Vocation Under Duress

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'If you want to change the world, start with yourself' Mahatma Ghandi

Introduction

To be a good clinician entails coping with diagnostic uncertainty, complex risk management and inadequate resources. It equally calls for the capacity to remain open-hearted and empathic. We now live in a world in which the politics of healthcare are viewed with apprehension and distrust. I'll be exploring how institutional pathology can be resisted if we respond not with fear but love.

First I'll review some of the changes I have seen during my professional lifetime. Second, I'll discuss current concerns in healthcare with reference to Abraham Maslow's hierarchy of needs. Lastly, I'll suggest how we might begin to address some of the deficits and their impact on healthcare staff, concluding with a spiritual perspective that may help to ease the burden of care.

Early days

The NHS was created in 1948 by Aneurin Bevan, then Minister of Health, from the ideal that good healthcare should be freely available to all. In the post-war years of my childhood, the NHS acted as a unifying social force, one in which everyone could take pride.

When I became a doctor in 1969, medical technology was generally affordable, patients did not question their treatments, they took on trust what was offered, and when things went wrong, did not generally blame it on doctors or nurses. Mistakes were doubtless made and were probably more easily concealed. But I am describing a time when doctors had the absolute confidence of their patients.

Hospital wards were run by senior sisters with long years of experience. The relationship between Sister and the consultant was crucial. They were, archetypally, mother and father presiding over the drama of life and death, sometimes curing, more often alleviating and other times helping people die as good a death as could be managed. I'll illustrate briefly something of the trusting nature of those times. A man in his forties was admitted with a mid-brain stroke, motionless and seemingly unconscious. While I was examining him, I noticed that his eyes, which were open, had a look of alertness about them. I asked him to blink if he could hear me. He not only heard me but could understand as well. He was otherwise entirely paralysed, known today as locked-in syndrome.

On the ward round I told my consultant what I had found. He took the man's hand, gave a nod to Sister and said kindly, 'I'll come and have a chat with you later'. The next morning I was in early and found the bed empty. I asked Sister about it. She deliberated, then looked me in the eye and quietly said 'he passed away in the night'. Instinctively I understood what had taken place.

I'm not debating the rights and wrongs of assisted suicide, simply recalling the basic goodness of people doing their best to help. We were not living under the threat of litigation. There were some bad people around before Harold Shipman, but they did not set the culture.

Behind the consultant and ward sister stood the hospital itself, ‘the stone mother’ as the psychoanalyst Henri Rey, who later supervised me at the Maudsley, called it. Patients with intractable conditions, whether physical or emotional, could rely on this mother, for while registrars might come and go, she could be counted on to stay and be entirely dependable.

These days she is not so dependable, as the Health Commission inquiry into mortality rates at Stafford Hospital reveals. Hospital-acquired infections are running at 10%, many of them antibiotic resistant, and along with iatrogenic effects of medication, dispensing mistakes and surgical errors of judgement, we have become aware how dangerous hospitals can be.

Changing times

After sitting the M.R.C.P., I left general medicine for psychiatry, applying to the Maudsley and Bethlem Royal Hospitals. There I observed that many patients were admitted because they needed sanctuary from whatever it was that was making them ill. As in general hospitals at the time, such decisions were made by consultants without administrators, as they were then called, questioning the need. (Now you have to be very ill, if not psychotic, to be admitted to an in-patient unit, where the atmosphere is too disturbed to be conducive of much respite).

These were also the dying days of the large mental hospitals. I remember visiting some of them. Care in the community was the new mantra and, of course, had much to commend it if it could be properly resourced and managed. Unfortunately, there was a cost – the dereliction of long-stay patients for whom the institution had become home. Those asylums were strange and surreal places yet there was a kindness among the staff, who understood that many of these patients were helped most by simply accepting them the way they were.

A few years later, I was briefly senior registrar to Dr Douglas Bennett at St. Francis Hospital in Dulwich, where something of the old style ambience remained. The main ward area was locked, yet no one seemed particularly at risk and the nurses customarily let patients in and out. I decided to hold a large group to discuss the issue. The patients and nurses all came, and Douglas Bennett too. To my surprise, the patients voted to keep the door locked. We generally put a lock on our front doors and these patients felt the same way.

