

Developing a Whole Person Approach to Health Care

Chapter Three

Developing New models of Healthcare

By Dr Michael Harper

Introduction

We are witnessing a period of a rapid advance of the scientific model. A much greater awareness of structure and function at the microscopic level is perhaps the primary fuel for this advance; and it takes knowledge into new directions. It is not just a more sophisticated comprehension of that for which we already have a working knowledge, such as the specific effect of active substances at cell receptor sites, but whole new areas of knowledge which have unravelled to powerful investigative tools – a prime example being the mapping of the human genome.

We have also witnessed a new rigour of approach in applying knowledge within conventional medical practice; evidence based practice has almost universally been accepted as the way forward at least in principle.

Yet given there are dissatisfactions with the way in which illness is approached in the West, one might expect something to have been done about it – the more especially because we are well into a new era in society, the post-modern era, where individuality and personal choice reign supreme (at least for those who can afford it); not surprisingly, there have indeed been many efforts to re-focus healthcare in a variety of ways. This chapter focuses on key approaches which have sought to identify what the problems are and redress them. We will begin by looking at an evidence based assessment of initiatives designed to increase patient centredness, and then look at historical and current initiatives to address perceived deficiencies in the way doctors and patients interact in much of what we might term modern evidence based medical practice.

Cochrane review of Patient Centred Care¹

This study aimed to assess the effects of interventions calculated to promote patient centred care, recognising that problems may arise as a result of health care providers focusing on diseases and their management rather than people, their lives and their health problems; and furthermore recognising that patient centred approaches are increasingly advocated by both consumers and clinicians. A variety of sources were searched for trials suitable for inclusion, and 17 met the criteria. Patient centred care was defined as a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease).

The studies were heterogeneous in every way – the interventions, the concerns upon which the interventions were focused, the comparisons made and the outcomes assessed. But without here going into more detail there was fairly strong evidence that in the majority of cases interventions designed to promote a patient centred consultation process did result in objective improvement in that parameter. When it came to patient satisfaction, of the 11 studies that addressed that issue, six demonstrated significant preferences for consultations which had been the subject of such interventions. The reviewers concluded that although interventions to improve patient centredness may be successful in that aim, there is little evidence of the effect on patient health care behaviours or on health status, and recommended further research.

The Balint Society

Within the framework of conventional NHS general practice, The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of regular case discussion in small groups under the guidance of a qualified group leader. The work of the Society involves both training and research, and although full membership is restricted to GPs who have attended regular meetings for a year, associate membership is open to paramedical professions as well.

Michael Balint (1890-1970) was a psychoanalyst from Hungary who emigrated to Britain in the 1930s. After the war he practiced at the Tavistock Clinic in London. His contribution to the area of general practice, however, was his work in the 1950s and 1960s in helping GPs to understand the psychology of the doctor-patient relationship. Enid Balint, also a psychoanalyst and Michael's (third) wife, was his colleague and partner in this work with family doctors.

In 1957 Balint wrote a book entitled *The Doctor, his Patient and the Illness*; this struck an immediate chord because it dealt with the reality of general practice – coping with the large proportion of patients with a multitude of symptoms, some of which may be related to physical disease and much of which is not. Hospital medicine, conversely, appeared much more easily retained within the parameters of physical disease. The overt recognition of the problems faced by GPs was appreciated, and the first Balint Group was formed – Michael Balint and a handful of GPs – to probe a little into what the real issues in facing “heart-sink” patients really might be. Surprisingly, in view of the fact that GPs were perhaps harder pressed than they are today, the concept caught on, fuelled by the support inherent in being part of a group who both faced the issues raised by such patients, and looked together for positive ways to better understand and help them. There was an understanding that to many patients the personhood of the doctor is in itself therapeutic. Indeed, at the outset of his book Balint proposed that the doctor is himself a drug; and “...no pharmacology of this important drug exists yet. To put this discovery in terms familiar to doctors, no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and maintenance doses should be, and so on. Still more disquieting is the lack of any literature on the possible hazards of this kind of medication, on the various allergic conditions met in individual patients which ought to be watched carefully, or on the undesirable side-effects of the drug.”²

What the Balint Groups did not do was radically change the nature of general practice; rather it supported doctors within it, helping their focus to become more patient centred, understanding both their patients and their reactions to them. The importance of this psychosocial element within the

consultation was recognized within the Royal College of General Practitioner's manifesto in 1972. The Balint movement continues today; indeed it is international, with the UK Balint Society being one of 36 groups worldwide. These maintain a corporate identity through regular International Congresses.

