Jeremy Swayne
Remodelling Medicine

Leseprobe
[Remodelling Medicine](http://www.narayana-verlag.de/b16219)
von [Jeremy Swayne](http://www.narayana-verlag.de)
Herausgeber: Saltire Books

http://www.narayana-verlag.de/b16219
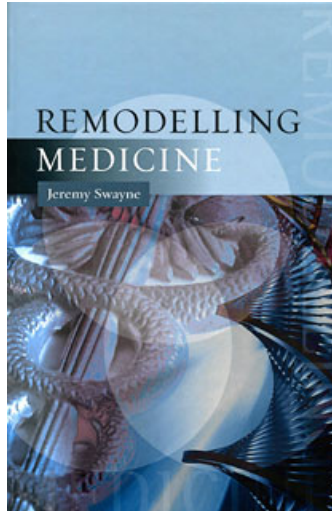
Im [Narayana Webshop](http://www.narayana-verlag.de) finden Sie alle deutschen und englischen Bücher zu Homöopathie, Alternativmedizin und gesunder Lebensweise.

9

MEDICINE IN CRISIS?

Summary

- Medicine as a health care system and as a healing vocation has reached a crisis point – a turning point, a time of decision, possibly of danger.
- The elements of the crisis include – a crisis of cost and resources, the increasing dangers of medical practice, the failure of mechanistic care to promote well-being, the loss of vocational commitment, a crisis of morale, and a crisis of morality.
- Medicine colludes in its own devaluation.
- But the crisis can be a turning point, an opportunity, if the medical professions are prepared to grasp it.

> Something has gone wrong with healthcare. Doctors tell us medicine is in crisis while nurses say they are in despair. Despite the commitment of health professionals, the good intentions of politicians and administrators and unmistakable support of the public, we face a crisis of caring, a crisis of costs and crisis of commitment. (College of Medicine Policy Document[1])

I begin this book with the words, "There is something wrong with the way we do medicine in the modern Western world". This is quite a mild statement set beside the assertion of some commentators, including some doctors, that medicine is in crisis. The NHS 60th birthday headlines quoted in Chapter 4 certainly suggest it. Crisis is a strong word, sometimes taken to mean a point of actual or impending disaster. That is probably not the case. But I have to agree that this harsher criticism is certainly true if we take crisis to mean, as it does, a turning point, a time of decision, possibly of danger. This is true of medicine in two senses: medicine as a healthcare system is in crisis, and medicine as a healing vocation is in crisis. The two kinds of crisis are of course related. The elements of both crises are already evident in earlier chapters and further evidence will emerge in later chapters. At this mid-point, here is a summary of these elements (see Box 9.1). You will recognise in some of them echoes of the predictions of Ivan Illich in *Medical Nemesis*.

BOX 9.1 *Elements of crisis*

- Cost and resources.
- Adverse effects.
- Loss of vocation.
- Loss of morale.
- Moral malaise.
- The devaluation of medicine.

A crisis of cost and resources.

The success of modern medicine, its ability to do so much, has turned into what David Peters, in an article addressing these issues calls, "a technological arms race against disease".[2] The costs of its weaponry have spiralled out of control, but magic bullets still have to be found and magic machines to elucidate our ills with ever greater precision have to be built. And everyone insists they have a right to them; both the patients who need, or believe they need them, and the doctors who need, or believe they need to use them. Clinical judgement, practical wisdom, watchful waiting, are seldom an acceptable management strategy now.

These facts recall that Engel's remark, "The enormous existing and planned investment in diagnostic and therapeutic technology alone strongly favours approaches to clinical study and care of patients that emphasise the impersonal and the mechanical". This is an observation that still rings true. This is that part of the crisis in medicine that he alleges, "derives from – the adherence to a model of disease no longer adequate for the scientific tasks of medicine".[3] It is one end of the spectrum of costly demand, rightly or wrongly perceived as medical need. At the other end are the escalating needs of chronic illness in an ageing population. Modern health care had become unaffordable before the financial crisis of 2008. That crisis has only shown up the cost crisis in medicine in high relief.

An exercise in the *British Medical Journal* to identify potential cost savings in the NHS in the light of the financial crisis is revealing. 'Experts' guide to saving money in health'[4] asked leading representatives of a dozen different medical disciplines to recommend ways of saving money in their field. It not only showed that the effect of the crisis, like the prospect of execution, does concentrate the mind, in this case to good effect in agreeing that something could be done. It also highlighted certain recurring themes. The

commonest was the overuse of diagnostic tests and investigations; usually as an unnecessary routine that added little or nothing to the management of the problem where clinical knowledge and acumen should suffice; sometimes multiplying costs because tests are ordered in batches that include several that are not relevant to the solution of the problem, sometimes inducing a further 'cascade' of tests to elucidate some vague apparent abnormality in the first test. Another theme was the use of procedures of little or no real therapeutic benefit, or procedures for which better alternatives exist. Another was better integration or delegation of services, sometimes to avoid unnecessary, prolonged, harmful or costly hospital admissions.