At the Maudsley there were no white coats and the nurses wore mufti, a trend that was becoming the norm for mental health services. Years later, as a visiting consultant I found it was sometimes difficult to tell who was staff, since clothing such as jeans was commonplace. On ringing the ward, the phone might be answered with a breezy ‘hallo’, and only the first name proffered, without it ever being clear who was actually in charge.

It also struck me that doctors no longer held the same authority. Multidisciplinary teams were being established with lead nurses and consultant clinical psychologists taking referrals, and some psychiatrists privately voiced concerns with having to take responsibility for patients they heard about yet never got to see.

I was interested in this ceding of authority not because I hold that it is sacrosanct but because I wondered what kind of Health Service we were heading for. A shift had started during the late 80’s, while I was still at St Georges Hospital in London. There had been a golden decade under the leadership of Professor Arthur Crisp, during which we had been able to strengthen clinical services with new consultant posts and develop higher specialist trainings. Then a new tier of administrators began to impose serious constraints on funding. Lengthy documents, punctuated with business-speak about the need for income generation and efficiency measures began to appear on our desks. This was before email, so we waded through them and tried to absorb what it meant for our service.

Demoralization sets in

This was a point at which we consultants could probably have continued to run the show, had we the stomach for dealing with cuts to services. But we never envisaged having to wrangle with each other over resources and we didn't like it. The government of the day, exasperated with what it saw as resistance to change and driven by political imperatives, began to set up Trusts. Almost overnight, doctors became hired hands.

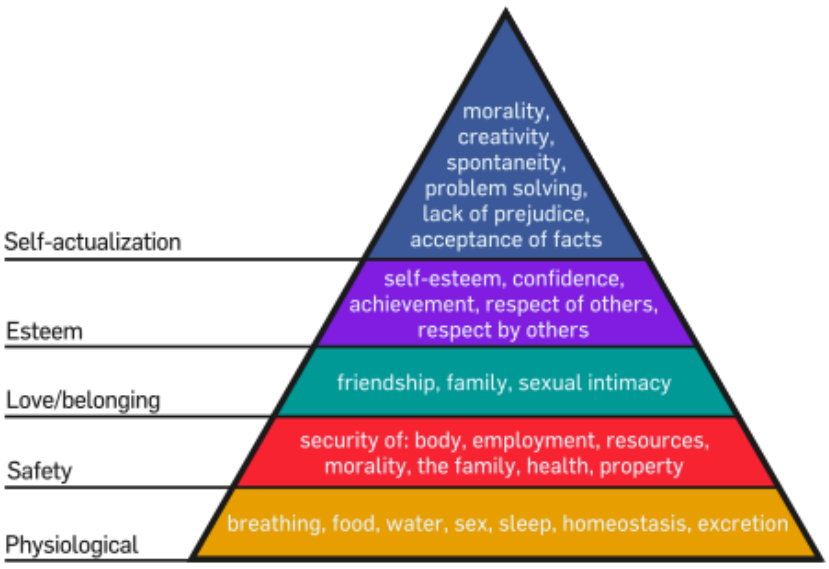
I'll mention one trivial incident symbolic of the changing times. I had by now moved to the Warneford Hospital in Oxford and happened to be visiting a patient at the John Radcliffe, the regional general hospital. To my surprise and irritation, I found that my car parking permit no longer worked at the JR. Overnight it had become a Trust, as we at the Warneford were also soon to become.

Before these changes, being a doctor in the NHS had felt like belonging to one big family that pulled together through thick and thin. Now we were following the American model of turning medicine into a business for which Trusts would soon be competing. Managers abounded whose horizons were financial and for whom patients were numbers on a page. Some doctors became medical directors, hoping to bridge the divide and do some good but often found themselves viewed with suspicion by clinical colleagues. An era of grievance had begun.

Advances in neuroscience in psychiatry over the last twenty years, together with new pharmacological and psychological approaches have resulted in improved treatment outcomes, so why should morale remain poor, why do staff feel burdened and how come charities like SANE and the Mental Health Foundation are deluged with complaints from service users?

