WHAT PEOPLE ARE SAYING ABOUT

RE-HUMANIZING MEDICINE

Modern medicine is engaged in a struggle to find its heart, soul, and spirit. This task must begin with physicians themselves. Dr. David Kopacz's *Re-Humanizing Medicine* is an excellent guide in how this urgent undertaking can unfold.
Larry Dossey, MD, author of *Reinventing Medicine* and *Healing Words;* executive editor of *Explore: The Journal of Science and Healing*

Brilliant, well-written, practical and inspiring, *Re-humanizing Medicine* provides clarity and understanding of the most pressing issues facing doctors (and patients) today. All doctors, including future doctors, should read this book and empower themselves to be the change that is so needed in our current systems of health care. As we physicians transform ourselves, we will transform the practice of medicine and be better able to serve those who seek our help.
Rama Thiruvengadam, MD, founder of Physician Heal Thyself Retreats™

Dr. David Kopacz bears exquisite witness to medical dehumanization and puts his heart and soul into a thoughtful, reflective, yet practical guide for countering its contemporary ills. This book can change lives, careers, and systems.
Stevan M. Weine, MD, author of *When History is a Nightmare* and *Testimony after Catastrophe;* director, International Center on Responses to Catastrophes, University of Illinois at Chicago.

Re-humanizing Medicine is a marvelous book about one person's journey to find meaning and quality of life in the practice of

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Foreword

(Internal dialogue of a busy academician)

'Why on earth should I read this book? I've got five articles to write, an accreditation visit to plan for, and a large new curricular element to roll out. Who has time for this? The darn thing is so long!'

'But you thought Dave Kopacz was one of the singularly most talented psychiatry residents you have ever had the pleasure of supervising! And you promised! And who knows what interesting things he has gotten himself into in the intervening years – after all, he made a gigantic trek to New Zealand just for starters!'

'Fine … fine. I'll skim it. The touchy-feely title is a little off-putting, but hey, you promised! Let's just do it and get it over with.'

Several hours later, so totally engrossed in the book that I asked my assistant to lock in reading time to my appointment schedule, I had totally changed my opinion about David Kopacz's book, entitled *Re-humanizing Medicine: A Holistic Framework for Transforming Your Self, Your Practice, and the Culture of Medicine*. It should be required reading for every medical student, resident, and practicing physician.

Medical education, and medicine itself, easily becomes a dehumanizing process. There are so many facts to be learned, so many procedures to be memorized, so many treatments to be continuously updated, just *so many*. It is easy to lose oneself in the process and fall prey to the stereotype of the physician who is always available, has all the answers, and has no personal life (or for that matter existence) outside the hospital. Physicians bemoan the limitations of the 80-hour work week as the loss of the days when 'patients came first.' Dave's book offers a compelling argument why losing oneself, however, is simply *not* in the best interest of the patient, the practice, or

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the physician himor herself.

The book divides itself neatly into five parts. The first points out the dehumanization of contemporary medicine through multiple examples, and the analysis of a variety of paradigms of medical models. The second part of the book describes the paradigm of holistic medicine more fully, while the third is a clearly written, step-by-step self-help section that helps the reader develop his or her deeper sense of humanity. The fourth part of the book builds on the third, describing how to take the new holistic viewpoint and put it to use in one's own practice. The fifth, closing the book, describes how the holistic paradigm, if used broadly, might re-humanize the culture of medicine itself.

Throughout the book, Dave uses very personal examples that put a real face on the dehumanization that trainees experience. Never bitter or accusatory, he is skilled at pointing out the system's many flaws without ever 'throwing out the baby with the bathwater' and calling for a mass revolution in an angry tone (to which the authors of many previous books have resorted when facing the massive issues in health care today, by the way). On top of the excellent personal examples, David draws on his impressive depth and breadth of knowledge in such diverse topics as psychotherapy, medical economics, health care reform, poetry, culture, holistic medicine, pharmaceutics, religion, and science to make very persuasive arguments. While the book at times may use terms unfamiliar to the physician, it becomes a 'cliff note' version of a huge body of literature that is deftly summarized and clearly written, something absolutely invaluable to the reader (and thus the large blocks of time currently in my schedule to read the book again more slowly, regardless of other obligations).

Particularly useful, and practical, for those already committed to the idea of a more holistic existence and practice, are Parts III and IV, full of exercises to transform elements of the self through a series of clearly described exercises, and thoughtful writing on using this new holistic framework as a tool for transforming one's medical practice. As the Associate Dean of an innovative medical school in the United States, I

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am strongly considering these sections (at least) to be required reading for our medical students.

It is clear that David Kopacz is a thoughtful, intelligent, well-read author with a great deal of important messages to convey. What also comes through clearly is the *person* behind the words, as generous, kind, and human as he was even in the midst of a demanding psychiatry residency several decades ago. It was this positive impression that made me promise to (and ultimately to) read this book, and I (and perhaps several forthcoming generations of medical students) will be the richer for it.

Debra Klamen, MD, MHPE
Associate Dean for Education and Curriculum
Southern Illinois University School of Medicine

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A really big thank you to all my patients and clients over the

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Dave Kopacz
Mission Bay Café
Auckland, New Zealand
November 20, 2012

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Introduction

Only connect! … Live in fragments no longer.
E.M. Forster[1]

The great error of our day in the treatment of the human body is that physicians first separate the soul from the body.
Plato[2]

Dehumanization in Contemporary Medicine

This book takes on the task of re-humanizing medicine. We start by recognizing that there is a problem with how medicine is currently practiced: it dehumanizes staff and clients, creating dissatisfaction, suffering, poor performance and medical errors. Dehumanization is an iatrogenic effect of the dominant paradigms in contemporary medicine – the economic/business model and the reductionist and materialistic approach of biomedicine. In the day-to-day practice of medicine, doctors are expected to see more patients in less time and to efficiently reduce people to symptoms, diagnostic codes, prescriptions, procedures and billing codes. This leaves little time or space for people – physician or patient.

Future doctors are attracted to medicine for idealistic and humanitarian reasons, but through training they often lose this idealism.[3,4] *How can we preserve idealism and humanitarianism in medicine?* Practicing physicians have high rates of burnout and job dissatisfaction. *How can we reinvigorate the practice of medicine and make it sustainable?*

A Counter-Curriculum of Re-Humanization

In medical school, I realized that I had to engage in a parallel education process in addition to the standard scientific curriculum. We could even call this a ‘counter-curriculum’,

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focusing on re-humanization. At times I found teachers, mentors, and fellow students who practiced this counter-curriculum, but often I had to seek it out on my own in order to balance my education. *This book is about that counter-curriculum of re-humanization.* Science and evidence-based interventions are one paradigm of medicine, but as human beings working with human beings, we must have a human framework as well as a scientific one.

As a medical student, the first research project I worked on was with Deb Klamen and Linda Grossman at the University of Illinois at Chicago. Our study examined symptoms of Posttraumatic Stress Disorder (PTSD) in relation to medical training and found that 13% of trainees in the study reported sufficient symptoms (relating to their internship year) to potentially qualify for a PTSD diagnosis.[5] The findings provide evidence supporting the need to change postgraduate medical education to reduce stress and to enhance the well-being of trainees. I went on to work with Linda and Deb on three other papers that examined medical students' beliefs and their attitudes toward the controversial issues of homosexuality, abortion, and AIDS.[6,7,8] These papers examined how medical student beliefs can shape attitudes that adversely impact medical care. The studies also allude to the fact that people are not purely rational beings, and beliefs, fears and stigma can undermine scientific reasoning or professional ethics. Even my student research experience was concerned with the counter-curriculum of exposing dehumanization and seeking re-humanization.

To re-humanize medicine, the people who work in medicine must be well-rounded, well-developed human beings, as well as safe and effective technicians. A great deal of time, energy, and money is spent in making sure that physicians are good technicians, but are they good human beings? Being a good technician (objective, detached, unaffected by emotion, protocol-driven) can actually interfere with being a good human being. Clinicians should not stop being technicians or scientists, but they have a responsibility to attend to their own humanity, as well as that of the client. The counter-curriculum

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provides a holistic framework for being a human being, for working with human beings, and for creating systems that deliver care by human beings to human beings.

A Holistic Framework for Medicine

A holistic framework is founded on multiple interacting and mutually influencing sub-systems. Scientific medicine and the objective, observable body make up just one dimension of human health. Sometimes the physical dimension is primary, for instance in physical trauma and surgery. Sometimes other human dimensions are more important. Emotion, mind, love, self-expression, intuition, spirituality, context and time all play a role in health and illness.

A holistic framework is a paradigm for understanding and interacting with human beings. It is a human systems approach and a way of being in the world. Holistic medicine is a philosophy, or a paradigm for understanding what it is to be human, to suffer, to be ill, to be healthy; what it is to change, grow and live. It helps us understand how disconnection can lead to suffering and how connection can lead to healing. Holistic medicine is not defined by using an herb instead of a medication, or by any specific technique or intervention. Being a good technician (whether biomedical or 'natural') is part of being a good physician, but being a good physician is more than just being a good technician.

