

‘Light in dark places’: exploring qualitative data from a longitudinal study using creative arts as a form of social prescribing.

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Background: This paper draws on a longitudinal study which explores the outcomes of an arts referral programme in General Practice in the South West of England since 2009. It focuses on the qualitative responses of the patient cohort during this period.

Methods: Using qualitative methods, and thematic analysis, this paper explores and considers the responses from n=1297 participants who provided feedback from an open-ended questionnaire on self-reported benefits of the arts referral programme.

Results: Participant reactions demonstrate that the programme provided a range of personal and social benefits that have rarely been considered or explored in comparative studies. In particular, the analysis suggests that participation provided opportunities through which participants were able to self-manage certain aspects of their health-related conditions and identify that they were able to make progress towards a better physical and /or mental health.

Conclusions: The evidence suggest that arts-based referral programmes, when used by health professionals, have a range of economic, social and well-being based benefits for participants, that may not have been fully appreciated. The consequences on self-management in health and social care require further investigation.

Keywords: Longitudinal study, Qualitative, Social prescribing, Wellbeing

Introduction

For more than a decade social prescribing has been on a trajectory towards playing a central role in addressing patient needs within primary health care (Bickerdike, Booth, Wilson, Farley, & Wright, 2017). However, what was once merely regarded as the provision of ad hoc advice from the doctor, ‘... *such as visiting a Citizens Advice Bureau for financial problems, or a dance class for exercise and loneliness...*’ (Brandling & House, 2009, p. 454) has increasingly become more formalised, structured and part of a supportive framework for physical and mental health intervention (Stickley & Hui, 2012). In the UK this has been encouraged by commissioning arrangements which better facilitate funding for activities with which patients can engage (NHS England, 2014).

One of the main treatment options that are now being offered to patients with a range of physical and mental conditions is the use of the ‘*creative arts*’ in social prescribing (Fleischer & Grehan, 2016). The importance of their role has been recognised by all involved in these programmes including patients, health professionals and art providers (Crone et al., 2012b). It is significant that the evidence base now involves a range of patients, health conditions, and settings (Fraser, Bungay, & Munn-Giddings, 2014; Puetz, Morley, & Herring, 2013; Renton et al., 2012; Stickley & Eades, 2013; Van Lith, Schofield, & Fenner, 2013).

The background to this paper is unlike any other on the subject of social prescribing. Since 2009 the authors of this paper have been part of a longitudinal study exploring the outcomes of an arts on referral programme in General Practice in the South West of England. It is now the longest study of its type in the world. Up until now the research team have primarily focused on quantitative data related to patient progress through the intervention and factors such as changes in mental well-being (and a qualitative evaluation of patient, artists and health professionals’ experiences of the intervention (Crone et al., 2012a; Crone et al., 2012b) . This paper marks a departure in that it focuses, instead, on the qualitative responses of the whole patient cohort, and draws on an archive of feedback from n= 1297 respondents who had been referred to an 8 or 10-week arts intervention programme over a seven-year period, between 2009 to 2016.

Social Prescribing and Artlift

The perceived value of social prescribing rests on a number of assumptions. The first, and key point is that it is argued that there is a wide range of voluntary and community based organisations that can support and assist patients with the management of their medical conditions (Ward, 2001). These organisations are considered to be better able to provide that support – in terms of both time and money, and as such they offer an opportunity to plug some of the gaps in more formal statutory based structures (Ward, 2001), and in times of austerity and financial pressures they encourage the opportunity for more people to be supported for less. South, Higgins, Woodall, and White (2008, p. 311) add that the *'voluntary sector is generally rooted in values such as empowerment ... and engaging with people on their terms...'*, and whilst Popple and Redmond (2000) take issue with these suppositions about the voluntary sector, there can be little doubt that these voluntary and community based organisations have a more extended reach into their local communities that can be distrustful and sceptical of statutory provision (South et al., 2008). As such these organisations provide an additional sense of added value – not only do they enable money to go further, their reach into communities that are difficult to access permits the provision of health interventions that might otherwise be rejected or ignored. As a consequence of this activity social prescribing can be regarded as having a further outcome – the development and improvement of locally based social networks that can continue beyond the purpose of the socially prescribed activity.