The Hierarchy of Needs

I'm next going to draw on the work of the psychologist Abraham Maslow in looking at what may have gone wrong. The term 'hierarchy of needs' was introduced by Maslow in his 1943 paper 'A theory of Human Motivation' and can be represented thus:



The hierarchy is usually shown as a pyramid, though Maslow himself never described it as such. Physiological survival comes first, then the need for safety, both physical and emotional, before we are in a position to love and value ourselves and others. Then it becomes possible to engage with real intimacy in relationships and, beyond that, to contribute to what is best in humankind.[1]

The first level, of physiological or bodily needs

I remember as a house officer working 120 hours a week on a one-in-two rota. We lived on enthusiasm. Since that time, sleep deprivation studies have shown that judgement becomes seriously impaired, with alarming loss of insight. These days many hospital doctors still work week-long shifts of 90 hours, despite the limit set down by the European Working Time Directive.

The military know from survival exercises that a group of people left to forage for themselves for just three days will start off companionably enough but before long the only conversation left is devoted to finding food and keeping warm - survival mentality has set in.

I'm reminded of the working lunches to which we consultants became inured - a cold, damp sandwich with a cup of lukewarm coffee - while we ploughed our way through new business plans, always with the shadow of cuts, now called efficiency savings, hanging over us. The name of the game was no longer planning new services but trying to hang on to what we already had. The enlivening chance to share work concerns in a friendly collegiate exchange was slipping away.

These privations were nothing compared to failures of patient care that have more recently come to light. The frail elderly are especially at risk, for whom the CQC (Care Quality Commission) has found that 18% of hospitals do not provide adequate facilities.

We now have the Francis Report on the Mid Staffordshire NHS Foundation Trust. To quote: '…patients were left lying in soiled sheeting and sitting on commodes for hours…left unwashed, at times for up to a month…forced to rely on family members for help with feeding…pain relief was provided late or in some cases not at all…families were forced to remove used bandages and dressings from public areas and clean the toilets themselves'.

Mental healthcare patients are not generally as helpless as the physically infirm. Yet the most vulnerable are always at risk, as was found in the case of the Winterbourne View Care Home exposed by Panorama in 2012, where there was shocking systematic abuse of young adults with learning disabilities and challenging behaviour.

Culpable individuals need holding to account. Yet, as in the days of the Third Reich, people who might otherwise be regarded as decent enough can get drawn in by sanctioned sadism. Instead of low paid, poorly trained care workers feeling like the underdogs, they could now wield power in a culture of brutal indifference. Truth might be the first casualty of war but altruism is the first casualty of privation.

When looking at what is happening to patients and staff, a systemic view has to take them together, for the roles are complementary; staff need patients as patients need staff, for neither exists without the other. Consequently, the symptoms of pathology are system wide.

[1] Personal needs are indicative of ego-function. Spiritual exemplars throughout history have, exceptionally, shown indifference to the needs of the ego in relinquishing the personal for the transpersonal.

The second level of need – safety

This concerns safety and security, not just for self but for the physical and emotional well-being of the wider human family. The physiology of a person under threat is in a state of high arousal, primed for flight or fight, and designed to last no more than about twenty minutes before returning to the resting state. Chronic high levels of arousal, when the only option is to soldier on, are highly injurious to body and mind. Enforced stoicism, especially when carrying responsibility for others but without the means to take effective action, leads to anxiety, depression and burnout.

In 2001, 20% of doctors were planning early retirement. By 2008 this had risen to over one third and today the numbers are higher still. Those who stay and fight for better conditions take a big risk, for whistle-blowers have been summarily suspended or pensioned off with gagging clauses. Over the last three years, 15 million pounds has been spent by Trusts dealing in this way with over 600 complainants. Earlier I illustrated the beneficial influence of the benign parental transference held by doctor and nurse working together with trust and respect. Here we have institutions behaving like tyrannical parents.

Now that this has come out into the open, the danger is that Trusts will be vilified without understanding how such a thing could happen. We have here the same dynamics applying to management. Directives issued by Government pressurise managers to put targets before people but which cannot realistically be met. Consequently managers live in fear of failure, fear of loss of funding, fear of being blamed for everything that goes wrong and fear of losing their livelihoods.

