteous and abrupt, his head quickly turning back to the screen. He clicks his tongue before a short, sharp intake of breath. He swings back to them both: a pressured man with an executive gaze: 'Look', he says, 'you haven't been here for ages and we're well behind with all your routine safety checks and measurements ... I'll have to run through them with you ...'.

Amidst a rapid *Blitzkrieg* of data procurement Dr V hurriedly tugs and tightens a Velcroed sphygmomanometer cuff onto Ivy's arm. While he is entering data onto the computer with his right hand, his left index finger pushes a button on the other machine. A soft electronic whirr signals increasing pressure; a brief hiss that the procedure is complete. Dr V looks at the read-out, but not at Ivy. He turns back to the computer to complete the entries. Dr V gets his patient-data, but his patient does not get her dose of doctor.<sup>3</sup>

Dr V's managed multitasking is a systole of activity. The diastole of (inter)personal mindfulness has almost vanished. That evening Dr V thinks of how he has lost his previous long-endured work gratification: he is losing his patience. Ivy, his long-endured patient, feels sad and unsafe: she has lost her Family Doctor.

Relationships are a kind of mindfulness, and vice versa.

\*

Such commissars of our 'progress' – systematisation and automation – can easily destroy as much as they bestow in human welfare. We therefore need much more reticent, intelligent discrimination – more mindfulness – in how we apply such things and 'roll out' our plans.

We need to think recurrently about how any attempt to standardise, proceduralise, mass produce, manage, measure or systemise humanly relevant activity may also – as collateral damage – destroy our mindfulness and relationships. More of something 'good' is sometimes worse.

Within our current NHS this applies to a wide variety of 'progressive' initiatives: Marketisation, Payment by Results, QOF, Care Pathways, manualised psychodiagnosis and psychometry, Commissioning ... the list can be long, but the essential message can be brief: systems in pastoral healthcare<sup>4</sup> may start with good intent, but become destructive when overextended.

It is this holism, this panmindfulness, I am interested in. I used to have colleagues who easily shared this view: such people are now mostly silent or gone.

\*

I am wanting to share these long, wide, multilayered views with Dr F. I want to rekindle a lost form of dialogue. I catch him at the end of a large and long institutional meeting. He creates a polite, if brief, hiatus of attention, but I

sense this is difficult for him. Already the strains of his official multi-taskings are showing: a gathering pallid weariness and a gaze turned both bleary and restless. He is rocking his weight between his legs and stroking a sheaf of conferenced papers, as if they might return the comfort. I briefly outline some concerns and my invitation.

His reply comes in accelerated bursts: 'Yes, that sounds really interesting ... I'm sure it's important ... But I can't see when we can meet: I've so much to do ... I just don't seem to have a spare moment ...'. His voice lowers, his gaze stills and looks vulnerable. He is checking me out: can he tell me? He does. 'The amount of work has been impossible ... Last week I forgot about a clinic and double booked myself. I've never done that before. I realise I've got to cut some stuff out ...'.

I nod understanding and his voice brightens and strengthens. 'Anyway, I'm going on a Mindfulness weekend, and I always feel better after it ... I do hope you can come on the short course we're organising ...'.

My nod is a friendly reception of signal, not a commitment.

He continues: 'As well as everything else, I've got a dissertation to complete for my Postgraduate Degree in Healthcare Management ... that will take me a few weeks. Maybe after that we can find a time ...'.

'What are you writing about?', I ask.

'Oh ... Predictable, I suppose: Mindfulness in Mental Healthcare ...' He looks at his watch. 'I must get on', he smiles and nods at me. His hiatus closes.

I leave with his distracted, nodded blessing.

\*

As I walk toward the Conference Hall's exit I sense my unease, signals of a familiar discrepancy. I like Dr F and his intent: he is a sensitive, thoughtful

man who has a benign interest in people and their welfare. But I do not care for his wish for systematisation and managed commodification in our very complex area of interest.

I think Dr F regards Mindfulness as a *Sanctuary*: a special place of restoration and detoxification in a world where we all may be driven to varieties of ADHD.

I am more interested in doing something about the world we are creating that renders our connections and attention so fragmented and distracted. Mindfulness, for me, is an attitude, a value system, an ethos, an endless gardening project, a love relationship. I want to be mindful in everything I think, everything I feel, everything I do. I want managing authorities to provide space, habitat and encouragement for these, but never instruction. I want a *suffusion*, not a sanctuary.

Any path to grace and enlightenment may be worthy but always uncompleteable. We must generate such things ourselves, and although the contributions of others are sometimes essential, they are best sought by the self rather than delivered by others.

Can we achieve such things by officially designed and packaged programmes? I doubt it: rather, we need to carefully watch, listen to and then incorporate the Tiffanys of this world.

She is alive in all of us.

\*

*'Facts as facts do not always create a spirit of reality, because reality is a spirit'*

GK Chesterton (1930) *Come to Think of It*

---

## Notes

1. I differentiate two meanings for this word: **mindfulness** refers to a generic capacity and discipline for sentience, and all the anciently derived routes to enhance this; **Mindfulness** is the currently popular ways of branding, manufacturing, packaging and distributing these. It is the latter I am questioning. Where *mindfulness* occurs at the beginning of a sentence this poses an ambiguous and inadvertent test for the reader.
2. All the events and dialogue recorded in this article did happen and are as accurate as this human can make them. The one deliberate departure is Dr F: Dr F is a fictitious composite of three 'real' similar senior colleagues and my exchanges with them. Personal anonymity is thus protected. Likewise my attention to a person-centred focus, but not identifiable individuals.
3. '**Dose of doctor**' was phrase first used by Dr Michael Balint in the 1950s. Balint was a free-thinking psychoanalyst who for many years worked with doctors to investigate the personal and uncharted aspects of their contact with patients – those that lay outside the usual procedures and biomechanical formulations. Balint's explorations added enormous extra scope to our understanding of people, and thus our therapeutic opportunities with them.

Balint's approach led to a gratified mindfulness among many interested GPs for about twenty years. The approach is much more invested in unpacking human complexity than packing it. The modern *forces majeure* – computerised informatics and systems management – are activities devoted to packaging. All else is liable to peripherality and neglect. As a result Balint's once-burgeoning legacy in the UK is now reduced to a few heroic enclaves.

4. **Pastoral Healthcare** includes all healthcare that is not likely to be swiftly and successfully resolved by well circumscribed biomechanical procedures. This, therefore, includes almost everything outside of acute medicine and

surgery: that is most problems in mental health, General Practice, degenerative disease management, rehabilitation or Palliative Care – all these require human engagements that cannot be adequately addressed by formulaic prepackaging. Attempts to short-circuit this has led to serious consequences. (Zigmond, D (2013) 'Institutional atrocities: The malign vacuum from industrialised healthcare', *Journal of Holistic Healthcare*, volume 10, issue 1, spring)

---

**Interested? Many articles exploring similar themes are available via <http://davidzigmond.org.uk>**

David Zigmond would be pleased to receive your [\*\*FEEDBACK\*\*](#)