# Successes and shortcomings of the medical model

(The success and shortcomings of modern medicine (discuss the scientific and humanistic model and variations)

Medicine has developed – and continues to develop – in a way which emphasises and accentuates the disease process; it focuses on what is wrong with the organism, what isn't functioning as it should, and asks the question - how can we put it right? It does so in a variety of ways; some have been spectacularly successful and others less so. In this chapter we seek to recognise and acknowledge both successes and failures, and consider the reasons for them.

Fundamental to a logical approach to curing disease is the understanding of what has gone wrong and why. Hence as medical students we are introduced to anatomy, physiology and pathology at the very earliest stages; once we have an initial grasp in those areas we are equipped to understand something of pharmacology – how external agents interact with the body at various levels to counter pathological processes, to normalise function, to limit disease progression. And this approach is accepted and recognised within the medical world as a whole. Indeed, many who practise complementary or alternative medicine will steer a patient toward the conventionally trained doctor in order to clarify diagnosis as much as possible. Moreover we are all interested in the lifestyle of the patient, recognising that much disease relates to environment, and the consequence of habits (such as diet and exercise).

It is perhaps at this point well to revise in our minds the course of the development of what we might call modern medicine, for it is as we remember that we can see where the failures have crept into the excitement of continually new discoveries.

So; prior to 1800 there was a therapeutic community folklore, largely based around herbal preparations and supported not by an evidence base but by an accumulated common experience.

For many there was also a belief that certain maladies had more to do with the spiritual realm than the physical, particularly in more primitive environments – and of course this persists in areas where folk religion continues to play a substantial part in peoples' lives.

Elsewhere, though such beliefs may have not expressed themselves, there was certainly a much greater acceptance on the part of physicians of the importance of dealing with the patient as a whole person – one might say because there was little alternative; one might equally say that there is a wisdom here which we are really only just re-discovering.

However, against this backdrop of what we might consider a primitive approach, there was a substantial knowledge of gross anatomy based upon studies and dissections over centuries – witness, for example, the anatomical drawings of Leonardo da Vinci (1452-1519), who admitted to having dissected 30 cadavers.

Moreover through the 18th and early 19th century considerable advances were made in microscope design, leading to an increasing awareness of microscopic structure as well. The great early physiologist Johannes Muller, for example, published his Manual of Human Physiology in 1830, and his student Rudolf Virchow's outstanding achievement was his conception of the cell as the centre of all pathological changes. Virchow's work Die Cellularpathologie, published in 1858, gave the deathblow to the view that disease is due to an imbalance of the four humours. Meanwhile in France Claude Bernard proposed the concept of the internal environment – the chemical balance in and around the cells – and the importance of its stability, and emphasized the importance of experiment in advancing understanding of physiology. In 1865 he published his Introduction à l'étude de la médecine expérimentale (An Introduction to the Study of Experimental Medicine) a substantial prelude to his planned magnum opus, which was however never written.

But these are a few among many, many notable and famous scientist physicians of the time; the point is that a scientific basis was being securely laid at this time.

Substantially in parallel with these advances was the seminal work of Louis Pasteur (1822-1895) in the field of microbiology. He not only established the causative link between micro-organisms and fermentation and disease, but was also the first to use vaccines for rabies, anthrax and chicken cholera; and of course he developed the technique we still call pasteurization. The advances in understanding which followed this early work were rapid, and the subsequent discovery of antimicrobial agents – particularly penicillin and streptomycin – paved the way for great advances in treating infectious diseases. Although the frequently inappropriate use of antibiotics has now led to the widespread problem of antibiotic resistance, nonetheless the untold good that has come from immunization programmes, the ability to treat infections and advances in environmental health is evident. We have to remember that in 1901, for instance, in the United Kingdom the average expectation of life at birth was 48 years for males and 51.6 years for females. By the 1980s life expectancy had reached 71.4 years for males and 77.2 years for females. Other industrialized nations showed similar dramatic increases.

And by the early part of the 20th century the scientific community – through advances in communication – were more able to work collaboratively as opposed to being in isolation one from another; this was a fact of enormous significance in progressing research and understanding.