For a business to succeed it must show growth. We might seriously question the sanity of perpetual growth in a closed system like Planet Earth, but this ideology remains the lynchpin of economics to this day. Yet every advance in healthcare costs more, not just in technology but due to the increasing care needs that go with greater longevity. Since resources can never catch up with demand, managers continue to crack the whip as they try to square the circle.

This leads to scapegoating. First the irksome problem is split off from the ambit of the self, or the collective self as in the case of the institution. The problem then gets projected elsewhere, best done by finding someone or something to blame. Finally, the denial of responsibility allows for the preservation of self-esteem, however shaky it may be.

Handing on blame is like passing around a bomb with a slow fuse. Doctors blame managers; managers blame Government (and doctors); Government blames the legacy of debt left by the Opposition; the Opposition does its utmost to persecute the Government which then comes up with some new system like GP-led commissioning groups. But it then turns out that one third of GPs are found to have conflicting financial interests when undertaking commissioning, so the General Medical Council needs new powers to monitor this and in doing so becomes another persecutor to add to the farrago.

The third level of need, of love and belonging

These are the primary social needs of friendship, family and sexual intimacy. For love to be managed appropriately and responsibly the first two levels need to be firmly established. Safe boundaries need to be in place for individual and group; otherwise as we know from the Jimmy Savile enquiry, perverse and predatory behaviour can thrive in institutional settings that offer both opportunity and concealment.

Here I want to focus on the archetype of the family and the bonds of kinship, not least those we form with our institutions, for they evoke strong emotions that start early in life. To begin with there is a group of just two, mother and infant. Even then, the wider group is present, for also acting on the mother are the key relationships she internalised from her own childhood, which she unconsciously presents to her baby. Then there is the influence of the baby's father, other family and friends, and often day care too, all of which shape a child's encounter with the first big institution - school. Some children shrink back, some throw themselves into the fray, while other stand on the side-lines and become observers of human nature.

No institution is experienced without emotion for in the transference it takes on a personal colouring, whether accepting or rejecting, tolerant or demanding, caring or indifferent. That's the one half; the other concerns how the institution actually behaves.

The generation of doctors to which I belong may have been politically naïve, but we shared an ideal for an NHS that we held in real affection, one that cared for us while we did our best to care for our patients. The kinship was nationwide, and extended throughout – doctors, nurses, emergency services, and ancillary workers, not least hospital porters.

While I was at Cambridge, one long vacation I worked as a porter at the Addenbrookes Hospital. It was an upstairs downstairs world and we were downstairs, ensconced in the bowels of the hospital. Apart from moving patients around and delivering mail, porters had to incinerate the hospital waste. We knew that without us the hospital could not last a day, yet how many doctors were ever likely think about that? Up in the corridors of power, if a doctor or nurse gave a nod of recognition to an approaching porter, we felt seen and valued. Feeling part of the family depended on such small and very human moments. Happily, most of the staff was friendly, and so were we.

Even without the rose-tint of nostalgia, this third level of Maslow's has a lot to say about the medical world of the '70s and '80s. Technology had not distanced people from each other as now. We didn't write emails, we talked to each other more, and consequently we understood each other and liked each other better. Years later, when decision making became the province of Trust management, aims and objectives issued from on high, no matter how laudable, never felt owned by the people expected to carry them out.

The fourth level, of esteem and respect

This represents a shift from personal to interpersonal - the best expression of selfhood when neurotic anxieties have been surmounted. Holding self and others in esteem is a pre-condition to the healthy functioning of any institution. Problems that arise are not driven by personal agendas. Since transferences no longer get in the way, there is less projection. People are better able to see things as they really are, feel more confident of their own sovereignty and - perhaps because they don't feel under threat – are genuinely more open to others. When people enjoy being together, feel connected and are helped to do what they are good at, more work gets done.

I used to run staff groups in various mental healthcare settings. Group morale was always a key concern. Sometimes we could usefully explore staff problems that were getting in the way of patient care. On the other hand, if a problem had its source elsewhere in the institution, trying to contain it in the group would risk colluding with the institution. Confronting such problems head on is not to be confused with acting out - more likely to happen when a group serves its leader rather than the leader serving the group.