It is hard work to maintain a complex identity that includes being a technician and a human being, but that is what being a medical professional involves: balancing different roles for the purpose of alleviating suffering and treating disease. Re-human-ization reconnects the art and science of medicine, the heart and the mind. A holistic framework encourages integration.

When you start to connect in a different way, you change the health care delivery system in which you work. What starts as personal dissatisfaction can become personal transformation, which changes systems. Institutions will always drift toward promoting their own interests over human interests. It is the responsibility of health professionals to ensure that they stay

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human, help their clients stay human, and ensure that health care delivery systems promote humanization rather than dehumanization.

Intended Audience and Purpose of the Book

I wrote this book for people who are looking for different ways of thinking about and practicing medicine. Dehumanization in medicine occurs throughout the world, particularly as business models replace humanitarian models of care. Many of the examples in the book are specific to the United States or New Zealand, drawing on my experience of practicing medicine in various settings in both countries; but whether dehumanization results from the profit motive of an insurance company (as in the US) or the bureaucratic processes of a national health system (as in New Zealand), the effect is the same. Re-humanizing medicine is a universal need.

This book is written specifically for clinicians, doctors, and physicians,[9] who face daily humanitarian[10] challenges in their roles, but is of interest to any health care professional or administrator. There are many fields where the application of a trained technique interferes with human connection, so teachers, trainers, educators and business people will find it relevant too. Of course, so will anyone interested in being a whole human being!

Since holistic medicine is a philosophy and a mode of being, I do not list diagnoses and alternative treatments. There are already a number of excellent books that review various complementary, alternative, and integrative medical techniques. The foundation of a holistic medical practice is you, not the services and techniques that you offer. Therefore, this is a book for people who are willing to change at a personal level in order to be better doctors and clinicians.

Contemporary medicine and holistic medicine are not inherently in conflict. My hope is that by defining holistic medicine as a paradigm, rather than as a specific technique, its benefits can be integrated with those of contemporary medicine. My primary argument is that the human elements of medicine need to be valued so that technical interventions

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occur within a human context.

Holistic Medicine, Re-humanization and the Quality Revolution in Health Care – A Convergence?

There is a worldwide trend in health care that, interestingly, overlaps with the philosophy of holistic medicine. This trend is a focus on quality, efficacy and safety, stimulated by the continual increase in the cost of health care. Experts are calling for a 'revolution in health care delivery,'[11] and 'system-wide change.'[12]

Many of the suggestions involve cost-cutting and standardization of treatment. The 'Quality Revolution' also raises issues related to re-humanization, such as putting the patient at the center of treatment, making decisions collaboratively, and establishing a 'continuous healing relationship.'[13] These are the strengths of a holistic framework – not only is it patient-centered, but it includes the concept of *healing* in addition to *treatment,* and it often encourages low-cost, low-risk lifestyle changes and preventative medicine. It may be that it is time for a Compassion Revolution and a Quality Revolution to join forces in order to make medicine more affordable, safe and effective, as well as more compassionate, caring and human.

Structure of the Book

The book is divided into five major parts. The first discusses the underlying paradigms of the biomedical and economic models of contemporary medicine and how these models have side effects of dehumanization. This critique does not mean that there is no benefit in the contemporary paradigm; rather it is an examination of the strengths and weaknesses of the underlying paradigms of the current system. The second part describes the paradigm of holistic medicine as a way of understanding the whole person. The third part is a 'self-help' section that outlines how you, as a clinician, can develop a

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more holistic and deeper sense of your own humanity. The fourth part is a ‘how-to’ component that describes how to create a holistic practice in any setting and how to re-humanize your practice. The last part describes the benefits of a holistic paradigm for re-humanizing the culture of medicine.

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Part I

PERSPECTIVES ON CONTEMPORARY MEDICINE

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Overview

How has contemporary[1] medicine come to be dehumanizing for staff and clients? We will review the history of medicine and see how it has been influenced by different conceptual and theoretical models, often with contradictory values.

In his book, *Humanizing Healthcare Reforms,* anthropologist Gerald Arbuckle describes different models of health care that inform different core value systems that lead to different priorities in reform discussions. The *traditional model* includes indigenous and pre-scientific understandings of health and illness in an environmental and spiritual context. The *foundational model* is based on the values of Western medicine: compassion, social justice and care for the sick and impoverished. The *biomedical model* is the predominant model in medicine today and is based on principles of biological reductionism, objective observation and the scientific method. The *economic rationalist model* views medicine as a commodity that must be managed through business principles in order to make a profit or control costs.[2]

A discussion of these different, and at times contradictory, models helps us to understand why contemporary medicine is practiced the way it is. The biomedical and economic rationalist models are those with the most current influence in contemporary medicine.

While the biomedical model has led to many scientific advances in treatment, it has a side effect of fragmenting our view of the whole person and leading to a technician mentality for doctors. The economic rationalist model has brought about standardization of care and focused on safety and regulation, but it has also led to de-professionalization and has de-emphasized personal human relationships in favor of provider-consumer business exchange relationships. Many doctors and health professionals feel increasingly marginalized by administrative bureaucracies and miss the values of ethics, care and compassion of the foundational model, as these values are not prominent in the biomedical and economic rationalist models of care.

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Chapter one provides an examination of how the biomedical and economic rationalist models (when not sufficiently counterbalanced by other more holistically-oriented models) lead to dehumanization in contemporary medicine.

Chapter two provides a critique of the biomedical and economic rationalist models by exploring philosophical perspectives within science; perspectives from religion, poetry and mysticism; and socio-cultural perspectives. The purpose of this critique it not to negate or eliminate the values of these models, but to simply provide a counter-balance by pointing out crucial aspects of health and illness which are not accounted for by these models.

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Chapter 1

Dehumanization in Contemporary Medicine

> The relentless urgency that characterizes most corporate cultures undermines creativity, quality, engagement, thoughtful deliberation, and, ultimately, performance.
>
> Tony Schwartz, Jean Gomes and Catherine McCarthy[1]

The first research project I worked on as a student examined symptoms of Posttraumatic Stress Disorder (PTSD) related to the internship year of medical training. I was drawn to this topic, although I did not know why at the time. In retrospect, the concerns characterizing this project have been defining my work ever since.

The PTSD symptoms experienced by medical interns could partly be explained by the occupational hazards of being a physician, such as exposure to death and illness and the sense of helplessness at not being able to prevent such suffering. However, I believe that some of physicians' distress is iatrogenic – it is caused by the system in which treatment is delivered. We cannot change the occupational hazard of exposure to intense existential situations in medicine. Existential engagement *is* the job of medicine. We can, however, change components in the system which are iatrogenic causes of dehumanization for doctors and patients alike.

Physician Dissatisfaction and Burnout

Stephen Bergman, aka Samuel Shem, dramatizes the trauma of medical training in his book, *The House of God.* He writes, 'I struggle to rest, and cannot, and I struggle to love, and I

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cannot for I am all bleached out, like a man's shirt washed too many times.'[2] He goes so far as to call medical education the 'doctor's disease.'[3] He details a list of ten rules for the House of God, such as 'the only good admission is a dead admission,' and 'the patient is the one with the disease.'[4] The cost of these cynical rules for self-preservation is that, in an attempt to save themselves, the trainees end up losing their own humanity. While *The House of God* is semi-fictional autobiography, it captures the dilemmas of dehumanization that face trainees and doctors.

Up to 60% of physicians in the US report symptoms of burnout, defined as emotional exhaustion, depersonalization (treating patients as objects) and a low sense of accomplishment.[5,6,7] High rates of burnout and stress have also been found in physicians in New Zealand,[8,9,10] Australia,[11,12] in the National Health Service in the UK[13,14] and in Canada.[15,16]

A number of recent books by physicians describe burnout and suggest ways to address it. Robin Youngson's *Time to Care: How to Love Your Patients and Your Job* focuses on how we can regain compassion and humanity.[17] Youngson is originally from the UK, but has worked in New Zealand for the past 20 years. American physician Lee Lipsenthal, in *Finding a Balance in a Medical Life,* examines the effects of stress on physicians' health, and how to counteract them.[6] Allan Peterkin, a Canadian physician, lists four major domains of burnout in his book, *Staying Human During Residency Training:* physiological, psychological and emotional, behavioral and organizational.[7] It is important to recognize that the effects of physician burnout are multidimensional, affecting both doctors and patients, and also the treatment that is given. It has been found to be related to poorer quality of care, patient dissatisfaction, increased medical errors and increased malpractice claims.[6,7,18,19]

Burnout is becoming a major concern even for health care organizations that employ physicians, as illustrated by Britt Berrett and Paul Spiegelman in their recently published book, *Patients Come Second.*[20] As they point out, in any business, 'you cannot take care of customers if you do not take care of

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employees. Healthcare is no different. We must find ways to engage … (our employees) … so that they WANT to provide great service to their patients.'[21]

The opening quote to this chapter, by Schwartz and colleagues, lists the effects of chronic time pressure in corporate environments, claiming that it *undermines creativity, quality, engagement, thoughtful deliberation, and, ultimately, performance.* We will look at what happens to the human beings working in a system when their work is affected in these ways.