It is in these contexts where Artlift programmes have been located – services run by community based organisations, located in at times small and local communities, based on relationships that are other than the professional-patient model seen in statutory organisations, where activities are perceived by patients as having a positive focus, and where referral from primary care demonstrates a more holistic, person-centred approach (Crone et al., 2012b).

Artlift is a form of social prescribing that has been in existence for a decade. It uses a variety of different art as a vehicle to support patients referred from a range of primary care based health professionals. Referral criteria include low mood, recent bereavement, being socially isolated, etc. (for a full review of the Artlift intervention see Crone et al., 2012). The art type included drawing, mosaics, painting, and creative writing, all led by an artist who is skilled and experienced in the particular media being used. The intervention began in 2009, and has since had nearly 1300 patients go through its process. Patients are referred from primary care settings for a multitude of reasons, but all principally with the increase of wellbeing in mind. Patients attend an eight- or (formerly) 10-week course of creative activities, which are

led by a local artist. Those that attend are not required to have any particular history of, or skill with, their particular art media; and are provided with required materials, and training to develop their skills in that media throughout the course and beyond. The patients are not taken through any formal therapeutic process *per se*, although it is argued (and supported herein) that the art itself constitutes a type of therapeutic process for participants. The intervention groups are made of individuals from local communities, and are not grouped according to specific medical need – meaning that each participant will be “anonymous” from the other in terms of their specific reason for referral. Group interaction is encouraged; however, nobody is required to speak about personal issues, nor speak at all if they prefer not to. Each artist is provided with training to prepare for working with a diverse group of patients with varying levels of support requirement, however they are not purposed to act as a therapeutic facilitator or counsellor, nor in any other capacity other than an artist instructing and guiding learning within an art form.

The present study seeks to investigate, in more depth and breadth than has previously been possible, what participation in Artlift means to the participants that pass through the intervention by examining their qualitative feedback received following taking part. We sought to understand, in the patients’ own words, how the therapeutic benefit of such an intervention was interpreted by the individuals that experienced it.

Method

Participants and procedures

This paper draws on data collected from archived material collected over a seven-year period. These data include feedback from individuals (n=1272 of a total n=1297) that have been referred for Artlift since 2009. As part of this referral scheme, participants are routinely provided with a “patient satisfaction form” on completion of Artlift. These questionnaires are anonymous, but are linked to the participants’ other data via a code that is not individually identifiable to that participant. The participants are asked to provide their opinion on Artlift, with the principal purpose of improving the programme for others in the future, and gaining understanding of the particular features of the programme that they did or did not enjoy. This questionnaire involves 10 questions on one side of A4 paper, and as such only provides a modest space for comment. The data herein are gleaned from hand-written responses from one of the questions that were included in this feedback questionnaire. The open-ended question was; ‘*what did you enjoy the most about the course?*’. The rationale for using this question for data capture was to enable a focus on

responses that centred on the therapeutic benefit to the participants. By using the response questionnaire, it is possible that participants were able to report their perspectives in a more confidential and anonymised method than in a focus group or interview, as used in previous published studies (Crone et al., 2012b). Originally all responses from n=1297 participants were included as the source of data source for this paper, but in data preparation it was found that some participants (n=25) had either failed, or decided to not answer this question. The study is therefore based upon responses from data from n=1272 participants. The data collection process, and methods adopted for analysis have received NHS ethical clearance.

Data analysis

Thematic analysis (Braun & Clarke, 2006) was used to explore the data. This included, familiarisation where data were read through in their entirety in order to appreciate the range of responses and the issues they covered. Once familiarisation had been achieved through this reading process, the coding process of thematic analysis was undertaken. Commonly worded or phrased answers were initially grouped together using colour coding on the spreadsheet. The responses ranged from short one or two worded statements, to more fully detailed responses in the form of longer sentences. This paper relies on these longer, more explanatory and context setting answers, so as to ensure that the 'voice' of the participants is heard above the process adopted by the authors.

Given that the data originate from open-ended questionnaires the analysis was initiated and carried out outside of the dynamic that typically takes places in the interaction between participant and researcher. Traditional notions in qualitative research regarding the importance and value of the relationship between the respondent and interviewer are challenged here in that the data were derived through other methods. The data analyst comes at previously collected data afresh, without any involvement in the collection of the original material may be regarded as being on '*...thin foundations ...*' (Irwin, 2013) because they do not have that context or relationship with the respondents; however this type of analysis is not uncommon in such large cohorts of participants (Quick & Gizzo, 2007).