Steve Denning, a pioneer in the field of 'radical management' emphasises the primacy of the need for the connectedness. He re-draws Maslow's schema thus:

Denning argues for a move away from top-down bureaucracy towards self-organizing teams that foster values and innovative solutions. This is the ethos of Silicon Valley and it isn't immediately obvious how the NHS could abandon its reliance on 'command and control' style of management. However, Denning is reminding us, as group analysis has been doing for more than fifty years, that humans are fundamentally social beings and we neglect this at our cost. The need to belong is hard-wired in us, whether put in terms of connection theory, complexity theory, attachment theory or object-relations.

The closest I came to experiencing working with Maslow's fourth level goes back to the '80's at St Georges'. But I will admit that our youthful enthusiasm would have died a slow death had we not had funds to implement our good intentions.

The fifth level, of self-actualisation

Maslow described two kinds of needs with very different functions. First there are the needs outlined so far, concerned with safety, nourishment, love, belonging, respect and self-esteem. Maslow called them 'deficiency or D needs'.

However, he wanted to give equal weight to psychological wellbeing. He felt that humanity aspired naturally towards 'being values' or 'B-values'. They include unity, transcendence, aliveness, uniqueness, justice, order and simplicity, goodness, beauty and truth. B-values are sustained by 'B-needs' that are expansive, for example, engaging in meaningful, helpful work and service, promoting justice and harmony and creative self-expression. The difference can be illustrated with one simple example: the need to be loved is a D-need and the need to love is a B-need.

Self-actualization includes: accurate perception of reality; comfortable acceptance of self and others; tolerance of human imperfection and the ability to laugh at oneself; living with vitality and spontaneity; being comfortable in solitude; desiring to work for the benefit humankind; a capacity for autonomy; appreciation of the gift of life; living fully in the moment and enjoying deep personal relationships, as well as fellowship with humanity. Lastly, Maslow describes 'peak experiences', moments when self-actualisation is crystallised in a feeling of oneness with all that is, accompanied by intense happiness that confirms the value, purpose and meaning of life.

Maslow distinguished two psychological profiles among self-actualisers; 'transcenders' who are drawn to peak experiences and 'non-transcenders' who Maslow called 'healthy self-actualisers' to underline their resilience and groundedness. These are not stereotypes; a businessman may be a transcender sometimes more so than the priest. Maslow believed that every human being has the potential for self-actualisation in one or other form, and that human society needs them both.

Caring for the carers

Let's consider how we might work with Maslow's ideas. Firstly, there are practical things that can be addressed. Beginning with the first level of need, there must be provision for proper rest and sleep. Food should be nourishing, with adequate time for eating in comfort away from the clinical environment and without being interrupted. This makes a big difference to working long hours. Bleeps could be filtered so that only genuine emergencies intrude at these times.

Doctors are afraid to complain about working hours and conditions in case it goes against their career prospects. The European Working Time Directive of 48 hours per week needs to be implemented as it was intended, not averaged out over six monthly periods. There are major resource implications - the Care Quality Commission recently stated that 10% of hospitals are not adequately staffed - but these problems have to be faced.

Trusts need to address the lack of confidence that doctors have in them. It used to be understood that doctors' first concern and loyalty was to their patients and that the hospital was there to provide the facilities. If the Trust already has its back to the wall, doctors feel unsupported when clinical mistakes are made and it is all the harder both to admit to errors of judgment or to whistle-blow. David Nicholson, CEO of the NHS has recently announced that 400 gagging clauses are to be lifted retrospectively with no further gagging allowed. There is also to be 'duty of candour', a contractual obligation for NHS providers to be transparent over failures of medical and nursing management and intended to restore the lack of trust between patients, their families and care providers when things go wrong.

Maslow's level of safety needs to be established before a workplace can feel friendly and welcoming. In order to have a sense of belonging and acceptance, peer group support is important. How would it be if consultants - others too - met weekly for lunch, not the notorious 'working lunch' but to share an hour together eating and conversing in peace and quiet? This used to happen before job plans had to account for each minute of the working day. Time and motion mentality may help set targets but is not conducive to goodwill and friendship, and the benefits that derive.