Running through these examples is the common thread that has already emerged – the tendency to do things because they can be done and that come to be expected, rather than because they should be done. But one other common theme was the need to 'invest to disinvest' by developing or implementing procedures or processes that could avoid or replace those

Figure 9.1 *The commonest theme was the overuse of diagnostic tests.*

that might be done away with. So the wasteful use of one sophisticated technique can sometimes be avoided by the introduction of another, possibly more sophisticated technique. It is a matter of the discerning and discriminating use of science and technology.

Modern medicine is increasingly dangerous.

Before the germ theory of disease was properly understood, before aseptic techniques were introduced and then antibiotics invented, most serious infections were lethal. And medical interventions often caused or transmitted those lethal infections. Most medical procedures, such as bloodletting, and surgical techniques often did more harm than good. Progress in medical science overcame these problems.

But now medicine has become more dangerous again. 'The risks of being a patient' in Chapter 8 discusses this. Surgery continues to get safer, but illness and death from the adverse effects of drugs is notoriously common. Hospital acquired infections cause unnecessary illness and claim lives. Numbers of hospital beds have been falling for some years, but rates of hospital admission are currently (2010) increasing by 6% a year. This means a rapid turnover in bed occupancy, which increases the risk of infection. *But* – one reason for the increase in hospital admissions is the reduced quality and accessibility of out of hours cover in primary care. *While* – the European working hours directive undermines comprehensive hospital staffing and jeopardises adequate training opportunities for hospital doctors.

Medicine is fraught with risk. Its direct risks are obvious, the adverse effects of drugs and technology, for example. Its indirect risks are sometimes obvious too, for example hospital acquired infection. But some indirect risks are not at all obvious. They include every biomedical diagnosis that misconstrues the more complex dynamics of illness and misdirects the therapeutic effort (see Alan Barbour's list of misconceptions and false starts in Chapter 7), and every medico-political manipulation of clinical practice (regulations, targets and guidelines for example) that subverts the wisdom and judgement of individual doctors on behalf of individual patients.

Mechanistic health care undermines well-being

This danger is such a recurring theme in the book that it hardly needs restating. The mechanistic vision of biomedicine seeks the control of disease but neglects the well-being of the person. It distracts attention from the 'story of sickness', that more holistic perspective which is necessary to make sense of the illness and enhance the well-being of the patient (see 'Health, well-being and quality of life', Chapter 12).

Medicine is losing its vocational commitment

The constraints and directives of biomedical priorities on the one hand, and social and political priorities on the other, are undermining the vocational satisfaction and commitment of health professionals. The mismatch of demand with resources, and of expectations with what is possible causes the frustration and unhappiness described by Moynihan and Smith[5] in Chapter 4, and the ebbing away of the vocational passion to do the job well described by James le Fanu.[6] Compassion is repeatedly acknowledged to be lacking in health care, not simply because people are incapable of it, but because often the system does not allow for it. If the motivation to become a health care professional is, at least in part, a desire to *care* for people, this lack of opportunity is frustrating and demoralising. And if the opportunity for compassionate care is denied, we should not be surprised if the well-spring of compassion sometimes runs dry.

A crisis of morale

> There is now a crisis of morale in the medical profession (that) has largely materialised since 1984 (when) medicine was the most popular career for bright school leavers and general practice was the number one career choice for British doctors. Something terrible has happened since then. Nobody wants to go into general practice any more and all the established doctors can't wait to get out. Everybody says the same thing – there is too much paperwork, we have lost our independence, and the pressures get more and more unbearable. We seem to have been taken over by the same alien culture that is spreading through the rest of modern society. (James Willis[7])

These words were written by James Willis, a GP for some 30 years at the time of their first publication in 1995, in a book called *The Paradox of Progress*. He and I were members of the same group of enthusiastic young

entrants to general practice in the late 1960s who were beneficiaries of the pioneering vocational training scheme that I described in Chapter 1. In fact the displacement of education by training (which is "the sort of process you use to prepare a performing animal"), is one of the demoralising features of modern medicine for James. But the programme we joined really was a vocational *education*, opening our hearts and minds to the challenges and riches of the sort of personal patient care that had attracted us to medicine in the first place. The paradox of progress for James and for very many doctors has been "the problem of retaining respect for human values in an increasingly systematised world". His two entertaining and deeply thought provoking books *The Paradox of Progress* and *Friends in Low Places* develop this theme.[6,8]

Broadly speaking there are three strands to his argument that are also central to my own. One is that for all our desire for technical mastery of disease processes it is the complexity and mystery of the individual human experience of illness that is at the heart of medicine's healing vocation ("These human things are really the things that matter *most* in the end"); our capacity to *understand* this and respond to it effectively is being eroded in the systematised biotechnical world of modern medicine. That is demoralising.

