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A Bridge between Mind and Gut: An Interview with Professor Peter Whorwell

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Interview

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Professor Peter Whorwell studied medicine at Guy's Hospital in London. He has the experience of working as a hospital doctor in London, Cambridge, and Southampton, and he also worked for a year in the USA. Since 1981, he has been Consultant Physician and Gastroenterologist at the University Hospital of South Manchester and his main area of interest is functional gastrointestinal (GI) disorders, and he is the director of South Manchester Functional Bowel Service. He is also medical advisor to international foundation for functional GI disorders and member of the European expert panel for functional GI disorders. He is the pioneer of research on use of hypnotherapy for the treatment of irritable bowel syndrome (IBS) and related conditions. He has published over 300 papers or chapters, has written articles for popular magazines and newspapers, and appeared in several radio and television programs on functional GI problems. In this short interview, he has shared some of his ideas about practice and education in medicine.

• Could you please introduce yourself and tell us how you became interested in functional GI problems?

My name is Peter Whorwell and I am a professor of medicine at the University Hospital of South Manchester. When I started as a gastroenterologist, I, obviously, studied all aspects of gastrointestinal diseases including liver diseases, but found that the most challenging to treat was a group of conditions called the functional gastrointestinal disorders. Moreover, the patients were not being taken seriously by the doctors; therefore, I gradually became more and more interested in the challenge of treating functional gastrointestinal disorders. As I got older, the unit was virtually devoted to the management of these conditions and research into these disorders. As most people know, functional gastrointestinal disorders, including irritable bowel syndrome (IBS), are particularly difficult to treat and most doctors only advise patients with IBS to take more fiber and assure them that they will learn to live with this disorder. This is clearly not good advice, since the condition completely overwhelming their life, and therefore, they really must do something more.

• How did you become interested in studying hypnotherapy?

In the face of not having very good conventional treatment to offer these patients, I thought that hypnotherapy might be worth a try. The reason I tried hypnotherapy was that back in the early 1980s IBS was thought to be a motility disorder.

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This means that the problem is only abnormal contractions in the muscles of the gut that cause spasms, and that is why the disorder used to be called "spastic bowel syndrome". Because of this and because I knew that hypnosis relaxes muscles (I had watched a television program on hypnosis), I thought perhaps it can be used to relax the muscles of these patients. Thus, the reason I tried hypnotherapy was almost on a wrong hypothesis because we now know that the cause of IBS is much more complicated than muscle contraction. Even though it was based on a wrong hypothesis, it worked, and therefore, I thought it worth pursuing. The other interesting aspect was that, as a physician rather than a psychologist or psychiatrist, I felt that if I want to perform hypnotherapy it would have to be in a more medical way rather than a psychological way. Fortunately, in those days, patients were not quite stressed as they are today and applying hypnosis in a medical way, "gut focused hypnosis" as we call it, seemed to work. However, evidently, you try to give the patient advice during hypnosis about stress management and those sorts of things. Since then, we have shown that hypnotherapy does seem to help or improve various physiological abnormalities we now know occur in IBS. IBS, in addition to being a motility disorder, includes hypersensitivity and various other abnormalities of pain control mechanisms and those also seem to be amenable to modulation by hypnosis.

• Today, management of chronic conditions is one of the main problems of healthcare systems, and in these conditions, many psychosocial factors are important and the doctor cannot change the majority of them. What do you think a doctor can do in this regard?

I think one of the problems with IBS is that it is what is called a chronic condition and I think healthcare systems are faced with great problems in the management of these conditions. In the modern medical model, everything seems to be acute and you put acute things right, and then, you get rid of the patient (for want of a better word) and the job is done. However, chronic conditions are lifelong conditions and we are not good at addressing these for two reasons. One is that many doctors are, I think, almost frightened by chronic conditions, because they feel incompetent because they are not helping the patient. Therefore, they start blaming the patient rather than telling the patient that he/she has a chronic condition and they are helping him/her manage it rather than curing it, because we cannot cure these conditions. The second reason is that healthcare systems do not support doctors in their role of helping patients manage these problems. In hospitals, they are given 10-15-minute appointments, and in general practice, 10-minute appointments and you cannot manage a chronic condition in 5 or 10 minutes. Thus, healthcare systems should allow doctors who are interested- as not everybody is interested- to spend more time with these patients. We have also found, over and over again, that the time spent with the patient is a good investment, because that patient will last longer on that advice than if you never get to the core of the problem. You need to get to the core of the problem. Patient education is absolutely vital. They need to understand the condition; they need to understand what you can do and more importantly what they can do. They have got to engage in their treatment. If they expect you as the doctor to put them right, it will never happen. Therefore, it is a case of partnership between you and the patient working towards an improvement rather than a cure and setting realistic goals, and doing that, it is amazing how many patients you can help. There are always some that you cannot help, but even though you cannot help them, you should not discharge them. You can still look after them and give them a point of contact with the medical profession. Because it seems grossly unfair that patients with chronic illnesses are caused to drift with no realistic and meaningful point of contact with the medical system.