Moving to the level of esteem and respect, there is a problem here for psychiatry, for we do not have an abundance of grateful patients and therapeutic triumphs. Many mental health problems are enduring and so much depression, together with constant concern about patients' self-harm, make for a high burden of stress on carers – something that used to be recognised in the early retirement option for mental health officers. Working in front-line psychiatry carries the insidious danger of draining joy out of life and leaving the tank empty.

The majority of mental health professionals I have known chose the speciality from a sense of vocation and at its best there is no finer act of service. However, if one is to be open to mental suffering and able to respond with empathy, on-going support is needed. Trusts and clinical tutors could start by endorsing Balint-style peer groups for this purpose, a function not to be confused with psychotherapy supervision or clinical tutorials.

Behind these small suggestions is an implicit reminder. In the turmoil of daily life, we can easily feel ourselves victims of a persecutory regime that is forcing us into a mould with

threats and demands to do more and more. But it only happens if we lose sight of our self-sovereignty and forget that we don't actually have to do everything we are told but can decide a great many things for ourselves.

This brings me to self-actualisation. Maslow has set out the pre-conditions that he argues are required, and they are impressive. His schema takes us from one step to the next and it all makes good sense. Meeting the needs that Maslow outlines would surely improve well-being and make for better healthcare. But if we simply waited for a social revolution to bring about this Utopia, we would wait for a lifetime. Fortunately, there are already good people around who have found ways to bring their creativity and compassion to bear and so it behoves all of us to try in our own way. I'd like to conclude with what I have found helps free me from some of the encumbrances that frustrate good intentions.

Things have to be the way they are

I began by reminiscing about how things used to be. It's worth doing because history can spare us from having to re-invent the wheel. However, this does not mean blaming anyone or anything for how things are today. On the contrary, my starting point requires me to take an entirely uncritical view of the state of the nation, and healthcare in particular. How so?

It means to recognise that everything ***has*** to be exactly the way it is. If it could have been different, then it would have been, but it happened ***this*** way. There never ***was*** any other option, since this present moment is the consequence of all efforts and activities, good, bad and indifferent that preceded it.

This is not to adopt a passive attitude, for here and now decisions are made which will shape what happens next, and so one's best efforts are called for. But when the arrow of time has flown on for a minute, an hour or a day, then once again, the way things turn out will have been the only way that they could. Consequently, modal verbs such as 'ought' or 'should' make no sense when applied to the time-line of history, since the path taken could only be what it was (since it was). Expressions of regret like 'if only' are likewise pointless. A better use of the past is in helping to make wise choices for the future.

This approach has a compelling logic about it and checks me from hankering after what didn't happen. It also eliminates the need to find someone or something to blame (including myself), which is always a waste of time and energy.

The nature of duality

What we take for reality is comprised of countless dualities on which our capacity for discrimination is founded. In the language of Kelly's Personal Construct Theory, every perception employs a bi-polar construct, whether between things, for instance, big versus small, or states of mind such as sad versus happy. We might equally refer to Carl Jung's archetypes, each of which has a negative and positive aspect. It does, of course, also make the point that in this world there can be no good without evil.

In fact, the balance of polarities throughout the natural world has been fundamental to Taoism for over 2,500 years. It is depicted by Taiji, the well-known symbol for Yin and Yang.

Trying to resist Nature's eternal play of opposites only ends in tears. In the words of Byron Katie, 'you can fight reality all you like but reality always wins'. Instead, to recognise that duality is woven into every strand of life helps bring acceptance of how things are.

We describe dualities as opposites but this can lead to a misunderstanding. Though they may seem opposed, they truly are complementary, being bound to the rhythms of Nature and all of life. The tide that comes in must go out; night follows day; birth must end in death.

How could we not expect bacteria to become resistant to antibiotics? Eliminate smallpox and the next thing we have HIV. Mess up the planet and we humans, the offenders, will be shown the door, for in the big picture, there is always an over-arching duality that re-asserts the natural order of things.

Yet this is no recipe for fatalism. Since duality exempts no one, we are each compelled to play our part in the interweaving of events. If a person is predisposed to destruction, they will find a role that in their eyes at least, legitimises violence. However, since every action brings about a reaction, there will be consequences, either meted out by the judiciary or, if not that, a life lived in fear of retaliation, for 'what goes around comes around'.

