

COLLEGE OF MEDICINE

SERVICE • SCIENCE • HEALING



Launch | Jubilee Rooms | 28 October 2010



Service,
Science,

Healing

Prof David Peters

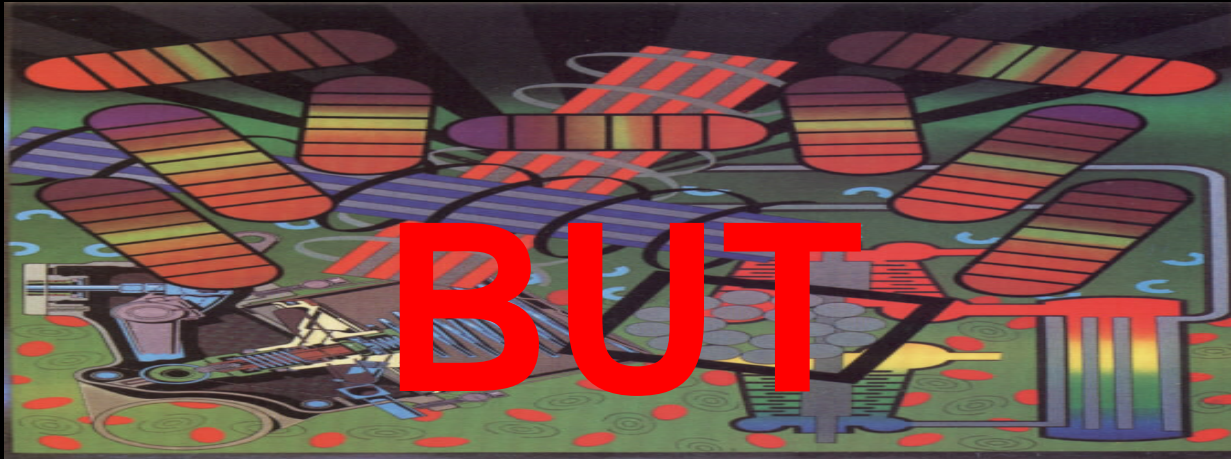
Clinical Director

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What's the problem?

Enormous achievements of science and biomedicine



- Rocketing costs, including ADRs
- Chronic disease often mediated by stress, lifestyle and environment
- Patients can feel fragmented, disempowered
- Many health workers' morale is low
- Co-morbidity, high users, MUPS
- Widespread concerns about drug side-effects
- Many people are voting with their feet (eg for CAM)
- Can we reap Biomedicine's benefits without its downsides?

What's the problem?

MEDICINE'S LINKED CRISES

COST

CURE

COMPASSION

COMMITTMENT

What's the problem?