Camfield and Palmer-Jones (2013), however, also remind us that the 'purist' approach to analysing qualitative data is misleading, not always achievable, and go on to note that academia has a long history of qualitative data collection and analysis that is undertaken by researchers who have had nothing to do with one or other stages of collection and analysis. This ranges from the established professor who uses students and research assistants to collect data that they will analyse at a later date from the comfort of their office, to the cross-national study that collects data *in situ*, and analyses information centrally.

Challenging orthodoxy, Camfield and Palmer-Jones go as far to suggest that '*secondary researchers may even produce more convincing accounts...*' (2013, p. 330) due to time, access to better resources, and through the use of hindsight.

It is in this methodological discussion that this paper is located, whereby the principal author began to explore and analyse the data in a contextual vacuum. As such he was left with having to accept the dataset for what it was, and trying to make sense of it as an archive. He was, however, supported by one of the previous qualitative researchers on this project (DC), who provided a peer referencing role in the analytical process.

Over the life course of this emerging data set, initial questions regarding the outcomes and processes involved in arts as a medium for health improvement in primary care have been investigated. In doing so it has become clear that there are indeed many facets to such interventions for patients. As a consequence, whilst the qualitative data per individual cannot be classified as rich, ironically for qualitative researchers, we can claim that the quantity of the data from the large participants sample provides a significant data set to explore and examine. We have also become increasingly aware, having been involved in the development of Artlift as an intervention, and the patient journey through it, that there is more happening in the experiences of patients than our previous quantitative, and qualitative data, has explored. With that insight, we engaged with other members of our health and social care research team, to examine the data with a different lens. This paper is the result of that opportunity, from their varying viewpoints.

During the first read through of data that had been presented on an archived excel spreadsheet, the principal author began to loosely group the statements and comments thematically - identifying commonalities and differences. These were tightened up in subsequent reading but very quickly it became obvious that the statements were far more than representing a simple satisfaction/ dissatisfaction with the activity that they had been involved with. Instead, it became evident that what was emerging was a reflective account of the process the respondents had experienced, and the meaning(s) that this had for them. These meanings, along with their exploration of the process they had been through, add context and depth to both the previous quantitative and qualitative evaluations regarding arts on prescription in the social prescribing context.

The analyses herein are derived from one of many questions available on the feedback questionnaire, which appeared to contain the most detailed data available; *'what did you enjoy the most about the course?'*. This single column had feedback from almost all 1300 individuals. As such the task of grouping the responses into thematic areas appeared a challenge. However, very quickly a number of key areas emerged that were later broken down further into smaller subsets. These overarching and emerging thematic areas were *Being with others; Being on my own; Doing something for me; Losing oneself; and Threshold.*

Results

Being with others

The opportunity to be with others was the most common response that participants gave to the question, and within this category this idea of meeting and being with people was repeated throughout. It was typical for this sentiment to be included in a 'catch all': -

'Meeting people. Also finding out what I can do!' Respondent 4027

'Meeting other people and trying something new' Respondent A1681

As such whilst these answers offered a positive benefit, they often lacked any further explanation or depth. Some, however, added further context, where the notion of 'meeting others' could be better understood. Answering the same question, other respondents suggested: -

'I enjoyed being with other people and doing painting' Respondent WS006

'Learning something new, being in a group' Respondent 0271

As such the notion of *'companionship'* or *'membership'* began to emerge from the responses, where participants noted that their enjoyment concerned: -

'Being part of a group' Respondent B0043

'Learning, companionship, being taken an interest in'. Respondent 2503

'Interaction with like-minded people'. Respondent 3133

Companionship and being with those who were 'like-minded' was further explained and underpinned by those who expressed the sense of not being judged by others: -

'Everyone was welcoming and I never felt judged' Respondent A1078

'It's very enjoyable as no one criticises you'. Respondent B0452

However, as we shall note later, a curious relationship between companionship and anonymity combined in an unusual way. In particular it focused on the time participants were together in the group: -

'...although none of us knew each other's problems it was nice to chat and care'. Respondent B0111

This was because the groups were a *'... safe environment to share private thoughts...'* (Respondent A0999), where participants were *'... able to talk freely about [my]feelings'* (Respondent 1165).