If a person is moved by love and kindness, a role more likely to attract will be to help other people. There are consequences there too, and working in healthcare without adequate resources is sure to be one of them. But such persons would not dream of trading a world of love for fear. Neither should we be daunted when trying to improve the conditions of healthcare. Maslow's schema reminds us of what we may aspire to regardless of any measure of success or failure.

Here again is a simple message. Rather than wringing our hands over the chaos that is all around, the task is simply to get on with doing what one is good at without fear or favour. That isn't easy, for we are all susceptible to fears of losing our reputation, credibility, friendships, job, health and more. These are, of course, the same fears that afflict many of our patients and remind us of our common humanity. Yet these fears must be overcome if we are to approach suffering with loving-kindness, without which nothing else will do.

I have used the phrase 'loving-kindness' here rather than compassion because we should not be afraid to speak about love. However, the word needs using with the right understanding. Unlike ego-driven love, there is nothing possessive about loving-kindness. The desire is simply for that which is in the best interests of our patients.

Being mindful of duality enables us to see the endless to-and-fro of life as scenes from a play. It is a drama of cosmic proportions and we are all playwrights, directors, actors and audience. So long as we don't confuse our roles with the essence of who we are, we can maintain equanimity when success is followed by reversal, or when a good plan dies in committee! In the drama everything comes and goes, including ourselves, so while we are here, in role as doctors, we simply do what we can for our patients with love and goodwill.

Beyond duality

The search for the non-dual arises when we want to know who it is that stands outside the drama, witnessing this play of dualities and watching oneself take part in birth, death and the life between.

In the teachings of Advaita Vedanta, the primordial source of 'all that is' lies beyond space or time, beyond subject and object and certainly beyond thought or word. Possibly the closest description is that of pure, undifferentiated awareness.

Lao Tsu wrote in the Tao Te Ching:

> *'The Tao that can be told is not the eternal Tao. The name that can be named is not the eternal name'.*

The non-dual mysteriously gives birth to space and time and myriad forms arise. As one such form, I can say of myself that 'I am' while about other things I can say 'I am not'. This duality doesn't stop with me; it applies to everything in the perceptual world. And so primordial awareness becomes conscious of itself.

Words can only point to what direct experience of the non-dual is like. It has been said that there is nothing to be done or to be sought, for everything is complete, undivided and whole, a state of 'is-ness' devoid of thoughts or feelings. There is only awareness, experienced with absolute equanimity. When I had such an experience, the emotions did not flow until it was over, at which point I was flooded with gratitude for life, and love for all therein.

From the non-dual perspective, it is possible to say in all sincerity that everything is perfect, and even the imperfect is perfect. But a word of warning; this may deeply offend those who are suffering hardship and loss, as indeed can the statement 'there is no such thing as a bad experience for the soul'. It is important to recognise that these are metaphysical statements and to understand the 'level' that is intended.

Religions speak of God. When envisioned, God takes on a form and is therefore perceived in duality (hence good and evil). However, in Advaita, since subject and object, self and other are simply the phenomena of duality, all lives are to be understood as manifestations of the one cosmic life and in this sense ***we are it***, illustrated by the aphorism 'There is only life, there is nobody who lives a life' (Nisargadatta 1973).

Some people open themselves to the non-dual through prayer, meditation, yoga, shamanic practices or taking entheogens. Sometimes the experience seems to seek out a person in lucid dreams, out-of-body experiences, a Near Death Experience, or a crisis of the emotions. But a peak experience may equally come unbidden, out of the blue, when suddenly everything is revealed wordlessly, unforgettably, in its totality and its unity. With it may come such a revelation of love as to inspire all future endeavours.

As psychiatrists we are circumspect about epiphanies in case they herald an incipient psychosis But there is a danger in being over-cautious and failing to recognise the benefits of such creative energies in everyday life. Further, while Maslow's hierarchy may be a counsel of perfection and a useful learning tool, the map is not the territory, and there are self-actualisers whose lives have been, and continue to be marked by suffering. Perhaps it's in the mix of nature and nurture. Some of us climb the pyramid while others find themselves catapulted to the top. Whichever route is taken, the result is the same: a heart that knows loving-kindness and kinship with humanity.

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