**HEALING MEDICINE'S LINKED
CRISES**

COST

CURE

COMPASSION

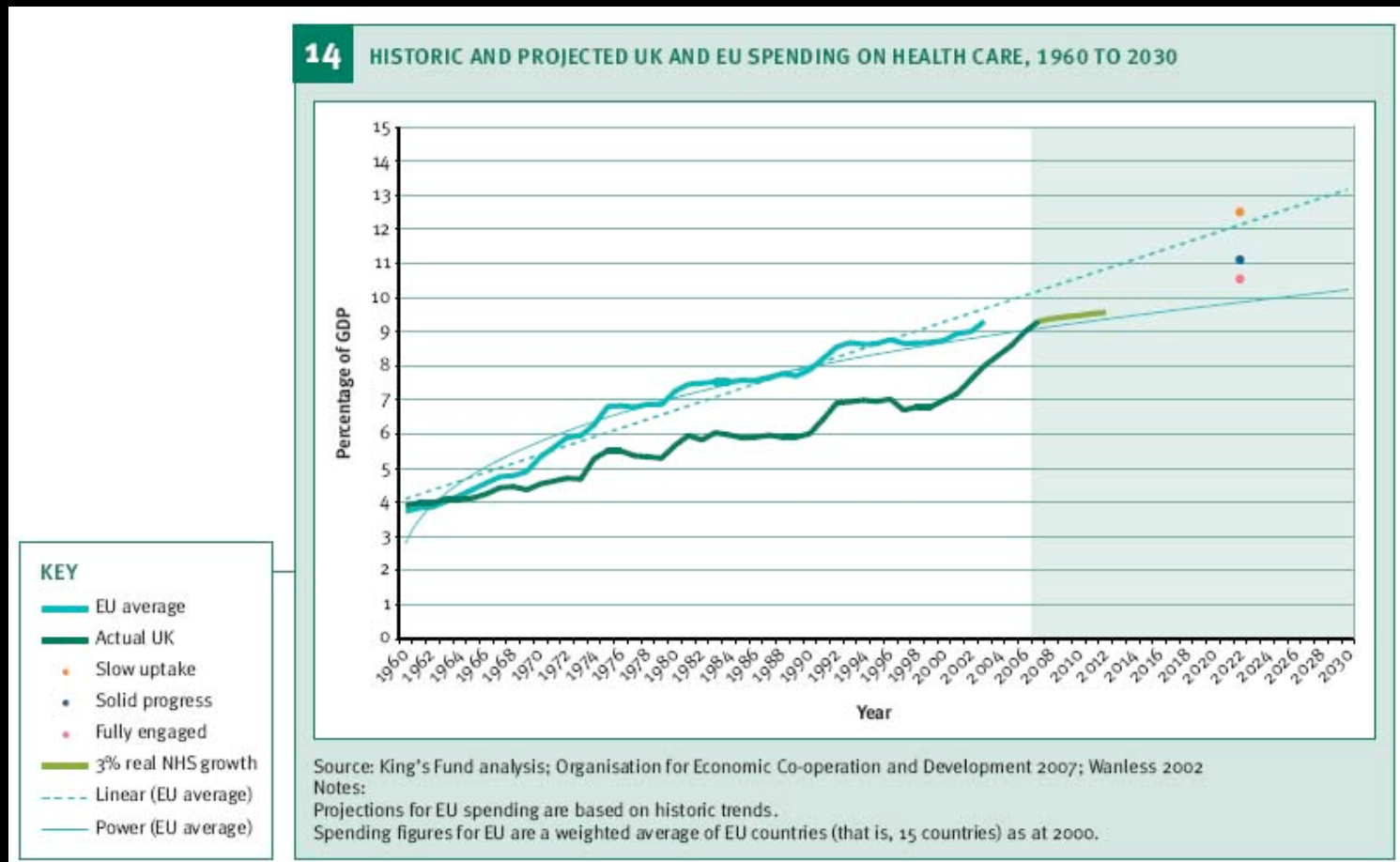
COMMITTMENT

Crisis of cost

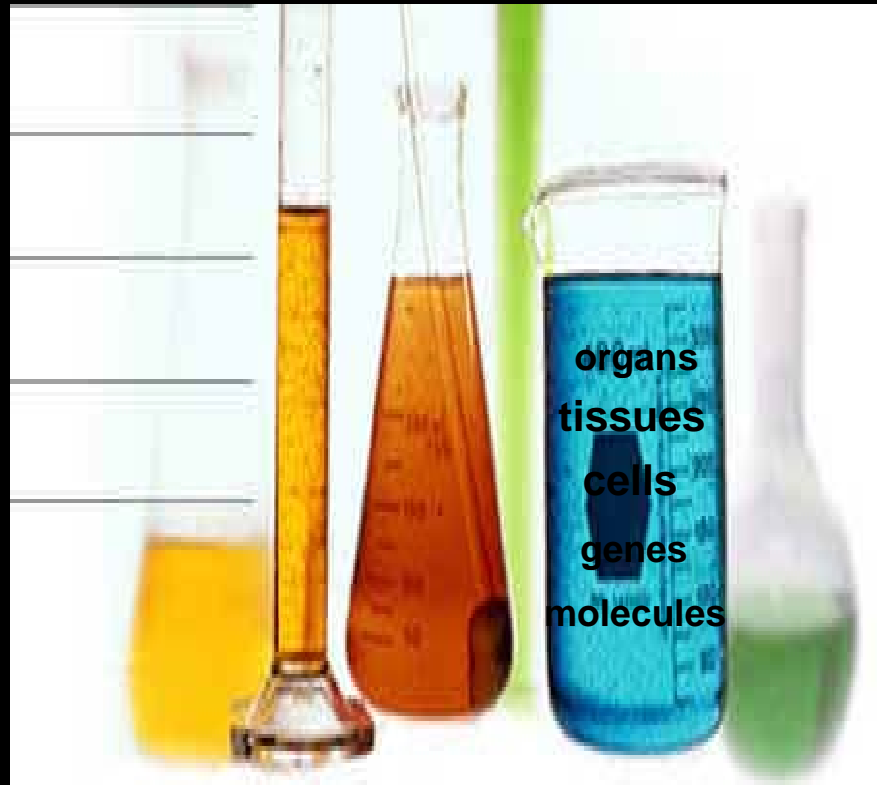
UK health spend was 5.5% of GDP in 1996-7