Salutogenesis

Another of the threads of new thinking is the concept of salutogenesis. Antonovsky (1979) proposed an important explanation to account for the fact that some people stay relatively well despite the trials and tribulations of their lives. He coined the term "salutogenesis," from *salus*, the Latin word for health and well-being, to emphasize that the focus of his model was on health rather than on disease.

The impetus for the salutogenic model came from Antonovsky's experiences with refugees who migrated to Israel from concentration camps after World War II. He noted that despite their deeply disturbing and horrific experiences, some of the refugees were surprisingly well.

With a training in both sociology and medicine, Antonovsky wondered whether a person's general outlook was a determinant factor in his or her well-being. Further work led Antonovsky and his colleagues to propose that indeed it was so, and that the primary areas within what we have just called "general outlook" are three; comprehensibility ("I can grasp what's going on"), manageability ("I can cope with it"), and meaningfulness ("there is a purpose behind it in the scheme of things"). Antonovsky proposed that these factors are important to health and well-being. He postulated that these three key areas are what give an individual a "sense of coherence" (SOC). He defined this more specifically as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (Antonovsky 1979). He proposed that the SOC and the three factors behind it are important to health and well-being.

Meanwhile Kobasa and his co-workers were pursuing a very similar line of research at the University of Chicago, and this resulted in broadly similar conclusions.

Elements wrapped up within this sense of coherence which have been demonstrated to affect health and wellbeing include the individual's appraisal of their situation, the social support they receive (this being defined as a sense of being cared for and valued, esteemed and loved, and being part of a network of communication and mutual obligation); religious belief; happiness, humour and love, and mutual romantic love. All these elements can reasonably be understood as contributing to one of the three areas highlighted above.³

We see echoes of this thinking in many areas. NHS owned buildings usually housing several primary care practices are called Health Centres. Many authors have researched and highlighted the value of humour, of religious faith, of marriage and of strong social bonds. The question, of course, is to what degree a given individual can, through a learning process, be enabled to adopt approaches to life which are truly salutogenic. Perhaps we should first consider ourselves; how "salutogenic" are our own lives?

Narrative Based Medicine

Doctors have a distressing tendency to so strip down the patient's story that crucial elements are lost. We so often fail to see the significance of what our patients say. Narrative seeks to restore to the patient the opportunity to tell the story, complete and unabridged.

Rita Charon is Director of the Narrative Medicine Program at the College of Physicians and Surgeons, Columbia University. She describes the thought process that led her to explore the concept of narrative medicine:

"I have been practicing internal medicine for over twenty years. After a few years of practice after residency, I realized that what patients paid me to do was to listen very expertly and attentively to extraordinarily complicated narratives – told in words, gestures, silences, tracings, images, and physical findings – and to cohere all these stories into something that made at least provisional sense, enough sense, that is, to be acted on. I was the interpreter of these often contradictory accounts of events that are, by definition, difficult to tell. Pain, suffering, worry, anguish, the sense of something just not being right: these are very hard to nail down in words, and so patients have very demanding "telling" tasks while doctors have very demanding "listening" tasks."⁴

Narrative medicine accepts that health issues – or indeed sickness issues – are an important part of the story of an individual's life. We have in the last chapter already heard Anatole Broyard's cry that the doctor should "enter into his fate", become part of the story, see the significance of his illness to him, the patient, rather than just seeing it as a professional challenge.

Life is a narrative. Illness is a part of that narrative. The processes of getting ill, being ill, getting better (or getting worse), and coping (or failing to cope) with illness, can all be thought of as enacted narratives within the wider narratives (stories) of people's lives.⁵ The point is: we cannot reasonably limit the experience of illness to the physical domain, but rather need to see it in a far broader, wholistic sense. To do so may open up to us new options both diagnostically and therapeutically.⁶ How, in the light of the whole picture, do I diagnose, and – also in the light of the whole picture – how should I intervene?

To recap: when we take a history from a patient, we are engaging in an interpretive act; we are discerning meaning within the context of a patient's whole life.⁷ Of course there are frequently times when the experience of illness is too glancing, too minor, to upset the course of life; it is at worst a glancing blow. But more often than we allow there is indeed meaning behind the experience of illness which materially affects our next steps as doctors, even to the point of sometimes recognising that the illness is at least in part the manifestation of some more existential malady, some deep inner wound perhaps compounded and rendered unbearable by a further grief or setback. The doctor we would like for ourselves discerns and acknowledges this personalization of illness, and at least has the humanity to provide an "interpretation in draft" to discuss with us, and contacts to provide us with help at the level which is needed.

Of course, there are always two narratives. There is the doctor's narrative, and the patient's. But the fact that the patient's narrative impinges upon the doctor does something of inestimable value for the patient. No patient wants their narrative to disable their doctor; that would be negative. But to move him? That is a different matter.