Organizational effects create high levels of dissatisfaction in physicians. A 2001 Kaiser Foundation study of 2,608 US physicians showed that 58% reported decreased enthusiasm for the practice of medicine, 87% said that morale had decreased in the last five years, and 46% were dissatisfied due to lack of autonomy.[22]

Miller, Goodman and Norbeck's book, *In Their Own Words,* is based on a 2008 survey of 12,000 physicians in the US by the Physicians Foundation, and it includes both the statistical findings and many direct quotes by the doctors themselves. The purpose of the study was to 'determine whether or not how physicians think about medicine is affecting access to care and, by extension, quality of care for all patients.'[23] A few of the disturbing findings: 94% of physicians report that paperwork demands have increased in the past three years and 63% said this led to spending less time with patients; 76% said they were at 'full capacity' or were 'over-extended and overwhelmed'; 78% characterized the practice of medicine as 'less satisfying' and 'less rewarding.'[24] Similar surveys in other English-speaking countries also show concerning levels of job dissatisfaction and burnout in physicians.

Richard Fernandez, in his book, *Physicians in Transition: Doctors Who Successfully Reinvented Themselves,* interviewed 25 physicians who left clinical practice. The doctors describe levels of dissatisfaction that led to career change. For instance, in the foreword, Michelle Mudge-Riley asks how someone would feel who was unhappy in medicine after all the sacrifice and years of training. She asks, 'Would you feel trapped? Like

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you'd lost yourself somewhere along the way? Maybe that you were a failure? … That's what I felt like.'[25]

Models of Medicine

The term 'model' designates a set of underlying ideas, concepts and values that shape a particular attitude and approach. For instance, in the US, we could say that there are two primary models of politics, the Republican and the Democratic. The Republican model is founded on principles such as: the role of government is to stay out of the way of the individual, and government should not limit individual rights. In this model, 'good' government is 'small' government. The Democratic model is founded on different principles, such as: individual rights are important, but sometimes the common good of society should come before the good of the individual.

There are many other values that make up a political party, but those serve as a good introduction to how there can be two different models for the same thing which are sometimes in contradiction with each other. The fundamental assumptions of the Republican and Democratic models share some overlap, but they have significant differences. They both represent legitimate American values; however, each model focuses on different values and as a result prioritizes spending differently. An American citizen may be a proponent of one model over the other, however, the core values of each model of individual freedom and social responsibility are equally consistent with "American" values.

Contemporary medicine is also made up of different models with different beliefs and values about what 'good' medicine is and what the doctor's role should be. While medical students and doctors are taught that medicine is a unitary construct (evidence-based biomedicine), there are different legitimate models of medicine, with different values and priorities. These values shape how health care delivery systems function, how doctors conceptualize their role and responsibilities, and even shape debates about how health care should be reformed.

Anthropologist and international medical organizational consultant Gerald Arbuckle has described a number of health

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care models, four of which will be used as a framework for understanding the influences in contemporary medicine. These are the *traditional,* the *foundational,* the *biomedical* and the *economic rationalist* models. Each will be briefly discussed in the following paragraphs.

The Traditional Model

In the *traditional model,* 'mental, physical and social health are profoundly interrelated.'[26] Stretching back into ancient times, medicine was embedded in religious, spiritual, cultural and mythopoetic domains. There was a degree of what we would consider scientific medicine that had evolved through cause-and-effect observations of the use of certain plants and herbs that we know today do have bioactive and therapeutic properties. However, the traditional model did not understand the efficacy of these treatments in terms of alterations of biochemicals; rather it focused on the therapeutic element as re-balancing vital energy; harmonizing what had been disconnected (heaven, spirit, body, earth); and bringing the internal into a new relationship with the external. This was a holistic, but non-scientific era of medicine in which health was understood as balance and harmony, and illness was understood as imbalance and disconnection. Ancient Greek and Egyptian medicine grew out of this 'traditional' matrix of the interconnectedness of individuals, environment, society and religion/spirituality. Indigenous cultures around the world today are very much influenced by this 'traditional model' of understanding health and illness in relationship to unseen forces, gods and Nature.

The Foundational Model

Arbuckle describes the *foundational model* of health care as rooted in the story of the Good Samaritan and grounded in values of 'holistic health, equity, social justice, respect, compassion, hospitality, courage and dialogue.'[27] He traces the history of this model from the early Christian era to the founding of health care systems in the US, UK, Canada, New

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Zealand and Australia. Whether through the development of religiously based health care systems or national public health systems, the foundational values of compassion, the universal right to health care and the goal of alleviating suffering influenced health care institutions in the 19th and early 20th centuries. Core values of this model are that health care is a basic human right, and that individuals, institutions and societies have the responsibility to give the gift of compassion and healing to those who are suffering. This era greatly influenced our ideals of humanitarianism in medicine.

The Biomedical Model

The *biomedical model* is the primary model that doctors and health care workers are trained in today. It is founded on science and technology; however, its emphasis on objectivity and detachment is at odds with the interpersonal, social and compassionate aspects of the *foundational model.* What is gained with the *biomedical model* is the ability to intervene with technology to save lives, particularly in acute situations such as infections, accidents, birth defects and tissue and organ injury. What is lost is the holistic aspect of the traditional model: viewing the whole person in relationship to their inner and outer contexts. The *biomedical model* has limitations in treating chronic conditions (which form the bulk of primary care visits) that do not have a quick and easy technological cure. The explosion of technology has come with a financial cost and this can be seen as a primary contributor to the development of the new, economic rationalist model in the late 20th century.

The Economic Rationalist Model

Arbuckle calls the next model the *'economic rationalist model'* of health care, and describes how it has led to the 'corporatization' and 'privatization' of medicine.[28] It is concerned with the business of medicine, such as profit and loss. He rightly points out that the 'American economic rationalist model is diametrically opposed to the foundational

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model.'[29] This model can be implemented to maximize profits, as in the for-profit sector in the US; or to minimize costs, which is more common in the national health services of most other industrialized nations. The motto of the economic rationalist model is that 'medicine is a business and it should be run like any other business.'

Models of Health Care in Action

Contemporary medicine in the US is increasingly influenced by the economic rationalist and biomedical models, while many doctors and patients complain about the loss of values of the foundational model and the holistic approach of the traditional model. There are other models of medicine, but these four will help us understand why contemporary medicine is the way it is and why dehumanization, burnout and dissatisfaction are so common today. Any given organization or country will have different percentages of influence from the different models. For instance, in the for-profit sector in the US, the order of influence might be economic rationalist, biomedical and foundational. In an academic medicine setting the biomedical model might be greater or equal to the economic rationalist influence. The traditional model has little influence in the US, although if the patient population was Native American, or heavily influenced by recent immigrants, an understanding of this model would become more important. In the US, aspects of the traditional model do appear through an interest in 'natural' medicine and traditional medicine systems, such as Traditional Chinese Medicine. Perhaps the spirit of traditional medicine is reappearing in the growing interest of both doctors and patients in alternative, complementary, integrative and holistic medicine.

When I started a holistic private practice, I did so because I felt I could not practice 'good' medicine within existing work settings because of the overwhelming influence of the economic rationalist and biomedical models. I created a new health care delivery system that was much more balanced regarding holistic (with elements of the traditional), foundational, biomedical and economic rationalist models of

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medicine.

Another example, contemporary medicine in New Zealand, contains all four of Arbuckle's models. The traditional model is emphasized in regard to Maori health and has some influence even in mainstream services. Many doctors still subscribe to the values of the foundational model. The biomedical model has a strong place in practice. The economic rationalist model comes into effect with government-led planning through the Ministry of Health and through the national pharmaceutical formulary (Pharmac). Different services within New Zealand have a different balance of the models, particularly if they are cultural services for Maori or Pacific Islanders.

Countries that have national health systems, like Canada, the UK, Australia and others, may have a similar balance to for-profit health care organizations in the US; however, rather than maximizing profits, the economic rationalist model's influence may be more focused on containing costs. The creation of national health services was largely an influence of the foundational model; however in recent years, with the global increases in health care costs, economic rationalist models have begun to have increasing influence in regard to allocation of resources and cost containment.

We will now examine in more depth the dehumanizing side effects of the biomedical and economic rationalist models in contemporary medicine.

Contemporary Medicine

> The great gain … (of the adoption of laboratory science as the primary approach in medicine) … had been a widespread dissemination and utilisation of scientific knowledge of disease and rational methods of treatment. The great loss was a severe eclipsing of the art of physicianship that had been slowly won over many thousands of years.
>
> Vincent Di Stefano[30]

Contemporary medicine has elements of all four of Arbuckle's

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models of medicine. But in the US, and increasingly in developed countries around the world, it is largely influenced by biomedical and economic rationalist values, while the values and approaches of the traditional and foundational models have receded into the background. These diminished values include compassion, viewing patients holistically and having the time to really listen to and understand patients.

The biomedical model of medicine has led to the rapid increase in expensive, technological studies and interventions. These in turn have driven up the costs of health care worldwide, to the point where health care systems in the 21st century are in economic crisis and increasingly enticed into an economic rationalist 'solution' in an effort to contain costs.