Professor Peter Whorwell

• What are your views about the current status of medical training in your country and in the world and what do you think needs to change?

I am not sure I would very much enjoy the medical training as it is today, but what you have not had, you do not miss, so probably I would still enjoy it. I fear that it is getting worse, because medical students are trained in this very physical and medical model in which you do a test, you find the cause of the problem, and you put it right. This is fine for the things for which this model applies, but in chronic illnesses, which quite often have very negative tests and vague symptoms, this is not going to work because you cannot necessarily find a concrete diagnosis. Even IBS is not a diagnosis. It is a collection of symptoms. Therefore, the management of these patients is challenging for medical systems and medical students are not being taught how to manage them. They are being taught how to treat acute problems, but not chronic problems. This needs to change, but I am not sure that it is going to change in the near future. I only now remembered a relevant example in our IBS clinic. We had two patients referred to the emergency team because they were in such severe pain, and the emergency team attended to the first patient. I went in there and they ignored me, so I thought I will leave them to it. They had a drip up and monitor on them and all sorts of things, and then, a stretcher was brought in and the patient was taken off in an ambulance. Then, in the afternoon, the same thing happened, and I could not believe that the emergency team were summoned again. I was not going to be silent this time and I asked to take over. She was having pseudo-epilepsy. We managed to find some Buscopan injection and it was all resolved, and so, she was not put on a stretcher.

I think, once the more challenging conditions, like cancer, ischemic heart disease, and diabetes, are managed better, which is inevitable, we will be left with these so called functional conditions. Then, we will have to learn how to manage them. Managing these patients reasonably well is incredibly rewarding, probably, in my experience, more rewarding than treating somebody with thyroxin for their thyroid disease or insulin for their diabetes. Since you are making a difference to these patients, where no difference was made before.

• Do you have any suggestions about the way in which this situation can be changed?

Regarding the possibility to change the situation, I think the point is that there is an obsession with tests. How do you change that? How do you make doctors talk to their patients? It is very difficult. What can you do to stop this obsession with investigation? I suppose it would be helpful if we had more doctors like me. Doctors who have sat in my clinic with me have said it has been useful to learn how to speak to these patients. They receive trainings with so called mock patients, the actors being the patients, and they go through all these role model training sessions, but it is not challenging in anyway and it is just ticking the

boxes. For example, there is a module about breaking bad news, but there is no module about how to deal with a chronically ill patient. The other point is that, in the UK education system, in order to get into medical school you have to have three A levels (the exams at the end of school) and you have to have them at a star level. I am not sure that you have to be super intelligent to be a doctor. I think you should have a good memory, but I am not sure you have to be super intelligent. Therefore, they select a group of people who may have very high intelligence, but not very high empathy. The other problem in this country now, I think, is that being a doctor comes with one of the best salaries of any occupation. Therefore, you attract people because of the financial rewards, and hence, they are not empathic to the patients. I think the other thing that still attracts people is that being a doctor carries a certain degree of kudos although not as much as before. Thus, people study medicine for the money, kudos, and because they are intelligent and I do not think these are necessarily the right qualities for the job.

- **If you were not a doctor, what would you do?**

If I was not privileged enough to be a doctor, I am not sure what I would do. I thought about becoming a doctor from the moment I could speak. Thus, I do not think I would have ever been any good at anything else. The only other thing that crossed my mind was being a pilot. However, I am not very keen on wars, and most of the training is done by the forces. I would have preferred to be a commercial pilot, but in those days you had to go through the forces to learn to be a pilot. Thus, I learned to be a pilot anyway, but in a private way. Therefore, I do not think anything would have suited me really, so I would be lost if I was not a doctor.

- **Who is your role model?**

With regard to role models, when I was a medical student, consultants in the United Kingdom were very arrogant despots. They were a very arrogant group of people who strutted around expecting students and young doctors to follow them around obediently. When they did speak to them, it was usually in a rude way. I did actually reverse model myself on people, so I thought I am not going to be like them. There was one doctor who was a surgeon actually, which was rather unusual. He did what I do today; he talked to patients, was very gentle to them, and chatted with them in a nice, non-threatening, and easy-to-talk-to manner. Therefore, he was actually my role model. Fortunately, he worked in the hospital where I was trained and I chose him as my role model.

- **Thank you very much for devoting your time to this interview.**

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