This notion of sharing wasn't just one way. It was reciprocal, mutual and interactive.

Being on my own.

Whilst many participants had a sense of companionship with their fellow attendees, others expressed the view that what they had enjoyed most about the Artlift courses was concerned with what they had got out of the courses as individuals. In the first instance this was expressed as an 'escape' from the everyday, where the regularity of a weekly Artlift session was concerned with *'getting me to go out'* (Respondent B0237), and being *'...a break from everyday chores...'* (Respondent B0146). Here then *'...being out of the house...'* (Respondent B0417) and having a *'...change of scenery...'* (Respondent B0231) was reward enough. As such, whilst Artlift activities were *'...something to look forward to...'* (Respondent 4166) which might *'...take [their] mind of things...'* (Respondent 2250) the activity wasn't always the benefit to respondents. It was instead, a vehicle by which the benefit of being 'away' both physically and mentally, could be achieved.

Doing something for me

Above all, Artlift provided an opportunity for respondents to take *'... time for myself...'* (Respondent B0202) and *'...to just be me...'* (Respondent B0373), where participants could have their *'...mind on creativity and not problems'* (Respondent B0138). On the one hand *'being oneself'* allowed for achievement, where participants might express surprise *'...at what I can do..'* (Respondent 3121), yet it also provided an opportunity for play. Here part of the process was concerned with *'...making a mess..'*

(Respondent 3395) and *'...getting messy like a child...'* (Respondent 3123). Indeed 'play' provided an opportunity where participants could either *'...find[ing] new things about myself...'* (Respondent 1923) or have time to *'...learn new skills...'* (Respondent 1559). For one respondent, however, the sessions provided an opportunity whereby they could *'...learn[ing] to let go and experiment'* (Respondent B0555).

Losing oneself

Although the Artlift sessions clearly provided an opportunity for *'safe escape'* many other respondents found the activities on offer to be a reward in their own right. Here *'...the opportunity and encouragement to try something I've never done since childhood...'* (Respondent B0490), and the sense of being able to *'achiev[e] something...'* (Respondent A0505). These new and re-discovered skills and hobbies could be undertaken at home, with the potential for the activity to still help them 'escape' mentally.

So, one of the themes that emerged was the idea that the Artlift activities provided a sense of respite. Indeed, one participant described it as *'time out'* (Respondent B0022). Another respondent (A1524), noted that it *'[t]ook my mind off my pain'*, and a further stated that it provided *'mind distraction'* that *'helps depression'* (Respondent 1480), even if it simply involved *'having something to keep my hands busy'* (Respondent 4081).

Whilst the notion of 'escape' was a commonly expressed feeling, many developed it further into the idea of *'losing oneself'* or *'switching off'* (Respondent B0057) in the course of undertaking one of the activities. One participant suggested that it *'[h]elps me forget about things...'* (Respondent 1945), another echoed a similar sentiment stating that what they enjoyed the most about the course was *'...[b]eing able to meet new people & 'forget' for a while'* (Respondent B0116). As a consequence, participants were able to *'...relax and lose myself for an hour...'* (Respondent 4544) and *'...focus[ing] on something other than my problems...'* (Respondent A0153).

Here then we can see that the Artlift activities provided participants with a sense of physical and mental space in which they were able to distance themselves from either the physical or mental ill-health they were experiencing. In some ways, it appears that the notion of a *'space'* being identified was simply a beneficial hiatus from the everyday and the mundane, and to some extent this is quite correct. Here the activity would appear almost irrelevant. However, for some respondents, it appears that this 'space' provides more than a break in routine. Others also began to express the view that the 'space' and break in routine provided an opportunity for 'change', 'growth' or coming to terms with a given situation. One participant described the Artlift sessions as *'... a good mood changer...'* that would *'give scope to improve*

me...' (Respondent B0429). Taking this notion of improvement forward, this one respondent (B0259) noted that being involved in the course had '*...moved me on*', intimating that they regarded the course as a 'journey' or a 'process'. Indeed, another almost adds to this notion by stating '*... I found the sessions cathartic*' (Respondent 1483). Finally, a further participant adds '[I]... *found it helpful after losing my father...*' (Respondent 4165).