Both the biomedical and economic rationalist models grow out of the philosophical position of 'logical positivism.'[31] The reductionist position of positivism could be stated as 'the only thing that matters is matter.' This means that both models value 'things' that can be observed, counted and measured. Concepts or values that are not reducible to the status of 'things' are considered irrelevant or non-existent from a positivist perspective. While the *economic* part of the economic rationalist model refers to profit and loss as primary motivators, the *rationalist* perspective is characterized by the notion 'if you cannot measure it, you cannot manage it.'[32] It is this emphasis on 'things' that objectifies and dehumanizes doctors and patients when it is not tempered by models that value aspects of people that are not reducible to things.

As we shall see, the scientific method and its counterpart, evidence-based medicine (EBM), have led to many advances in medicine at a cost of many things that make medical care warm, caring and human. The belief that good health care can be achieved through counting and measuring things with an eye always on profit translates into the enormous influence wielded by insurance companies and government bureaucracies, as well as pharmaceutical companies. In this regard, the control of medical care has gradually shifted away from the doctor.

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The Scientific Method

The biomedical model of contemporary medicine is based on science, a method of studying and explaining how things happen in the world. Science takes the whole of something and then breaks it down into its component parts. Thus, the field of biology (the study of life) can be broken down into gross anatomy (parts of the body that can be seen with the eye), histology (microscopic anatomy) and physiology (the study of organs and biochemical interactions). The body can be broken down into many different levels, but each level is mutually inter-dependent with the others. No level can exist apart from the others. In reality, there is no such thing as a living kidney or heart existing outside the larger context of a human being with emotions, dreams and spiritual experiences.

One side effect of science is that it creates more fields of study as technology provides new ways of dividing up reality. The study of life was once limited to what the naked eye could see. Around the 1600s, the microscope was invented, opening many new dimensions that previously had not been known to exist. With the discovery of bacteria and microorganisms and their role in some diseases, the fields of microbiology and infectious disease emerged. There were many early theories of how life processes occurred, but eventually the study of organic chemistry came about through the analysis of chemical structures and reactions. Molecules were eventually 'discovered,' then atoms, then subatomic particles, then all sorts of bizarre sub-particles and forces. The search for the most fundamental building block of nature and life has been elusive and could possibly be an infinite regress. Each new level of discovery opens many new doors.

As medicine has become more scientific, specialties and sub-specialties have proliferated. In the first half of the 20th century, most physicians in the United States were primary care doctors. However, by the end of the 20th century, there was a shortage of primary care doctors as most medical students chose specialty training.[33] The trend toward sub-specialization can be viewed as a natural progression of greater scientific understanding of sub-systems in the human body.

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(The financial incentive to make more money as a sub-specialist also drives this choice.) This has led to the development of a vast number of different medical specialists for different parts of the body. Whereas a family doctor used to treat most concerns from birth to death, we now have obstetricians for pregnancy and delivery, pediatricians for childhood and geriatricians for old age. Additionally, there are doctors for every organ in the body: psychiatry studies the brain and behavior; hematology studies the blood; cardiology studies the heart; oncology studies cancer; surgical oncology specializes in cutting out cancer from the body; and radiation oncology specializes in killing cancer cells with focused beams of radiation. Now, we have the growing field of genetics which studies DNA and illness. With increasing technological advances in MRI, fMRI, SPECT and PET scans, new sub-specialties of radiology are developing that can not only study static tissue, but also measure various functional states of internal aspects of the human body. The level of detail in which we can analyze the human body is constantly increasing.

The tendency to break things down into small parts which are managed by sub-specialists fragments medical care. This is one of the primary complaints of patients in today's medical system: no one is in charge and no one is coordinating care. In other words, no one sees them as a whole person. Patients feel 'bounced around' from doctor to doctor. As the depth of focus in sub-specialties increases, there has been a corresponding loss of breadth. An analogy is the zoom feature on your camera. The more you zoom in on an image, the more fine detail you can see. But this occurs at the cost of losing sight of the bigger picture and the context. I, myself, remember periodically being disturbed while doing my surgical rotations in medical school when I would suddenly remember that the 'thing' I was leaning on for leverage to hold a surgical retractor was in fact a person, not an armrest.

Another side effect of medical science is that it studies the individual in relation to large groups, rather than the individual as themselves. Statistics are used to calculate

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whether a given treatment has a better chance of helping a group of patients than a placebo treatment tested on a different group of comparable patients. It may be that a treatment only helps 50% of people, but it still could be considered an effective treatment and be approved by the US Food and Drug Administration if this 50% is statistically significantly higher than the percentage of people helped by placebo, 30% for instance. A treatment does not have to help everyone, or even most people. It only has to prove itself to be statistically superior to no treatment at all (placebo). Also, a treatment effect may only be a 10% improvement in symptoms, but if a large enough number of people have this improvement, it can be statistically significant. Scientific medicine focuses on the people it can treat, but there are substantial numbers of people who do not respond to standard treatments. While there are many protocols for 'treatment-resistant' patients, the lack of efficacy of standard treatments should be an indication to review the diagnosis as well as an invitation to include other dimensions of intervention beyond the pharmaceutical.

Under the influence of the biomedical model, contemporary medicine attempts to standardize treatments by dictating what the 'best' medications are, what the best dose of medication is and how long a patient should take it. These determinations are based on statistics and averages and published as evidence-based guidelines. Many people still do not respond to the 'best' medication, and an individual may do very well on a medicine that is not considered the 'best.' Also, the average dose of a medication may be too high or too low for a particular person. In this way, medical science is an abstraction from the individual. The guidelines of medical science will always have to be tailored to fit the individual. Science is so respected, deified even, that sometimes doctors end up treating numbers and abstractions and lose sight of the actual person. The chronic time-pressure can lead doctors to take shortcuts by automatically following a guideline, rather than using their own clinical decision-making abilities.

Science's emphasis on objectivity, numbers and measurement has contributed to a devaluation of

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individualization of treatment approaches, subjectivity and the human and interpersonal aspects of the doctor–patient relationship.

Evidence-Based Medicine (EBM)

> Clinical algorithms … discourage physicians from thinking independently and creatively. Instead of expanding a doctor's thinking, they can constrain it.
>
> Jerome Groopman[34]

Currently, there is a lot of attention given to 'evidence-based medicine.' We can see this as a logical outgrowth of the conceptual systems of the biomedical model and the economic rationalist model in which good medicine is that which is measurable, objective, repeatable, standardized and unvarying from individual to individual. To practice in an evidence-based way is to prioritize treatments that have been scientifically proven to help patients, but the danger is that this can replace critical thinking and decision-making. As the Groopman quote suggests, excessive reliance on algorithms can dumb us down. If everything is a protocol and the practice of medicine is simply following a guideline, one should be able to make a simple computer program that would diagnose and recommend treatment. Indeed Groopman draws this conclusion regarding contemporary medical education: 'the next generation of doctors was being conditioned to function like a well-programmed computer that operates within a strict binary framework.'[35] There may also be a loss of individualized treatment.[36] The risk is that EBM may become less human and more cold and machine-like.

I will use the example of depression to look at the benefits and shortcomings of evidence-based medicine. There are many treatments that are scientifically proven to help alleviate symptoms of depression, including various forms of psychotherapy, exercise, socialization, dietary changes or supplements, medication and the treatment recommended by my favorite study: swimming with dolphins.[37] However,

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physicians tend to jump to medication as the first option. Scientific studies favor pharmaceutical interventions because it is easy to have a placebo control group, whereas this is more difficult for exercise, acupuncture, or meditation. Also, pharmaceutical companies are the major funding source for studies of treatment efficacy, leading to more research on medication than on non-medication modalities. (To my knowledge, dolphins have not funded any research on their natural anti-depressant effect on people.)

To be diagnosed with major depression a person must meet five out of nine clinical criteria for two weeks or more. One issue with scientific medicine, and particularly in psychiatry, is that people can have similar symptoms and yet have different conditions. For instance, the same symptoms of fatigue, weight change, insomnia, sad mood and social withdrawal could be caused by hypothyroidism, prednisone or beta interferon treatment, grief, the break-up of a relationship, substance abuse, the depressed phase of bipolar disorder, personality disorder, dysthymia (low-level depression), major depression and a lot of other conditions as well. Because of these complexities, physicians are taught to use the biopsychosocial model which takes into account multiple dimensions of cause and effect. However, the appeal (for both doctor and patient) of a quick and powerful intervention like a pharmaceutical often takes precedence over interventions that are equally effective but sometimes longer-lasting and less expensive. While I cite depression as an example of a medical condition that has many other determinants in addition to the biological, similar arguments can be used for any chronic condition such as obesity, high blood pressure, diabetes, high cholesterol and pain conditions.