The early part of the twentieth century saw changes in medical education, too.

Although the medical profession in the UK has been regulated by the General Medical Council since 1858, the learning process was weighted toward apprenticeship until this time, when the necessity of a rigorous scientific education was more recognized.

In the United States we see the same pattern; the Carnegie Foundation for the Advancement of Teaching, for example, published in 1910 a report by the educator Abraham Flexner. In the report, which had an immediate impact, Flexner pointed out that medical training should truly be an education rather than a "mysterious process of professional initiation or apprenticeship". As such, it needs an academic staff, working full-time in departments, people whose whole responsibility is to their professed subject and to the students studying it. Medical education, the report further stated, needs laboratories, libraries, teaching rooms, and ready access to a large hospital, the

administration of which should reflect the presence and influence of the academic staff – in other words, a teaching hospital which instills into students the science of medicine and not just the art.

Over the course of time these advances naturally affected medical practice, which had perhaps relied formerly on the art of instilling confidence (not always with good reason) and promoting trust in a paternalistic doctor who affected to know more than his patient. Not that we have escaped that mind set entirely!

Particularly after WW2 more precise diagnostic tests and more effective therapies were made possible by refinements in the understanding of biochemistry and physiology, opening the way for more precise diagnostic tests and more effective therapies. Advances in diagnostic imaging have had a great effect, too.

The success of mainstream medicine in the UK led to its recognition and support by government, and after WW2 its free availability to all (and, indeed, it remains free to all save for the standard fee for prescriptions).

Perhaps it was not recognised what a brave piece of legislation the National Health Service Act of 1948, which led to this state provision, was; few could have forecast the expanse and expense of technical and therapeutic advances, and the increase in uptake of services by an aging population who defy death but not disease.

There are perhaps two main pressures faced by the NHS of today; one is the cost of providing healthcare facilities and drugs, and the other is the adequate provision of doctors, nurses and allied professionals.

The former has led inevitably to thoughts of rationing, and some form of restriction of treatments to those with a reasonable evidence base to support their use – by, for example, the institution of hospital and practice formularies and by the formation of the National Institute for Clinical Excellence.

The widespread introduction of the clinical governance agenda also places clear responsibility upon clinicians to practice in line with an evidence base, and ongoing debate about professional regulation further promotes a standardised approach to treatment of patients, as well as a concern to not only embrace but be able to demonstrate good professional and ethical practice in all areas. All of which is, of course, very creditable, if perhaps somewhat restrictive of individual freedom, perhaps even flair.

Let me summarise what we have covered thus far.

Medicine has negotiated a transition over the centuries from being an art frankly devoid of much science to being a science indeed, with a focus on researched evidence for efficacy.

Following an evidence base is of crucial importance in individual practice, and every doctor is aware of the need to know that evidence base in his or her particular area of practice.

Parallel with this are two “flies in the ointment” of modern medicine – the cost of increasing demands made upon it by an aging population with escalating expectations, and the short time available for consultation with the doctor – something which has at least in part precipitated a dissatisfaction on the part of many and an increasing interest in complementary and alternative medicine. Perhaps for the sake of completeness it is worth also acknowledging a widespread anxiety regarding the toxicity of newly introduced drugs, something which not infrequently manifests itself after a decade or so of use (witness, for example, the current concerns over mandibular necrosis as a side effect of bisphosphonates).

Having substantially affirmed the progress of medicine, let us now examine its shortfalls in greater detail.

We note above that early medical practice was an art devoid of much science.

But many consider that the pendulum has swung too far; that medicine now has too few within its ranks who recognise the need for the art – and by “art” I mean a set of skills and competencies which enable relationship and trust to be built up between patient and practitioner to the true benefit of both. They see all too clearly the shortcomings in a reductionist model focussing on the physical – perhaps more clearly than do doctors.

So interest has instead been focussed on that inter-relationship between physical, emotional, spiritual and social well-being; and this is the nub of our interest. To care for the whole person is essential if we are to be truly “caring”. And people want to be cared for! This is a theme which we shall develop in this book. For now, let it suffice to state that dysharmony in one of these areas – physical, emotional, spiritual or social – can have a substantial modulating effect on symptomatology within the other areas – a far greater effect, indeed, than is generally accepted.