Threshold

This final group of statements appear to underline the fact that referral to Artlift provided opportunities whereby participants were able to encounter, identify and begin to document '*threshold moments*', in which they were able to recognise personal growth and change, and then progress with a change in their psychological outlook. Embedded in some of the data above, whereby participants have identified the value of the group, their role within it, and the opportunities created by the task for them to either 'lose' themselves or even 'find' themselves, some respondents began to speak about their engagement with the Artlift programme as a form of healing, or a journey to another, better, psychological state. Here then, the ability to both identify and articulate it is significant. Reflecting on the notion of healing, one respondent explained it in this way: -

'I found the sessions cathartic' (respondent 1483).

Another added: -

'It's moved me on' (Respondent B0259)

Reflecting on the past a further added:-

'I have been in a dark place...' (Respondent A1798)

Being 'moved' out of a 'dark place' locates these participants 'elsewhere'. Specifically, they imply they are no longer in the 'place' they occupied prior to starting Artlift.

Discussion

In reviewing and opening up this qualitative archive of patient self-reported data we have begun to give voice to patients participating in what remains an unusual service. To our knowledge, this data set, whilst limited potentially in its depth, is varied in its breadth, and, importantly, is the largest of its kind within the field to date. It is significant therefore, that some of the themes we have identified are echoed elsewhere in the literature on arts and wellbeing, particularly those late to notions of being provided with a *'safe space'*, playfulness, and feelings of empowerment provided by such opportunities (Haeyen, van Hooren, & Hutschemaekers, 2015; Heenan 2006; Huet & Holttum, 2016). An important theme to emerge, which has been highlighted as a potential process of change within arts on prescription in a recent review, and is a crucial in influencing well-being, is the concept of self-discovery (Ryan & Deci, 2000; Van Lith et al., 2013). Insight into self-discovery in this analysis provides further evidence for these programmes to foster this, although the explicit pathways that allow self-discovery in this context are not completely clear. However, it is likely that a combination of the thematic areas described herein aggregate to support this process. The identified themes from these data are not only important elements of positive wellbeing (Ryff, 1989), but they are also coherent with themes described in the broader literature on arts and wellbeing, as well as social prescribing as a whole, where more traditional qualitative methodologies have been used (Chatterjee, Camic, Lockyer, & Thomson, 2017; Crone et al., 2012b; Stickley & Eades, 2013).

Comparing these findings to more traditional forms of primary care referral, such as the largely standard model of group therapy (in whatever form), there are some key differences, but also striking similarities. From living with physical illnesses such as cancer, to mental health conditions such as eating disorders, and beyond to more pastoral wellbeing concerns such as bereavement; referrals for group therapy have been a mainstay of primary health care in the UK for some time.

What is unique about programmes such as Artlift, however, is that they are not needs-specific; meaning all referred patients will attend sessions for any variety of medical reasons, and each Artlift group will be comprised of individuals with any type or combination of mental or physical health need. This provides a very distinct experience from traditional group therapy settings, where individuals will all attend for a common reason, whether that be for dealing with a lifechanging diagnosis, or striving to release themselves from psychological or behavioural condition. This may be highly beneficial for the patients, as they will not be seen through a lens of their disease, and will have the opportunity to engage with their art, and their group, in a more holistic manner. This is particularly important considering those patients

with both physical and mental health needs, and a recent call has been made for clinical practitioners to encourage this “whole person” perspective (Naylor et al., 2016).

Another unique quality this type of intervention constitutes is the lack of direct therapy; where participants do not have a trained counsellor or therapist guiding conversation, prompting themes, or encouraging disclosure. Instead, the participants are encouraged to engage in “art for art’s sake”, thereby leading the therapeutic benefits to manifest in less obvious or direct ways; and perhaps allowing them to derive their own therapeutic meaning from the activity both individually, and as a group. Finally, there is the element of creativity inherent in this type of intervention, where participants are able to develop or enhance skills in art, and to create physical pieces of art that serve as a memorialisation of their time in the group. This is likely a very powerful part of the Artlift experience, and is something that makes this kind of intervention distinct.