Some brave doctors try hard to create a meeting of these two narratives, and the reflections of the doctor can provide a way for this, given only that they take a form which can be shared with the patient.

I include an example of such reflection by a doctor, but in poetic form; it is a reflection of a hopeless situation. The patient comes from a socially deprived background; she has severe arthritis and carpal tunnel syndrome, treated, but too late; and her hand is exquisitely painful. She comes into his consulting room and dumps it on his desk “as if it were an intransigent villain”. “It’s worthless”, she says. I quote the doctor: “No matter how hard I try, I cannot render this patient invisible. I cannot simply ignore her, make another referral, or fool with her medications. This lady is too tough, too opaque.”⁸ So he writes his poem: I do not know whether he shared it with her; I rather hope he did.

The Knitted Glove

You come into my office wearing a blue
knitted glove with a ribbon at the wrist.
You remove the glove slowly, painfully
and dump out the contents, a worthless hand.
What a specimen! It looks much like a regular hand,
warm, pliable, soft. You can move the fingers.

If it's not one thing, it's another.
Last month the fire in your hips had you down,
or up mincing across the room with a cane.
When I ask about the hips today, you pass them off
so I can't tell if only your pain
or the memory is gone. Your knitted hand
is the long and short of it. Pain doesn't exist
in the past any more than this morning does.

This thing, the name for your solitary days,
for the hips, the hand, for the walk of your eyes
away from mine, this thing is coyote, the trickster.
I want to call, Come out, you son of a dog!
and wrestle that thing to the ground for you,
I want to take its neck between my hands.
But in this world I don't know how to find
the bastard, so we sit. We talk about the pain.⁹

Is there not a deep reality in this for us? The poem is not fully coherent in some aspects, or not to us; but it is a *crie de coeur*; he says to his patient “Your hurt is hurting me, and it hurts me more that there is nothing I can do except bear it with you for a little time of reflection.” I see love threaded through his words. So would the patient. Would she thereby find healing? It all depends how we define healing, and to what degree we consider it should be complete.

This author also reminds us of an English physician named Thomas Percival who published a book on medical ethics in 1803. In it he enjoined physicians to "unite tenderness with steadiness" in their care of patients.¹⁰ Within the term "steadiness" Percival included objectivity and reason, along with courage and integrity. And by "tenderness" he meant humanity, compassion, fellow feeling, and sympathy. Percival highlights that a coldness of heart often develops in practitioners who fail to cultivate tenderness alongside steadiness. Both are necessary, he says; we must hear the patient with tenderness and patience, and beware of that measure of detachment which suppresses fellow feeling – whilst yet retaining objectivity. Many find this balance difficult, but we all know it is fundamental to good medical practice.

The “flipside” is when it is the patient who writes the poem, or tells the story; and we enter into it because to do so is to enter into his or her life; it modulates a bald description of the symptoms. I quote again from Greenhalgh and Hurwitz.

Robert's story

Doctor: Tell me how you first found out that you were diabetic.

Patient: Well my tongue started to get very, very dry and also I was drinking excessive amounts of liquid and also I had an upset stomach. So I went to my doctor and told him all this, and all he told me was that I had an "upset stomach." And I told him then that I think I am a diabetic and he told me that I was talking a load of rubbish.

Doctor: Why did your symptoms suggest diabetes to you?

Patient: Because I have been with a diabetic before who has now died. I had known him since he was 9 years old, so the symptoms I had, he [had] described to me before. And that is how I knew I thought I was a diabetic. So I went to another doctor and he told me the same thing: that I had an upset stomach. So I waited and waited and waited. Then I decided to go back to my doctor, when my water was starting to crystallise, and he told me that I had VD.

Doctor: What do you mean?

Patient: When I was passing the water, the end of my penis started getting all white and also sometimes when the water hit the pan it was starting to go clear white.

Doctor: What happened next?

Patient: Well, I decided to go down to the VD clinic ... and I went in there on the Friday night and I handed him the letter. And he read it and he said to me, "What do you think you have got?" And I said, "I think I have got diabetes." And he said, "What [idiot] sent you here? He should have seen this before you were sent here." So he said to me, "Look I cannot do anything for you tonight, but please report down to the hospital the next morning." (That was Saturday morning.) So I went back home and I came down the Saturday morning, but with me walking down on the Friday night and the Saturday morning, which normally takes me about 5 minutes, took me 35 minutes just to reach the bus stop.

Doctor: Why was that?