The question is: how can we marry true whole person care with good, scientific evidence based medicine?

It is not a question of providing disjointed care for one area, or two, but rather acknowledging and treating the dis-ease of the whole.

If there is an interplay between these four areas, many will argue that there needs to be a co-ordinated input which acknowledges and explores all of them, as appropriate (and sometimes, for simple acute problems, it is not appropriate; a diagnosis and appropriate treatment is all that is required).

This cry to be acknowledged and engaged with as whole people has come from many of our patients; have we heard it? *Have* we analyzed the reasons for the growth of CAM? Have we heard the words of those patients with the gift of expressing the felt lack within the conventional medical approach?

The answer is that to some extent we have; witness the interest in narrative medicine, allowing the patient the time (and perhaps courtesy) to tell their own story in their own way. That is nothing new; many of us were encouraged to do that when we trained.

Narrative medicine simply re-emphasises the importance of listening and prioritises it against our desire to hone in on what *we* think we need to know, at least in the first instance, for there is healing in being listened to.
COMMENT Add a discussion about what others have been saying and where the shortfalls – narrative medicine, patient centred approach, CAM, salutogenesis (prevetive medicine), pallmed, spirituality in health, autonomy, narrative, complexity
**10/2/07 I don't think I can do more than this at this point without completely changing the structure of this chapter. Thoughts?**

And there have been other examples of new thinking – for example, the emphasis on patient centred approach[i], salutogenesis[ii], patient autonomy[iii] and complexity science. We shall look more closely at such new approaches in the next chapter.

But for now it is safe to say that by and large we have yet to work out how to modify our practice of medicine to accommodate what is being asked of us. It is undoubtedly happening to varying degrees here and there, and there are proponents of change; but the system as a whole has not changed to allow whole person care as defined to be the normal expectation.

Occasionally a particularly expressive patient rises from the ranks and speaks. We close this chapter with contributions from two such. They are very different; they both have much to say to us. The first is James, who writes:

"Since I was 16 I have developed various chronic conditions which have had a progressively disabling effect upon me. These began with pain in my hips, extended to my feet, hands and lower back. I also developed skin problems and fatigue associated with problems in my bowel. Most recently I have developed serious problems with my voice. I am now seriously disabled and unable to leave my house without assistance. Yet I continue to work, remain active in voluntary associations and pursue an intimate and loving marriage. So am I healthy? I'm not quite sure how I respond to this question, I find it easier to say that I'm happy and that seems to me more important than being healthy -- even if survey after survey seems to indicate that people think health is the most important component of happiness. But how have I reached this conviction?

"Perhaps the most important step has been to resist the medical establishment . . . the dominant medical culture"

Perhaps the most important step has been to resist the medical establishment. By the medical establishment I don't mean all medics but rather the dominant medical culture, in fact non medics often hold more tightly to this culture than medics. As I see it this medical establishment has a number of key beliefs:

Happiness requires health

You have a duty to seek a cure

Diagnosis by a medical professional is the most important thing.

I have repeatedly had the experience of being criticised for not seeking a cure even though most of my experience in so doing has been negative and more of a hindrance than a help. People seem to find my lack of belief in a medical cure deeply disturbing. Similarly I have found that professional diagnoses are not particularly useful, but what is crucial is developing a clear understanding of what I am experiencing. I need to find a language to describe my embodied experience. Generally this hasn't been the language of the medical establishment. And if I don't resist their interpretations I can never find my own story.

Second I have developed the conviction that my disabilities are in some way a gift. They are integral to who I am and through them I have become more in touch with my essential nature and more able to learn how to love. Whilst they might be physically disabling, spiritually they have been liberating. Even my longing for healing, which I certainly have, is part of the spiritual journey into which my disabilities have led me.

Third I have grown in awareness and acceptance. From the spiritual point of view, and it seems to me that the spiritual point of view is always the most important, despite its marginalisation by the medical establishment, the critical step is to develop an awareness of what I'm feeling in my body and a parallel awareness of the emotions that this creates. This is absolutely the bedrock of happiness and health. From this awareness I can begin to accept my condition not in a passive way but actively working with it to empower myself and not let anger and bitterness devour me.