When doctors blindly follow protocols and guidelines, they stop being clinicians and become technicians. Technicians relate to people through the application of techniques, which are standardized methods of intervening to promote a particular outcome. In his book, *The Illusion of Technique,* the philosopher William Barrett defines a technique as a 'standard method that can be taught. It is a recipe that can be fully

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conveyed from one person to another. A recipe always lays down a certain number of steps which, if followed to the letter, ought to lead invariably to the end desired.'[38] While Evidence-Based Medicine and the Quality Revolution strive for standardized treatment interventions, science-fiction writer Philip K. Dick cautions that standardization can lead to a loss of humanity, what he calls 'androidization.' He writes that, 'Androidization requires obedience. And, most of all, predictability. It is precisely when a given person's response to any given situation can be predicted with scientific accuracy that the gates are open for the wholesale production of the android life form.'[39] According to Philip K. Dick, we must be careful not to lose the 'human' as we strive for predictable and replicable behavior. His distinction between the android and the human sounds a lot like Groopman's critique that younger generations of doctors are being taught to be more machine than human.

Barrett cautions against over-reliance on technique. He states that it

> has become a general faith, widespread even when it is unvoiced, that technique and technical organization are the necessary and sufficient conditions for arriving at truth; that they can encompass all truth; and that they will be sufficient, if not at the moment, then shortly, to answer the questions that life thrusts upon us.[40]

Barrett's cautions address recent cultural belief systems, of which contemporary medicine is one example, in which the over-emphasis on technique obscures other sources of truth and other dimensions of humanity.

Economics and Time Pressure

The economic aspects of medicine are not taught in medical school, yet economics play a major role in shaping how physicians practice today. Look at a simple breakdown of how much money a physician can bill for seeing patients for different session times. In many practices, how much you bill

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determines your salary. This may seem completely irrelevant to those who have only worked in public systems on a fixed salary. However, your employer (whether public, private, or NGO/non-profit) will want you to see enough patients to make sure that the clinic is not losing money, so the economics of medicine affect all practice settings. Let us use the following numbers for a comparison, which were, incidentally, the fees in US dollars I used when I first opened my private practice (I include the psychiatric billing code):

60-minute visit (90807): $150
30-minute visit (90805): $100
15-minute visit (90862): $75

This leads to an hourly income/productivity (assuming collections are equal to billing) of:

One patient per hour: $150
Two patients per hour: $200
Four patients per hour: $300

There is the old saying that 'time is money,' and in medicine we can quickly see that there is a relationship between time spent with patients and money earned. A physician who sees four times as many patients a day will bill twice as much as a physician who sees one patient per hour. This means that if a physician sees four times as many clients, writes four times the number of notes and does four times the administrative work, they will make twice the income. This simple fact is an issue that all physicians must appreciate, because how they prioritize their values has a major impact on how they practice medicine. If physicians make income their top priority over other values (the economic rationalist model) they will have less time to spend with each patient. There is a point where a physician cannot provide the same quality of care to more clients in shorter visits. A physician cannot provide the same quality of care in a 10–15-minute appointment as they can in a 30-minute appointment. The less time a physician spends with clients, the more he (or she) will rely on a reductionist

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biomedical model and the less he will be aware of holistic factors in health and healing. If a physician has other values they hold higher than money or science (or if they strive for a balance of values), they may see fewer patients and make less money, but have a better quality of life and be better able to provide high-quality health *care*. One problem in contemporary medicine is that individual physicians feel they have a diminished ability to make decisions about how they spend their time. Reimbursement by Medicare has been decreasing in the US; employers want physicians to see more patients to generate more billing; and physicians want to pay off all those student loans. All of this can contribute to a powerful feeling that external agencies are 'forcing' physicians to practice in a certain way. This is also the acculturation pressure exerted by the economic rationalist model.

Insurance Companies and Government Bureaucracies

Insurance companies in the United States are commonly criticized by doctors and patients alike for the bureaucracy they introduce into health care. Private insurance pays for about one-third of all health care (36%) in the US. The federal government pays for roughly another third (34%), out-of-pocket payment is 15%, states pay for 11% and private funds 4%.[41]

Insurance companies play lesser roles in the delivery of health care in other countries. In New Zealand, only 5% of all health care is paid for by private insurance companies, while 66% is through the Ministry of Health (national government), 16% is out of pocket and about 10% is through ACC (Accident Compensation Corporation).[42] ACC is a government-run accident insurance agency in New Zealand. In the UK, private health insurance accounts for 11.5% of health care.[43] Although insurance companies play smaller roles outside of the US, nationalized health care often introduces complex administrative bureaucracies that can interfere with the doctor–patient relationship. For instance, burdensome paperwork, medication formularies and the shifting emphasis of programs and initiatives with each election can still come

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between doctor and patient. Many administrative systems can take on a life of their own and there is the risk that the doctor will become more focused on trying to navigate the system than on connecting with patients. Dehumanization will be the side effect.

Countries around the world are struggling to create affordable and effective health care delivery systems. The amount of money spent on health care does not directly translate into how 'good' a country's health care system is, at least in terms of life expectancy. For instance, in 2007 the US spent US$7,290 per person on medical care, yet the average life expectancy was 78 years, less than most other developed nations. The UK spent less than half than the US (about US$3,000 per person) but had a slightly higher life expectancy of 79 years. New Zealand spent even less, about one-third of the US (US$2,500 per person) and had an even higher life expectancy of over 80 years. Japan, perhaps the best value for money, spent about US$2,500 per person and yet had a life expectancy of almost 83 years. Another thing to consider is that people in Japan had an average of 12 visits to a doctor per year, residents of the UK and New Zealand had an average of four visits, while in the US, the average was less than four visits per year.[44]

Why is the US spending more than twice that of other countries on health care? Are we really getting our value from that expenditure? It appears that higher cost and fewer doctor visits are side effects of the US health care system when compared worldwide. There are many reasons for the rising costs of insurance, which are beyond the scope of this book, but rapid increases in expensive medical technology, 'defensive' medicine to avoid lawsuits, multiple layers of health care businesses each with their own profit motive and layers of administrative bureaucracy surely contribute. This dramatic difference in the cost of the US health care system was recently made clear to me when I was pricing international travel health insurance and found that there are two rates: the most expensive rate includes the US and the entire world; the less expensive rate is for the entire world, excluding the US.

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As insurance companies in the US have come to play a larger role in the day-to-day practice of medicine, they have introduced a style of doctor–patient interaction that is at odds with the humanitarian aspects of medicine. Insurance companies grow out of the economic rationalist model, with its values of efficiency, cost-savings and productivity. As we have seen, this model has values that are diametrically opposed to those of the foundational model of medicine, which are compassion, connection, universal right to health care and a focus on the whole person. Insurance companies view payment for health care as 'loss' rather than as a positive health benefit. When the language of 'loss' is taken to the extreme, and applied in the short term of quarterly profits, spending money is to be avoided at any cost (pun intended: the 'cost' of the economic rationalist model is human cost, as economic values are placed above human values). Insurance companies have, increasingly, taken on the role of deciding which tests and treatments are indicated. This frustrates doctors as it takes decision-making out of their hands. Similar feelings are expressed by doctors in New Zealand working with ACC, the government-funded accident insurance program. Some models of insurance, such as managed care and capitated care, have 'incentivized' doctors to become 'gatekeepers' who stand between the person who is ill and the provision of services, and are rewarded for providing less care. When doctors and health care delivery systems interact daily with insurance companies, they start to think like insurance companies, viewing the provision of health care as a 'loss' rather than a benefit.

Historically, the HMO model of health insurance grew out of a previous American health care crisis in the early 1970s. Paul Ellwood, director of the American Rehabilitation Foundation, proposed the concept of a 'Health Maintenance Organization.' His goal was to shift the focus of health care from tertiary care to preventative care, which a plethora of research shows is more cost effective. In practice, however, the HMO concept became more of a cost-containment policy than a preventative health policy. While US Senator Ted Kennedy was calling for a

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national health plan, the Nixon administration opted for the HMO model with a call to 'change the incentives in health care.'[45] The health care system today in the US reflects these changed incentives, and physicians have experienced a diminished sense of control in the daily practice of medicine. Furthermore, the language of business has been hybridized with that of medicine. The insurance industry became an intervening agent between the doctor and the patient.

Managed care has not successfully contained costs in the US and it created layers of bureaucracy that interfere with the doctor–patient relationship. Physicians and patients alike have experienced interference as care is limited or denied. Managed care has effectively taken away doctors' role of being the primary decision-makers about medical treatment and evaluation, while doctors still carry all the liability for treatment outcomes. HMOs and insurance companies have also increased the amount of paperwork for physicians, such as filling out treatment request forms. When ordering a test, the physician must consider whether it is covered under the HMO and maybe even place a call through the interminable automated phone tree to reach an agent of the HMO to try to request 'prior authorization' for a procedure. HMOs often dictate which medications a physician can prescribe, and this 'formulary' is constantly changing. The aversive experience of interacting with insurance companies can condition the physician into prescribing certain medications for people under certain insurance plans because it is easier than constantly pushing back on the encroaching system.

Even after a patient leaves the office, the physician may still have more administrative work to do, sometimes stretching out over weeks of phone calls and faxes. The pharmacy may call, stating that a medication is no longer covered or that it requires prior authorization. Sometimes the reason for denial is readily apparent, but other times it is obscure, such as getting prior authorization for an inexpensive generic medicine or for a 'quantity limit' override in which a doctor has prescribed more pills a day of a medication than the insurance company will routinely pay for, such as an arbitrary limit of 100 pills

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per month. If a patient is prescribed four pills a day of a medicine (120 pills/month), they have to pay a second copayment to get the 20 pills beyond the 100/month that the insurance company will cover. So the physician has to fill out more forms or make more calls, which takes more time out of their day and competes with the patient for attention. Most clinics in the US do not schedule time for physician paperwork, so this time ends up being taken out of face-to-face time spent with patients and/or personal time (as completing necessary paperwork is not a billable procedure).

