A Better Grounding for Person-Centered Medicine?

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There is nothing like medicine to attract reformers. Their arguments include claims that orthodox medicine produces iatrogenic harm, it is too expensive, it is arrogantly exclusive of other systems of practice, its practitioners lack empathy and communication skills, and its practitioners are wilfully ignorant of their patients’ beliefs and needs. Entwistle and Watt (2013) have done a good job of gathering together the suggested modes of reform from the last 50 years or so. They might well have gone back to Peabody (1927) and Osler (1948), and beyond to Colles (1881) and even to the Salerno school of the 11th century, because there is a long history of people and movements that have sought to make medicine more humanistic, more considerate, better behaved. There is an equally long history of criticism of the medical profession for its materialism, cynicism, and capacity for self-serving. All such criticisms deserve careful attention, and the profession’s modern response has been to introduce processes that can be seen to deal with specific shortcomings. Yet the reform movements still proliferate—humane medicine, patient-centered care, narrative-based medicine, empathic care, mindful practice, values-based medicine, and most recently—and perhaps significantly—person-centered medicine (Ekman et al. 2012; Henry, Zaner, and Dittus 2007; Miles and Mezzich 2011a; Miles and Mezzich 2011b). The latter has become an umbrella term for Entwistle and Watt to cover all the qualitative reform movements that remain alive, if not flourishing. In doing this, they do us a service by reminding us of the common ground that these movements share. It should also remind us—although the article avoids dwelling on the matter—that all the current schemes are offered as alternatives to the immense influence of evidence-based medicine (EBM).

To explicit critiques of EBM there seems to be no end (Grossman 2008; Harari 2001; La Caze 2008; Lipworth, Carter, and Kerridge 2008; Lipworth, Little, and Kerridge 2011; Miles and Loughlin 2011; Raman 2011; Timmermans and Angell 2001; Timmermans and Kolker 2004; Tonelli 2006; Worrall 2002). Volumes have been written about its epistemological, ontological, social, hermeneutic, and interpersonal shortcomings, and the harm it produces. There is only an embryonic form of public health ethics, yet public health is a paradigm of EBM. It gathers data en masse, and draws statistically based conclusions, but is only now stopping to consider the ethical implications of its impact on social practices and perceptions of health and the duties and rights involved in political definitions of healthy living and the parameters of the healthy person. Yet EBM flourishes and retains its following, even among those who can see its limitations. Entwistle and Watt offer a new and engaging insight to the values that underpin the critiques of EBM, but I am doubtful that their
tightly argued abstractions will capture the hearts, minds, and imaginations of those who matter in this conflict of discourses, the members of the medical professions. Sociologists and perhaps philosophers of medicine seem far more likely to adopt its precepts—but that will not necessarily change medical practice.

What Entwistle and Watt are doing is initiating a new subdiscourse to the medical reform discourse (Fairclough 1992; Gee 1999; Little, Jordens, and Sayers 2003; Swales 1990). They are introducing special terms to capture their ideas, terms such as “person-al” and “capabilities,” the latter drawn from the discourse formulated by Amartya Sen (1993) and Martha Nussbaum. They ask us to situate persons in their social context, to consider their autonomy as relational autonomy, and above all to consider their human capabilities and their person-al capabilities. I really hope that they can manage to attract support, because I agree with their arguments and their conclusions. To achieve a profession populated (almost) entirely by those who can respect the social context of every patient, can be aware of capability theory, and engage with the real preferences of patients would be marvellous. Medicine would indeed flourish, as long as it retained its technical abilities to treat effectively, and its research capacities that sought to bring better and safer treatments to bear on suffering people.

There are several impediments to such an achievement, none of them saying that we should not try to attain the goals that Entwistle and Watt suggest. First, there is the imperfection of human nature; second, the question of public trust in doctors; third, the knowledge of medical virtues already possessed by doctors; fourth, the uncertainty that the professionals have about the reality of the discourse of reform; and fifth, the implacability of the system within which health care must be delivered.

Most doctors try hard to relate to their patients. Some do it well, because they are natural communicators. Others do it badly, but can be taught techniques for showing empathy. Still others have no talent for relation and communication, whatever they are taught as students or as graduates. The same can be said of lawyers, priests, and shopkeepers. People are as they are, and changing their natures poses just as many moral problems as paternalism in doctor–patient relationships. Medical schools increasingly try to select people with approved motives to do medicine, and demonstrable communication skills and capacities for moral reasoning. Perhaps this will make a difference in the long term, but the neophyte from the medical school will need to cope with and resist at least some aspects of the enculturation that happens when people enter the established systems of hospital and office practice.

The second problem is with trust. Curiously, it does not seem to be distrust that we must deal with, but the high level of trust that patients repose in doctors (Hardie and Critchley 2008; Jenkinson et al. 2002; Lipworth et al. 2009). They trust them (with notable exceptions) to tell the truth, and they trust them to be moral in their research and practice. Why would this be so if doctors are communicating so badly, showing so little empathy, and so little concern for the social context of their patients? This phenomenon needs explaining, and incorporating into any theory of medical reform. It would be terrible to lose sight of something so central to the delivery of health care. It needs explanation and it needs explicit measures to preserve it.

The third issue is that of knowledge. The Aristotelean and Platonic view that knowledge of the good makes it impossible to do what is bad has been extraordinarily persistent. Educating doctors is seen
to be the best way to give them grounds for virtuous behavior. But our own research suggests that doctors have a very good knowledge of a particular form of virtue ethics that emphasises phronesis expressed as relevant beneficent action according to person and context (Little et al. 2011). Increased knowledge alone does not seem to guarantee any profound change in the perceived shortcomings of doctors.

It is against this background, then, that reform movements must operate—against entrenched human nature, against a high level of trust invested by the public, and against an already sophisticated understanding of medical virtues. Thus, medical professionals view with some skepticism the attempts at qualitative reform, and this is the fourth problem for qualitative reform. To shift the nature of a discourse, the target audience has to perceive that there is a real issue at stake (Little 2012). EBM provides a good example. When it was first proposed, it was immediately clear that the majority of medical interventions were supported by evidence of the weakest kind. The move toward higher level evidence through clinical trials and meta-analyses seemed therefore to bring something that was much needed to medicine. It promised to provide the hard evidence for advice and actions that was missing from the more traditional practice of conventional medicine. While EBM has lost a good deal of its almost transcendental status under severe critiques, it remains viable because numerical evidence is seen as a “real” part of good medical judgement and practice.

Fifth and finally, medical reform has to consider the system in which health care is delivered. Patients trust doctors and scientists, but not the system in which they work (Morrell et al. 2011). Doctors have clear ideas about medical virtues, but express resentment of the bureaucracy that constrains their abilities to deliver services. No one seems to question that the complexity of modern health services demands a complex administration, but the majority of people (doctors, nurses, other health care workers, patients, and their families) distrust and dislike the way in which the system depersonalises them, makes them wait, and makes them feel devalued and vulnerable.

Entwistle and Watt sketch a fine system that would encourage respect, mutual acceptance of social backgrounds, good practice, and a particular attention to “person-al capabilities” in health practice. They have been meticulous in defining the terms they use, and they point in the direction they would like their discourse to move. Their article is written with a persuasive modesty that is very appealing. But their discourse, like every other within the qualitative reform movement, faces at least the five problems just outlined. Their preliminary work certainly deserves to be seen as addressing a “real” problem, and it deserves to be included within the rubric of person-centered medicine. I very much hope that their further work and their persistence of belief will carry them over the five hurdles identified here, and over the many others that I have no doubt missed.

References