Projected UK spend 7.2% of GDP in 2006-07

More than 12% by 2020 unless trends change



Crisis of cost



In 2006 global spending on prescription drugs topped \$643 billion

BIOMEDICINE



understanding disease
by taking the body apart

**Person-centred medicine focusing on
resilience and self-regulation**



‘balance and energy’

Crisis of cure

- Advances in medicine: people more likely to recover from acute heart attacks and infectious diseases
- Long-term conditions (LTC) have filled the gap
- LTCs include heart disease, mental health problems, arthritis, musculoskeletal pain, respiratory illnesses + some communicable diseases such as HIV/AIDS
- By 2020 it is estimated that chronic diseases will be the primary cause of death and disability in the world

(Epping-Jordan 2001)

Crisis of cure

- 60% of adults in England report a chronic health problem and a quarter of this group have three or more problems (British Household Panel Survey 2001)
- 80% of GP consultations are taken up by them
- These individuals tend to become heavy users of secondary care
- People with LTCs receive more prescriptions, more diverse drugs from therapeutics groups and have more medical procedures (Heywood et al. 1998)
- Depression is a very common co-morbidity

Crisis of cure

- People commonly seek help for chronic benign illnesses which relapse and remit but which are persistent
- Eg osteoarthritis, IBS, headache, fatigue, fibromyalgia, mild-moderate depression, dysmen, mild allergies
- Conventional interventions may be ineffective, or unacceptable or come with substantial risks. (eg NSAIDs c 14,000 hospital admissions in the UK from GI bleeds, c 2,000 deaths pa)
- Some self-care techniques can provide safe and empowering options for managing LTCs and chronic benign illness. Eg exercise in depression, diet in diabetes, Ornish intervention in CVD (diet, exercise, meditation)
- Some treatments deriving from complementary medicine may fill 'effectiveness gaps' and prove cost-effective (eg acupuncture in persistent low back pain)

Crisis of compassion and caring



- 'a deep awareness of the suffering of another coupled with the wish to relieve it'
- 'includes honesty and may involve both courage and generosity'
- 'frequently requires health workers to give something of themselves'

Kings Fund Point of Care Compassion
Workshop November 2008

Crisis of compassion and caring

Factors preventing compassion:

- The natural, human defences staff develop to cope with their regular, frequent or in some cases continuous exposure to their fellow human beings in varying states of physical pain and distress, to suffering, terminal illness and death
- Conflict between perceptions of professionalism and compassion
- Lack of systematic role modelling or mentoring
- Training that emphasises professional detachment
- Staff stress and burnout

Kings Fund Point of Care Compassion Workshop November 2008

Crisis of commitment, values & burn-out



Why bother with the Art of Medicine?
What does 'health' mean anyway?
Values? What *are* my values?
What are the system's values?
I don't feel valued.....
Is healthcare worth it?
Why have I lost interest in healing
people?