While many doctors feel they can effectively multi-task, any patient knows that human beings really are not very good at multi-tasking, as they sit patiently while the doctor calls pharmacies, insurance companies, prepares faxes, takes phone calls about other issues, is interrupted by office staff and in-between all this speaks to the patient. Chabris and Simons, in their book, *The Invisible Gorilla,* present a great deal of research on how people cannot multi-task effectively. Perhaps the best known and most dramatic example is their study in which subjects count the number of passes a basketball team makes. About 50% of people concentrating on this task miss seeing a person in a gorilla suit walk on to the middle of the court.[46] Research such as this has profound implications for health care delivery systems in which doctors are bombarded by information and interruptions while trying to perform numerous clinical and administrative tasks and speaking with their client. It also makes one wonder what kind of gorillas in our midst we are missing as we count lab results and procedure codes.

Even once doctors have completed all of their work providing services, there is still the issue of collecting payment. In the US, doctors and clinics can set whatever price they want for a given procedure or service. However, they rarely get paid this amount. Every insurance company, as well as government-funded Medicare and Medicaid, can independently decide how much they will actually pay. So doctors may do the same work, but get paid vastly different amounts depending on the insurance coverage of a particular client. Take for example a

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30-minute psychotherapy session with medication management (90805). For instance, take a service that has a fee of US$100. One private insurance company might pay the full amount, while another company pays $85.17, Medicare might pay $48.09, while Medicaid might pay $25.34. This creates an accounting nightmare to try and keep track of billing and collections. The frustration that these differential billing systems invoke is another source of distress and dissatisfaction for physicians and can, again, distract the physician from connecting with the patient.

Personal Example

What can be done in the face of this dehumanizing pressure of an unchecked economic rationalist model? This book will explore different responses in later chapters, but I'll give one personal example. In my private practice, I worked with an insurance company that distorted the meaning of an extended-release, 'once daily' medication to mean that they would only authorize one pill a day per prescription. Even though the FDA-approved maximum dose was higher than the strength of one pill, the company would only authorize one pill per day. To get the maximum dose of the medication, which the patient was taking, I had to prescribe four different prescriptions with four different pill strengths and the patient had to pay four separate co-payments. This was after numerous phone calls back and forth between the pharmacy, the patient, myself and the insurance company.

What I did in response to this company's practice: first, I appealed the declined prescription (which was denied using circular reasoning); second, I did my best to ensure that the patient could get the medication dose they had been on for years for the lowest expense possible; third, a number of different patients with this insurance plan had similar problems, so I filed a series of complaints with the state insurance regulatory agency (which did not see a problem with the practice); fourth, for this, and several other reasons, I dropped out of this particular insurance network, as I considered it unethical. Not every doctor can decide whether or not to participate in an insurance network, but you always have a voice, even if you cannot make

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the final decision. A question to ask yourself is, 'Have I done everything I can to challenge this injustice?'

Pharmaceutical Companies

> Conflicts of interest between physicians' commitment to patient care and the desire of pharmaceutical companies and their representatives to sell their product pose challenges to the principles of medical professionalism.
>
> Troyen Brennan and colleagues[47]

Pharmaceutical companies straddle two paradigms, the biomedical and the economic rationalist. They use a biomedical model to create many useful medications that alleviate pain and suffering and sometimes cure disease. However, the primary interest of pharmaceutical companies is to sell more medication and to make more money – not necessarily the best interests of the patient. They want physicians to prescribe the 'newest' and 'best' medicine, which really means the medicine that their company makes. Pharmaceutical representatives try to appear as emissaries of science, but they are really well-paid sales people who are highly trained to influence doctors' prescribing practices. Of particular significance is the way that pharmaceutical companies become another layer of competing interests between the doctor and the patient.

Do We Even Need a Pill at All?

Some authors express concern about 'the medicalization of everyday life' in which pharmaceutical interventions are used to address issues that are normal or might be addressed more effectively and less expensively in other ways. For instance, Moynihan and Cassels, in their book *Selling Sickness,* describe the expansion of approved uses for pharmaceuticals for more and more conditions, often with only shaky scientific evidence. They make a good argument that the pharmaceutical companies are actively working to expand their markets (recent lawsuits penalizing companies for false marketing also

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attest to this), while at the same time, people are more and more willing to accept a medical explanation for what was previously viewed as a problem of life. In their book, they describe how medications for aging, menopause, obesity, hyperactivity and other 'syndromes' have been approved through the US Food and Drug Administration (they also point out the conflicts of interests in the FDA in that pharmaceutical companies are now partly bankrolling the salaries of those who are supposed to be objectively evaluating scientific evidence). Moynihan and Cassels see this problem as going beyond that of greedy industry profit-motives, arguing that 'the $500 billion dollar pharmaceutical industry is literally changing what it means to be human.'[48] A recent *Reuters Business Insight* report designed for drug company executives

> argued that the ability to 'create new disease markets' is bringing untold billions in soaring drug sales. One of the chief selling strategies, said the report, is to change the way people think about their common ailments, to make 'natural processes' into medical conditions … The coming years will bear greater witness to the corporate sponsored creation of disease.[49]

Many syndromes have well-documented evidence for non-medication interventions, such as irritable bowel syndrome (IBS), hypertension, high cholesterol, obesity, type II diabetes, metabolic syndrome, fibromyalgia and chronic fatigue syndrome. In some cases, lifestyle changes (diet, exercise, stress management) may actually 'cure' these conditions, meaning that the person no longer has the syndrome. A good argument can be made that using preventative, mind–body and lifestyle approaches is more humane, has fewer costs long term, has fewer medication side effects and has positive side effects of empowering people in regards to their health and their lives.

The Cost of Pharmaceuticals

The amount spent on prescriptions in the US doubled from

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1999 to 2008, up to $234 billion per year. Almost 50% of Americans were reported to have used a prescription medication in the previous month.[50] According to Wazana, in the year 2000, the pharmaceutical industry was spending US$5,000,000,000 per year on sales representatives, and an estimated US$8000–13,000 per year per physician.[51] Brennan and colleagues reported that in 2000 the pharmaceutical industry sponsored 314,000 events specifically for physicians.[52] Dana and Lowenstein report that between 1989 and 2000, the US FDA

> judged 76 percent of all approved drugs to be no more than moderate innovations over existing treatments, with many being a modification of an older product with the same ingredient. All of this money is spent with the goal of convincing doctors to prescribe a given pharmaceutical company's product, which may not even be any better than generic alternatives.[53]

What Will All That Money Buy? How the Pharmaceutical Industry Influences Doctors

Studies show that physician prescribing patterns are influenced by pharmaceutical representatives, regardless of whether or not physicians consciously believe that they are influenced. Dana and Lowenstein review social science research on this topic and discuss the concept of *self-serving bias,* which states that individuals will unconsciously make decisions that maximize their own personal benefit. The article concludes that, first,

> individuals are unable to remain objective, even when they are motivated to be impartial, demonstrating that self-serving bias is unintentional. Second, individuals deny and succumb to bias even when explicitly instructed about it, which suggests that self-serving bias is unconscious. Third, the studies show that self-interest affects choices indirectly, changing the way individuals seek out and weigh the information on which they later base their choices when

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> they have a stake in the outcomes.[54]

Wazana's review of 29 studies on gift giving and pharmaceutical company interactions with physicians concludes that,

> although some positive outcomes were identified (improved availability to identify the treatment for complicated illnesses), most studies found negative outcomes associated with the interaction. These included an impact on knowledge (inability to identify wrong claims about medication), attitude (positive attitude toward pharmaceutical representatives; awareness, preference, and rapid prescription of a new drug), and behavior (making formulary requests for medications that rarely held important advantages over existing ones; nonrational prescribing behavior; increasing prescription rate; prescribing fewer generic but more expensive, newer medications at no demonstrated advantage).[55]

Embracing 'evidence-based medicine' has created a tremendous business opportunity for pharmaceutical companies as well as a booming industry for the physicians who draft these guidelines. If a pharmaceutical company can prove that their medication is the best (or, even better, the only) treatment for a certain condition, they can have a powerful endorsement that encourages all doctors everywhere to prescribe their medication. Similarly, if a guideline is developed that argues for the increased use of medications for milder conditions, pharmaceutical companies stand to make a lot of money. Pharmaceutical companies, insurance companies and academic physicians are all striving to create treatment guidelines to shape how doctors treat patients. Moynihan and Cassels outline a number of instances where there appear to be conflicts of interest. Choudhry and colleagues report that almost 90% of clinical guideline authors have some relationship with pharmaceutical companies and they caution about the risk of conflict of interest between these groups.[56] Marcia Angell

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warns us of this same issue.[57,58]