The second strand is the entanglement of medicine with the culture of our society and medicine's collusion with its dehumanising tendencies. ("Technical hubris has brought with it nemesis for the personal aspects of life.") That is demoralising, although perhaps more insidiously so.

The third strand, which underpins the other two is that "our present course is based on a wrong paradigm, an out-dated understanding of the way in which reality operates". James describes this way of thinking in terms borrowed from Guy Claxton as the 'over-mind',[9] a dominant managerial modus operandi in which rules and regulations stifle the wisdom and insight of conscientious, resourceful, free individuals, and human complexity is subordinate to statistical norms. The over-mind is afflicted with paradigm paralysis, the McNamara fallacy (described in the next chapter), and scientific tunnel vision. For any doctor motivated at all by a healing vocation all this is deeply demoralising.

A subtle but profoundly important element of this disturbing situation that James Willis brings out in both his books is the debilitating effect of regulation on the mind. Rules, targets and protocols are designed to improve efficiency, and they can give the impression that the practitioner knows what he or she is doing. But the impression that this knowledge represents a true *understanding* of what is going on may be an illusion. The level of regulation currently imposed upon medicine devalues, displaces

Figure 9.2 A crisis of morale.

and even de-skills the immensely versatile human mind. It deprives doctors of the creativity of mind that is so essential to solving *human* problems, as opposed to analysing technical ones. This 'cognitive fluidity' is the distinctive attribute of the human mind. Its application, its use in solving complexity, is what the mind is for. It is a doctor's most useful tool. The level of regulation to which it is now subjected is alien to it, and deeply demoralising.

For example, from *The Paradox of Progress*: "The idea that regulation is a good thing *per se* is an illusion. Regulation destroys humanity. It undervalues the individual human being, his mind, his motivation and his integrity. Unfortunately GPs have to some extent colluded in the process of reducing their practice to a lot of sterile formulae. They have done this because they have shared in the illusion that this is what is necessary for progress". And from *Friends in Low Places*: "Rule following is absolute. It is blind, and it produces terrible, empty certainty. Actions based on rule-following may be *indistinguishable* from actions based on understanding. But in fact they come from entirely different places. . . . We now live in a world in which it is increasingly being assumed that the application of formulae trumps the application of understanding. . . . All you have to do is in order to do medicine is to *follow the instructions*. Paint in the numbers, join up the dots, look up the rule, surf the net, print out the answer."

chastening but at the same time inspiring book that all health care professionals, and certainly doctors, should read. It is chastening in that it sheds a harsh light on our lapses of moral responsibility, but inspiring in that it affirms the 'virtues' that lie, or should lie at the heart of our vocation and our professional role. In that second quotation they get right to the heart of the matter – our responsibility to a person in need within 'a special kind of human relationship', a very special and highly privileged relationship. Our responsibility is to do what is right and good for that person in seeking to achieve those 'ends and purposes of medical activity', which Pellegrino and Thomasma later define as "the restoration or improvement of health and, more proximately, to heal, that is to cure illness and disease, or when this is not possible to care for and help the patient to live with residual pain, discomfort or disability". We must be faithful in doing what we are trusted to do, "that is, to serve the healing purposes for which the patient has given their trust in the first place".

This is by no means an easy task. In fact it can be very difficult. It requires a substantial measure of what they call phronesis – a concept introduced by Aristotle meaning practical wisdom, moral insight, the capacity to discern what moral choice or course of action is most conducive to the good. Phronesis is the capability to consider the mode of action in order to deliver change, especially to enhance the quality of life.[12] These qualities are hard to come by. And they are not the automatic fruits of a medical education, even though they are traits of character whose formation is every bit as important as the technical education that a student certainly will receive. The responsibility to be faithful to the individual patient is made an even harder task by a health care culture in which this relationship of trust has been in many instances displaced by a contractual relationship threatened by litigation, by a policy or market driven relationship, or by a relationship in which the health care professional has become the technical servant of the patient's autonomy. True discernment of what moral choice or course of action is conducive to the good may be seriously compromised by social and cultural constraints such as these, however well-endowed with practical wisdom and moral insight we may be.