Life is a journey. For some people this is expressed through travel, their career or their family relations. For the person with chronic illness this journey must largely be an internal one. We must explore the bizarre and magical spaces of our embodied pain and struggle. It is a dangerous journey; depression, resentment and annihilation lurk at every step but it is also, as the spiritual masters of all ages have taught us, the only journey really worth taking. For it is this interior journey which teaches us to be truly loving and therefore fully able to relate to our fellow creatures and the whole immensity of the universe. And if chronic pain is what has initiated me into this journey should I not welcome it? I think I can do no other."

Another such patient is the late Anatole Broyard, who, on being diagnosed with carcinoma of the prostate, implores the medical profession to be both technically competent and to enter into his personal agony. The following quotations come from his book Intoxicated by my Illness. "The knowledge that you're ill is one of the momentous experiences in life", he reminds us. "I had dawdled through life up to that point, and when the doctor told me I was ill it was like an immense electric shock…all my old trivial selves fell away, and I was reduced to essence. I began to look around me with new eyes and the first thing I looked at was my doctor."[iv]

What did he *not* want his doctor to be like? "He said he wanted to examine the architecture of my bladder. I pondered the word "architecture". Was it justified, or was he being pretentious? . . . I thought, I can't die with this man. He wouldn't understand what I was saying."

He goes on to say what he was looking for in a doctor – besides competence, of course. “I would say I want one who is a close reader of illness and a good critic of medicine…I would like a doctor who is not only a talented physician but a bit of a metaphysician, too; someone who can treat body and soul.” Careful word by word analysis of this statement brings riches!

He develops the thought. “To get to my body, my doctor has to get to my character. He has to go through my soul. He doesn’t only have to go through my anus. That’s the back door to my personality.”

He goes on to say he wants a doctor who has read a little poetry as part of their training. He doesn’t want someone sterile…”I would like my doctor to understand that beneath my surface cheerfulness I feel what Ernest Becker called “the panic of creation” and the “suction of infinity.”” Someone who allows himself to feel “the alone-ness of it all.” He wants a doctor who would join him, to “wrestle with my fate together”. “To the typical physician, my illness is a routine

> “I would like my doctor to understand that beneath my surface cheerfulness I feel….the suction of infinity”

incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity.”

He wants a doctor who would be “bonded with me for a brief time, give me his whole mind just once, *brood* on my situation for perhaps five minutes.” He wants identification and engagement, and he wants to see the light of understanding and compassion in is doctor’s eyes, and an appreciation of things beyond the physical. To be precise, he says “every patient invites the doctor to combine the role of the priest, the philosopher, the poet, the lover. He expects the doctor to evaluate his entire life, like a biographer.” He goes on to speak of how answers to the patient are born from “the intersection of the patient’s needs with the doctor’s experience…” Help me, he says. “My soul is fibrillating.”

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Do we see where modern medicine so often fails? Will we see the shadow cast by such powerful light and not pretend that there are no failures? And, if we will, are we prepared to ask ourselves how we might reach out to those whose souls are fibrillating, to bring them competence and comfort, the comfort of a meeting, of an engagement sufficient to see where the ghosts are gathering for that patient?

Perhaps more challenging, will we act as agents of the perhaps profound changes needed to make such an engagement within the reach of every patient who needs it? This is the challenge we face. This is the challenge we address in these pages.

## References

[i] Little et al *BMJ* 2001;322:468

[ii] Dr. A. Antonovsky: Health, Stress and Coping (1979) published by Jossey-Bass Publishers, San Francisco.

[iii] **patient autonomy** refers to the capability and right of patients to control the course of their own medical treatment and participate in the treatment decision-making process

[iv] This and following quotes from Intoxicated by my Illness, Anatole Broyard, Ballantine Books 1993

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**Article reference**: http://www.wphtrust.com/handbook02.html "Successes and shortcomings of the Medical Model" by Dr Michael Harper, first written 10 March 2007, this version updated on January 25, 2008 , © WPH Trust

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