There Is No Free Lunch: Banning Pharmaceutical Gifts

As the quote about conflicts of interest at the start of this section plainly states, there is an inherent conflict of interests between pharmaceutical companies' commitment to sell medications and the doctor's commitment to patient care. The article states that physicians' 'commitment to altruism … scientific integrity, and an absence of bias in medical decision making now regularly come up against financial conflicts of interest.'[59]

This article by Brennan and a panel of academic physicians warns that no matter how small gifts and payments to physicians from the pharmaceutical industry are, they must be regulated. Gifts that cause potential conflicts of interest include:

> meals; payment for attendance at lectures and conferences, including on-line activities; CME … for which physicians pay no fee; payment for time while attending meetings; payment for travel to meetings or scholarships to attend meetings; payment for participation in speakers' bureaus; the provision of ghost-writing services; provision of pharmaceutical samples; grants for research projects; and payment for consulting relationships.[60]

When I started my private practice, I decided that I would not have any branded information or items in my practice. I still chose to meet with pharmaceutical representatives, but I had to police the waiting room to remove items they would leave there. Personally, I think any meeting with a pharmaceutical representative must be done very cautiously, if at all, and all educational material they provide is suspect. Decisions around pharmaceutical agents are ethical issues, and the concept of self-serving bias shows that you may not always be the best judge of your intentions. For more information about the interaction between the pharmaceutical industry and doctors, see the 'No Free Lunch' website.[61]

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Pharmacophilia (the love of pills) and Dehumanization

We have examined the various ways that the pharmaceutical industry tries and succeeds at influencing doctors' prescribing patterns. When this influence is combined with the pressure to see more patients to increase business revenues, it can be seen how prescribing more medication could be a compensation for spending less time with patients, particularly in the context of a materialistic culture that values objects over less tangible human interactions. In this sense, *the pill has come to replace the doctor–patient relationship.* The physician gets to feel like they have done something (instead of just feeling like they should have spent more time actually listening to the patient). The patient feels like at least they 'got' something tangible from the brief visit with the physician.

Increased prescribing and decreased consultation time is a symptom of the materialization or objectification of the doctor–patient relationship. Instead of the relationship being viewed as a potentially healing interpersonal interaction, it becomes a transaction in which money is exchanged for an object: the pill. The patient views the doctor as a means for getting a pill and the doctor views the patient as a biochemical imbalance to be manipulated with a pill. Instead of a human being who is suffering and a human being who has learned how to alleviate suffering, there is a passive body whose health depends on taking a pill and a technician dispensing an object. The relationship does not matter and the technician becomes inter-changeable with other technicians because the mediating variable is the pill, not the relationship. Similarly, the human being of the patient becomes a 'consumer' in a line of consumers. If medicine becomes primarily about objects giving objects to other objects, it has become dehumanized.

In the psychotherapy literature, there is a word for the replacement of a relationship with an object: *fetishism.* In a fetish, there is an obsession with an object that replaces human interaction. Psychoanalyst Robert Stoller, in his book, *Observing the Erotic Imagination,* describes the motivation behind reducing another person to a body part: 'we anatomize them … because we cannot stand the revelations of intimacy, we deprive others

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of their fullness.'[62] Stoller believes that reducing the other to a body part or replacing a relationship with an object is a psychological defense against the anxiety of relationship. The risk is that the process of dehumanization goes both ways. One cannot dehumanize someone and remain human oneself. It is not a human action to treat someone else as an object. The act of dehumanizing another 'dehumanizes the dehumanizer.'[63] Stoller is concerned not just with the physical aspect of human sexuality, but with sexuality as an expression of human intimacy and inter-personal connection.

The reduction of a human being to a body part is one of the primary complaints raised about contemporary medical practice. The contemporary physician, rather than relating to the complexity of a human being, focuses only on a body part or an organ system and then tries to find the right pill to fix that problem. If the physician can remember that they are using a reductionist model for a specific purpose and can then shift focus back to the whole person, this is the use of science at its best. However, if the physician forgets that they are using a reductionist model and comes to perceive that model as reality, they have become an impaired physician and an impaired human being; they have dehumanized themselves in the process of dehumanizing the patient.

Doctors can get stuck in this mode of interaction, or even worse, they can defensively hide behind it because the *intimacy* of genuine human interaction is too anxiety-provoking. The pill can serve as a fetish object that replaces or even represents genuine interpersonal relationship. Objectification is a very dangerous force in contemporary medicine and it is a major contributor to the dehumanization of all the human beings in the health care delivery system, patients and clinicians alike. This is not to say that doctors should not focus on body parts or prescribe pills, but that this should be one skill doctors have, while retaining their capacity to *be* human and compassionate in their clinical interactions.

The next section further explores aspects of objectification and dehumanization in medicine.

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I–It Medicine and I–Thou Medicine

External forces such as the insurance industry, government regulation and the pharmaceutical industry would not shape physician behavior if there were not a corresponding internal representation of these forces within the physician. People have treated other people like objects throughout human history – this is not an invention of economic biomedicine. We could even say that dehumanization is part of what it means to be human, that we all have this potential within us.

Martin Buber speaks of the distinction between 'I–Thou' and 'I–It' relationships. *The Cambridge Dictionary of Philosophy* describes these different kinds of relationship:

> I-Thou is characterized by openness, reciprocity and a deep sense of personal involvement. The I confronts the Thou not as something to be studied, measured, or manipulated, but as a unique presence that responds to the I in its individuality. I-It is characterized by the tendency to treat something as an impersonal object governed by causal, social, or economic forces.[64]

This distinction between I–Thou and I–It resonates with our present discussion about human and professional relationships on the one hand and android and technician relationships on the other hand. Perhaps what makes a human being *human* is the necessity of choosing between the 'I' of humanization and the 'It' of dehumanization.

Physicians have actively and passively created the current health care delivery system, in cooperation with economic and social forces. Physicians share the same socio-cultural beliefs that shape economics and society, and thus can embrace the economic rationalist model. They are trained as scientists and taught concepts of 'clinical detachment,' 'objectivity' and 'neutrality,' that grow out of the biomedical model. There is a need to teach appropriate boundaries in medicine, otherwise physicians would be doing all the things that physicians do in soap operas, like having affairs with their patients and getting over-involved in their lives. However, a good boundary is

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different from detachment. A boundary is a lot like a cell membrane; it is an active process requiring energy in deciding what to let in and what to let out. The membrane does not keep everything out, nor does it keep everything in – it is a continual decision-making process. A boundary is still a connection, but it is a form of connection that is monitored and constantly re-evaluated with the aim of creating a therapeutic relationship.

Detachment[65] is a severing of human relationship. It is cold, disconnected, uncaring and it withholds the Self of the physician from the patient. It is not a positive goal to strive for. While it is true that a clinician sometimes needs some distance from human relationship in making important clinical decisions, he or she is still responsible for being a caring and compassionate human being who is emotionally available to the patient. It is also the responsibility of the physician to manage the professional boundary with the patient. Maintaining human connection and managing professional boundaries may seem like contradictory responsibilities, but that is the work of being a professional.

We, as physicians, should strive for scientific objectivity *and* human connection; these can be difficult tasks to juggle at the best of times, but even more so if we do not have a conceptual paradigm that has room for both. How do we integrate different conceptual paradigms so that we provide treatment that is technically safe and effective and also care that is humane and compassionate? The holistic framework that will be developed in this book addresses this dilemma.

What about Health Care Reform in the US?

Worldwide, governments are concerned about the cost of health care and want to make sure they are getting value for money. Arbuckle usefully points out in his book, *Humanizing Healthcare Reforms,* that reforms will be structured according to the underlying philosophical model used to understand health care. A biomedical model would lead to more objective and protocol-based treatments such as is found in evidence-based medicine. An economic rationalist model might also favor

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evidence-based medicine, but for slightly different reasons based on economic return on money spent. A foundational model would lead to reform that returns to the foundational values of medicine, such as compassion, social justice, equity and humanitarianism. Before we reform medicine, we should be clear about what our values are and how we define 'good medicine.' In later chapters, I will introduce a holistic framework that allows for the integration of many different models of medicine.

Contemporary medicine has become increasingly corporatized with CEOs and CFOs now making business decisions about how doctors will practice medicine. While we can blame the fragmentation and disconnection in medicine on the influence of pharmaceutical companies, insurance companies and the business side of medicine, it can be said that these are issues that are found in society as a whole. Technology that replaces or competes with face-to-face interactions; larger suburban homes with the corresponding loss of public meeting places; commuter culture – all contribute to fragmentation and disconnection in society. These factors are consequences of our current values of efficiency and speed over connection and quality.

One way of looking at the loss of compassion in contemporary medicine is as an expression of a larger societal problem, namely the general loss of authentic human interactions. This view suggests that the forces shaping medicine are larger than the health care system. This also means that if you, as a physician, choose to challenge disconnection and dehumanization in your own practice, you are also challenging a larger societal issue.