This is the crux of our moral responsibility towards our individual patient and the society we serve. Pellegrino and Thomasma are uncompromising about it: "If doctors, as a healing community really want to recapture a sense of moral integrity, the most important thing they can do is to resist and refuse to do anything that violates the promise to act in the patient's interests. . . . Were physicians to take moral leadership, the medical profession could be a model and an inspiration for others." This means we *will not* "reshape our ethical codes to conform to the ethos of

the market place" or any other social or cultural influence that is demeaning to the special kind of human relationship with which we are entrusted; that we *will* "stand firm in the belief that being a physician imposes specific obligations that forbid turning oneself into an entrepreneur, a businessman, or an agent of fiscal, social, or economic policy"; or adopt any role or attitude that is less than completely faithful to the ends and purposes of our vocation.

Aspects of this moral responsibility have been implied in much that has already been said in previous chapters, and the theme will recur in later chapters too; particularly with regard to the quality of the therapeutic relationship (Chapters 12 and 15), to truthfulness in medical science (Chapters 10, 11 and 18), and with regard to the relationship between medicine, society and culture (Chapter 17). Here are some of the attributes that Pellegrino and Thomasma commend as virtues in medical practice:

- *Phronesis* – which they also describe as practical intelligence that summates the virtues and applies them to particular situations. It provides the link between the intellectual virtues – those that dispose to truth (as represented by art, science, intuitive and theoretical wisdom), and those that dispose to good character (e.g. temperance, courage, justice, generosity).
- *Prudence* – the indispensable connection between cognition of the good and the disposition to seek it in particular acts.
- *Trust* – The central importance of trust has already been emphasised in Chapter 8, and the 'ingredients' of trust are described in Chapter 15 ('The heart of the matter').
- *Justice* – the strict habit of rendering to others what is due to them. This is not always compatible with autonomy.
- *Fortitude* – the tenacity to obtain the required treatment for a patient; resistance to any pressure or temptation that will diminish the good of the patient.
- *Temperance* – self-control, discretion; the responsible use of power on behalf of patients.
- *Compassion* – the ability to feel something of the unique predicament of the patient.
- *Integrity* – a close correspondence between the integrity of the practitioner and the integrity that we are seeking to restore in our patient; between the person of integrity and the integrity of the person. The completeness, wholeness and unity we seek to restore in our patient must be reflected in ourselves and in the integrity of our values.

But these are uncontroversial moral attitudes that are quite easy to discuss in the abstract and sign up to. A more immediately affecting and shaming example of a moral failing at the practising heart of UK medicine is revealed by hospital doctor Max Pemberton, writing in the *Daily Telegraph* about his experience participating in *The Jeremy Kyle Show* on television.[13] He describes his deeply chastening realisation of the demeaning attitude of some (many?) doctors to the 'underclass' who are the show's usual guests – as he suggests the middle class 'voyeurs' of the programme are likely to regard them (gaining 'A Hogarthian glimpse into their excesses and debauched lives'). "They don't have time for the likes of me", one guest explained when he asked why she had not been to her doctor for help. "For people who are disempowered and disfranchised like her (those living on sink estates, unemployed and uneducated), doctors are distant, fearsome creatures who don't listen and don't help. They dismiss her and the problems she faces, despite the fact that she is in far greater need than the middle classes who clutter up surgery waiting rooms. . . . For those who feel marginalised and ignored by the medical profession, Jeremy Kyle (and his faultless aftercare service) is a saviour." If it is fair to generalise this insight across our society, then the crisis of morality in medicine has a personal aspect that requires a *metanoia* (change of heart and mind) of us all.

Resolving the crisis

We cannot deny the crisis described in this chapter. But this is not a point of impending disaster; it is a point of decision, a turning point, an opportunity. The momentum for change described in Chapter 3 is sufficient to exploit that opportunity. It is this book's acknowledged ambition that the analysis of the crisis and the arguments and recommendations for 'regime change' (Part 5) presented here will add to that momentum. The energy, resources and vision necessary for this evolution, this metamorphosis and remodelling, are the inherent properties of the healthcare professions – if we have the courage and determination, and the humility to realise them.

References

1 College of Medicine Policy Document 2010. Available from the College of Medicine. 19 Buckingham Street, London WC2N 6EF and online at www. collegeofmedicine.org.uk
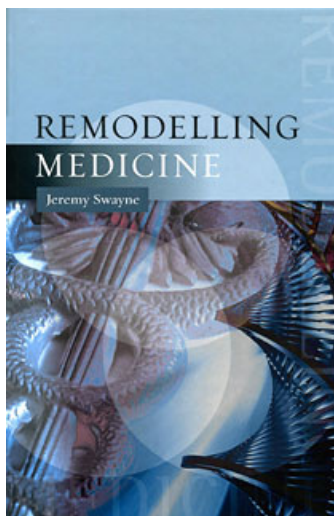
Jeremy Swayne
[Remodelling Medicine](#)

512 Seiten, geb.
erschienen 2012

Mehr Bücher zu Homöopathie, Alternativmedizin und gesunder
Lebensweise www.narayana-verlag.de