Patient: Because I was so weak I could hardly move at all. So I went down, got down to [the hospital], went in and told the [nursing] sister at the reception that I would like to see somebody from the diabetic clinic. And she read the letter. Then she told me that I could not get an appointment until a fortnight. At this stage I was really very angry and I started shouting at her. As that started, a nurse came out from casualty and she read the letter. As soon as she read the letter she shouted to a nurse to get a wheelchair, she dumped me in the wheelchair, and took me straight upstairs to the diabetic clinic.

The story was of an incident decades before. But what influence may it have had on Robert's experience of diabetes? How might he have dealt with the selective deafness and blindness, and indeed the gross discourtesy which he encountered?¹¹

In a later chapter we shall look at hospice medicine, and consider tools used for the measurement of pain; suffice it to remind ourselves for now that pain and distress are modulated by many factors.

Integrative Medicine

Integrative medicine combines conventional medicine and complementary medical practice. It is characterized by an open-ness to and awareness of the interaction of mind, body and spirit, and how the relationship between these components of the whole being affect the dynamics of health and disease.

One of the foremost proponents of integrative medicine is Dr Andrew Weil, who (though formerly achieving some notoriety through his intimate knowledge of psychoactive plants) is currently Director of the Program in Integrative Medicine at the University of Arizona's College of Medicine, and named as one of the 100 most influential people in the world by Time magazine in 2005. His approach to health addresses three key concerns;

- firstly, that conventional medicine is too disease orientated and concentrates too little on health and healing
- secondly, that different medical approaches are appropriate to different conditions (hence although there is an undoubted role for emergency medicine there is also a role for complementary approaches – especially for those chronic conditions not well managed by conventional medicine, such as skin problems and functional gastrointestinal disorders)
- thirdly, that it is wise to pursue a lifestyle appropriate to maximizing health and happiness, accepting that this (lifestyle) will change with increasing age, and recognising the body's inherent capacity to heal itself.

His thinking is encapsulated in a series of immensely popular books, including *Eight weeks to Optimum Health* (1997) and *Healthy Aging* (Oct 2005).

Interest in integrative medicine extends widely, particularly in the USA. Kligler et al report on the development of a set of curriculum guidelines for medical schools in integrative medicine during 2002 and 2003, under the auspices of the Consortium of Academic Health Centers for Integrative Medicine – a group “working together to help transform health care through rigorous scientific

studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing, and the rich diversity of therapeutic systems.”¹²

Maizes et al, in an earlier paper¹³, assert that dissatisfaction with the U.S. health care system is increasing despite “impressive technologic advances”, and highlight that this dissatisfaction has led to medical schools starting to teach CAM (complementary and alternative medicine). They continue to highlight the University of Arizona’s development and implementation of a comprehensive curriculum in integrative medicine. They then define the term, and clarify the extent of the work of that medical school within the field; I quote:

“Integrative medicine is defined much more broadly than CAM. It is healing-oriented medicine that reemphasizes the relationship between patient and physician, and integrates the best of complementary and alternative medicine with the best of conventional medicine. Since its inception in 1996, the Program in Integrative Medicine (PIM) has grown to include a two-year residential fellowship that educates four fellows each year, a distance learning associate fellowship that educates 50 physicians each year, medical student and resident rotations, continuing medical and professional education, an NIH-supported research department, and an active outreach program to facilitate the international development of integrative medicine.”

Integrative medicine incorporates elements of conventional and complementary approaches. It is worth adding that the evidence base for many complementary interventions is much more slender than for conventional medicine; despite this, Giordano et al comment that in the USA the best predictor of use of CAM is higher level of education¹⁴. There is nonetheless obvious concern that the research base for CAM should be strengthened; Giordano reports that “The National Center for Complementary and Alternative Medicine of the National Institutes of Health has declared their top strategic priority to be investing in research” – this seems particularly important in light of the fact that over 70 American medical schools are offering courses in CAM. Of course, some CAM therapies are much more difficult to objectively assess for efficacy, and indeed the whole concept of integrative medicine places a higher premium on health as assessed in a wholistic way by the patient; nonetheless there is evident concern that conventional doctors will be much less inclined to embrace an integrated approach without adequate evidence base to support the change.

But it does appear that the concept of integrative medicine is surfing a wave of popularity; there is no desire to throw out the great advances of conventional medicine, but significant desire to integrate them with what is perceived as a more subtle approach to healing particularly appropriate to chronic disease and natural aging, and with a new emphasis on a positive and healthy relationship between patient and physician.

Conclusions

The overall message is that the art of medicine needs to be revived – not in a paternalistic way, but through sharing more fully in the patients’ experiences of illness and facilitating patients’ own choices as to what to do next. This is the common thread that runs through all these different approaches covered in this chapter. There is a challenge being thrown out to us. The question is; can we find the way to change the way we practice within the constraints under which we work?

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