Many doctors have come to feel that they are powerless to change the way that they practice, let alone larger societal problems. Doctors I have met in the United States and in New Zealand are frustrated with the many forces impinging on their practice. As physician Peter Salgo states in his *New York Times* piece, 'The Doctor Will See You for Exactly Seven Minutes,' doctors 'have felt powerless to change things.'[66] He goes on to say that the power for change lies in patients demanding more

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time with their physicians and more genuine collaborative relationships. While I do think that people have a responsibility to advocate for themselves, I think that we, as physicians, need to challenge the sense of powerlessness that we have accepted as part of our daily practices. True health care reform will therefore require reform of society and reform of individuals. This book will look at ways of transforming the physician in order to reform the practice and culture of medicine; ultimately, this will have larger societal implications as well.

In *The Birth of the Clinic,* Foucault wrote that the 'first task of the doctor is therefore political: the struggle against disease must begin with a war against bad government.'[67] I have always taken this quote to mean that humanitarian ethics require the physician to challenge bad administrative policies that get in the way of good medicine.

In the United States, following President Obama's election to a second term, we are facing a new wave of health care reform under the Patient Protection and Affordable Care Act. There will be a natural tension in this reform between cost-cutting elements and elements supporting human connection, between a 'Quality Revolution' and a 'Compassion Revolution'. Using Arbuckle's terms, we could see this as an attempt to integrate the biomedical and economic rationalist models in terms of quality and the foundational model in terms of compassion. The difficulty lies in making sure that any reform encourages foundational values of compassion and client-centeredness.

The Quality Revolution

The Quality Revolution focuses on issues of safety, efficiency, technology and communication as ways to improve health care. The hope is that through a focus on quality, health care will be better and this will decrease costs in the long term. An important concept in terms of reform is the 'Patient-Centered Medical Home' (PCMH), to which the American Academy of Family Physicians (AAFP) devotes a web portal.[68] It illustrates five elements to the PCMH: a foundation in family medicine, quality care, practice organization, health information

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technology and patient-centered care. The element of *quality* consists of creating a 'culture of improvement,' updating care plans and risk assessments, using risk-stratified care management principles, incorporating patient safety into clinical practice and coordinating transitions in care. The element of *health information technology* includes having an Electronic Health Records (EHR) system and utilizing evidence-based clinical decision support tools. The element of *practice organization* has to do with financial planning, embracing a culture of change and creating a staffing model that supports a PCMH approach (team-based, defined roles, flexible schedules, health care coaching and care coordination and patient-friendly environments).[69] Some of these elements overlap with the concept of the micropractice (which we will discuss later in the book): low overhead, use of technology and eliminating layers of personnel between the patient and the doctor.

The Compassion Revolution

Some elements in the PCMH overlap with the Compassion Revolution. The element of *patient-centered care* fits with a focus on compassion as it creates a health care system that works around the patient, supports shared decision-making, empowers patient self-management and includes patient feedback and patient advisors on the structure and function of the health care delivery system. These principles are very similar to those of holistic medicine, as is the emphasis on a systems and whole-person focus. The AAFP adds a *family medicine foundation* to the Patient-Centered Medical Home. This includes a continuous healing relationship, whole person orientation, family and community context and comprehensive and coordinated care.[70]

Compassion is a large part of what this current book focuses on and it should be apparent that many of the PCMH concepts overlap with a holistic medical practice. The reason that I am calling a focus on compassion a *revolution* is that there is a growing focus on compassion in medicine that I believe is symptomatic of the degree of disconnection and dehumanization in contemporary practice. Many of the authors

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and organizations cited in this book could be considered part of the Compassion Revolution in medicine: Robin Youngson and the Hearts in Healthcare organization, Rama Thiruvengadam and Physician Heal Thyself Retreats™, Melanie Sears' book, *Humanizing Health Care,* Lee Lipsenthal's *Finding Balance in a Medical Life,* Allan Peterkin's *Staying Human During Residency Training,* the work of the American Holistic Medical Association and organizations like Heal Thy Practice, all focus on enhancing the whole person of the practitioner and the client. Parker Palmer's organization, Courage and Renewal, has a health care branch and has started an annual health care conference. Also, the influence of mindfulness has reinvigorated an interest in the well-being of physicians and health professionals. ALIA (Authentic Leadership In Action) grows out of the Buddhist Shambhala tradition and has run leadership programs specific to health care and medicine.

Disconnection in contemporary medicine is both costly (thus motivating the Quality Revolution) and dehumanizing. While there may be a tension between the Quality and Compassion Revolutions, they both stem from dissatisfaction with the same source: the current practice of contemporary medicine. For this reason, there is an inherent logic to combining compassion and quality as we move to reform and transform medicine. If health care in the US focuses only on quality, neglecting compassion, we will not be able to heal health care, but will only maim it further.

A recent article by Harding and Pincus states that, in the current health care system in the US, the 'problems are so widespread that trying harder within the current system is not enough. System-wide change is needed.'[71] Their call for system-wide change is similar, in many ways, to my argument for transforming the culture of medicine. The authors mention the Institute of Medicine's '10 Rules for Patient/Consumer Expectations of Their Health Care':

1. Continuous Healing Relationships beyond face-to-face encounters
2. Safety as a system property

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3. Cooperation and Collaboration among clinicians and institutions
4. Evidence-based decisions
5. Individualization, care is customized to respond to individual patient circumstances and values
6. Patient as source of control, shared decisions between patients and clinicians
7. Shared knowledge, free flow of information
8. Anticipation of needs
9. Transparency in system performance
10. Value or continuous decrease in waste[72]

We can see that the focus of holistic and integrative medicine on individualized, patient-centered care, collaboration, preventative medicine, low-cost lifestyle modifications (compared to high-cost pharmaceutical interventions) and on the therapeutic value of a positive therapeutic relationship appears to have a prominent place in the new health care revolution, which the authors call a 'paradigm shift.' The call for a 'continuous healing relationship' is particularly relevant to our current book on enhancing healing through a transformation of the person of the clinician and the relationship between people and systems. While elements of the Quality Revolution focus on cost containment, it also provides motivation and a framework for redefining the role of physicians/clinicians and enhancing the therapeutic relationship. The call for quality therefore has substantial overlap with this book's argument for re-humanizing health care and for a whole-person focus.

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Chapter 2

Health and Illness: Paradigms and Perspectives

> Statistics cannot substitute for the human being before you; statistics embody averages, not individuals. Numbers can only complement a physician's personal experience with a drug or a procedure, as well as his knowledge of whether a 'best' therapy from a clinical trial fits a patient's particular needs and values.
>
> Jerome Groopman[1]

Perspectives from Within Science

Let us look at a critique of contemporary medicine from the perspective of science itself. Science is a tool, a perspective or paradigm that can be used to understand the world and ourselves. It is very good at working with objective, material data. It is also good at drawing out relationships that are not easy to see on the surface. For instance, not everyone who smokes gets cancer, but science allows us to meaningfully compare large numbers of individuals who do smoke to those who do not, in order to reveal a correlation between smoking and cancer. Science is not so good at explaining non-material aspects of human being like spirituality, love, creativity, meaning and purpose. Science is the study of 'things.' There are many aspects of human experience that are 'thing-like.' However, there are many other aspects of human experience that are not reducible to the status of things. Thus, science is poor at understanding subjectivity and individuality.

The Limitations of Science and Scientism

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purposes anything that cannot be measured and tested does not exist.[5]

Science is one way to examine the components of life, whereas scientism mistakes what is perceived through the lens of science as the only reality. Scientism mistakes a detail for the whole of reality. In other words, it focuses on only one dimension of reality perceived and interpreted through science. In scientism, the tools that are used to perceive reality, such as numbers, statistics, protocols and test results, eclipse awareness of the whole person. Beahrs discusses the trade-off between having a precise explanatory model and a model that can be generalized. 'It is not hard to see that the more we attempt to make a model adequate – both precise and reliable within a given area – the fewer number of cases it will adequately describe.'[6] Beahrs comes to the conclusion that we need more than one paradigm for understanding human reality to give the best medical care possible to individuals. He embraces what science is good at and then recommends a multidimensional model of understanding health and illness that includes science as well as other modes of understanding. He concludes that 'increasing scientific precision and respecting human uniqueness are two processes that must coexist and that cannot be fully reconciled to one another. On the one hand, each limits the other's scope, but on the other hand, ensures that it will be employed only where most appropriate.'[7] What Beahrs' work provides is a lesson in the philosophy of science that allows us to contextualize science as one modality, among many, for understanding human experiences of health and illness.

Perception, Knowledge and Error in Contemporary Medicine

Medical education today is focused on imparting to doctors the latest evidence-based treatments embedded in the current scientific understanding of disease. Doctors are not encouraged to think philosophically and the curriculum does not include the history of medicine and science. Doctors are not taught to understand the role of beliefs and expectations in shaping

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Gray states, 'I first heard it attributed to a University of Chicago President addressing an incoming Freshman class: "Half of everything we teach you is wrong … unfortunately, we don't know which half."'

Gray then lists a number of different people who have said or written similar things, including two from medicine: 'Richard Ruhling, MD: One of my professors, John Peterson, MD, was taught at Harvard that half of medical education was not true; the only problem was, they didn't know which half.' 'John L. Meade, MD, FACEP: When I started medical school, a professor told us that half of what we would be taught in the next 4 years was wrong; unfortunately, we didn't know which half was wrong just yet.'

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