Despite these very obvious structural and foundational differences, there are very clear similarities apparent with the themes identified within this paper and those identified in traditional primary care referral therapy settings. The theme of *being with others* is something that resonates with the data from the group therapy setting, with evidence from a variety of types of therapy and types of group all identifying similar themes concerning connection to others and trust (Laberg, Törnkvist, & Andersson, 2001; Olsen & Skjaerven, 2016), mutual support (Lefebvre-Chanson, Boissou-Bonnet, & Rolland, 2017; Olsen & Skjaerven, 2016), and sharing (Lefebvre-Chanson et al., 2017; Mackenzie, Carlson, Munoz, & Specia, 2007). Equally, the theme of *threshold* is a very familiar story with group therapy data, with studies describing how participants identify their own personal growth (Mackenzie et al., 2007), feelings of being changed at a very individual level (Laberg et al., 2001), understanding that they now have new coping tools (Nilsson, Svensson, Sandell, & Clinton, 2007), and a new awareness of the self (Binder, Holgersen, & Nielsen, 2009; Olsen & Skjaerven, 2016). The theme of *losing oneself* is not something that perhaps would be expected to be echoed within group therapy settings, however one study looking at group therapy for women with postnatal depression outlined a theme of “escape” in terms of the participants’ feelings of isolation in their daily lives (Lefebvre-Chanson et al., 2017). Similarly, another study looking at mindfulness therapy in a mixed cohort of patients found reports of ‘*going into yourself and exploring*’, which is reminiscent of our participant’s comment regarding ‘*finding new things about myself*’ (Mason & Hargreaves, 2001). Finally, the experience of Artlift participants continuing to contact and meet with their group is also echoed amongst other group therapy research, albeit with groups and activity function that is perhaps more conducive to continued assembly such as patients with rheumatic disease carrying out

movement therapy (Olsen & Skjaerven, 2016), and mothers with postnatal depression (Lefebvre-Chanson et al., 2017). This is a far more beneficial termination to the official programme than other traditional interventions, which is where participants have cited feeling at a loss, or as if *'the carpet has been pulled from under us'* (MacCormack et al., 2001; Mason & Hargreaves, 2001, p. 204). Having the capacity to continue the art activities with their Artlift group will likely allow patients to terminate their engagement with the group on their own terms, in their own time. These similarities underline the notion of arts on prescription as therapy – but without therapeutic facilitation or structure. The similarities to more conventional forms of primary care referral despite the very obvious differences in form and structure are indicative of a more subtle and intrinsic process of change that necessitates careful exploration in future work.

The similarities to conventional forms of group therapy, in terms of their therapeutic benefits and processes, are balanced by the positive differences observed to traditional therapies, which has important implications for policy in primary care referrals. Formal therapy, whilst undoubtedly effective, can by its nature bring about difficulties and challenges that are likely to be avoided in this non-therapeutic setting. As participants are not being asked to 'share' or divulge personal, intimate thoughts and feelings, there is less scope for interpersonal conflict, or social barriers to change. The change being observed in interventions such as Artlift is, rather, a by-product of engaging with arts; allowing participants to engage with the group in their own way and at their own pace. This lack of directed process is likely to prevent challenges to individual agency, however future studies are clearly warranted to uncover the mechanism of therapeutic change from such interventions.

Another key difference to traditional primary care referral therapies is that the Artlift mode is supportive of continuance, and is relatively easy for participants to self-sustain; thereby allowing participants to disengage with the activity on their own terms, without continued public spending. Whilst there is a formal set of referral criteria for Artlift; the nature of these, and the referral process itself, enables participants in the Artlift groups to be brought together without an overt classification of diagnosis, needs or symptoms; this allows some anonymity within the group, which is not seen in most traditional group therapy settings. This does not seem to detract from the benefit that is observed in this intervention; in fact, the opportunity to forget about their troubles appears to be a commonly cited positive aspect of Artlift, and has been alluded to in similar studies (Heenan 2006). Future studies in this area are clearly needed to understand how this element of 'diagnostic anonymity' impacts on the connection that participants feel with each other, and the ability to adequately address their individual needs. There is

also a need to understand how the creative process is involved in the therapeutic process of such interventions; with a need to explore how individuals see the specific benefit of the activity to their needs.

Given the apparent satisfaction and effectiveness of Artlift as a psychosocial intervention, and its associated benefits in terms of its self-sustaining qualities, it is clear that such interventions should be developed further for patients in primary care. For researchers, there is an obvious need now to move our focus forward from gathering an evidence base on efficacy, to understanding the contextual and procedural nuances of the therapeutic processes involved, so that we may understand how it works, for whom, and importantly for patient care, how this information can be applied in practice to make it better.

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