embracing complexity

Holistic

BIOSPHERE

CULTURE

COMMUNITY

FAMILY

BODY-MIND

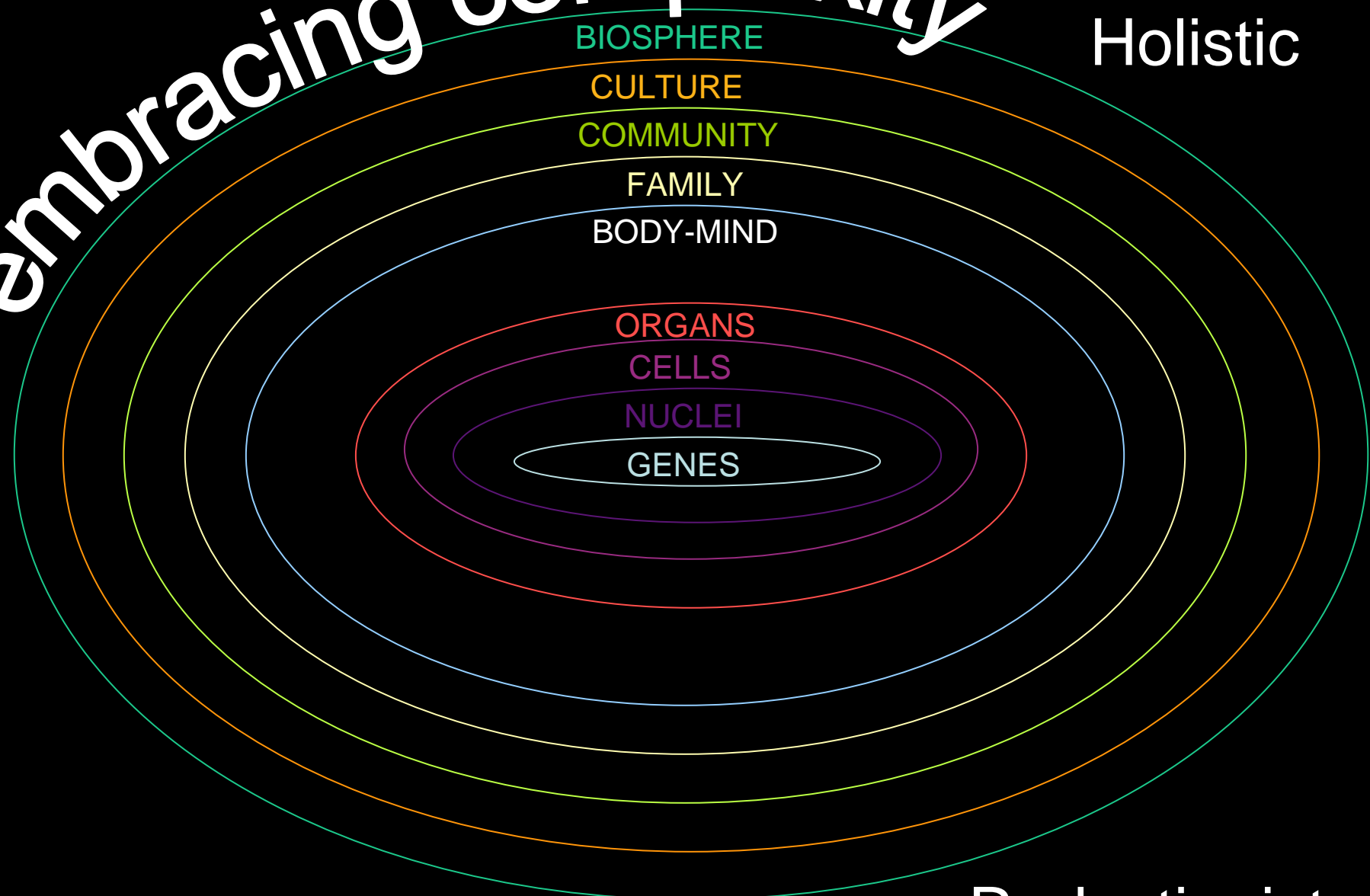
ORGANS

CELLS

NUCLEI

GENES

Reductionist



George Engel father of the biopsychosocial model

8 April 1977, Volume 196, Number 4286

SCIENCE

The Need for a New Medical Model: A Challenge for Biomedicine

George L. Engel

At a recent conference on psychiatric education, many psychiatrists seemed to be saying to medicine, "Please take us back and we will never again deviate from the 'medical model.'" For, as one critical psychiatrist put it, "Psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought,' mixed metaphors, role diffusion, propaganda, and politicking for 'mental health' and other esoteric goals" (1). In contrast, the rest of medicine appears neat and tidy. It has a firm base in the biological sciences, enormous technologic resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments. It would seem that psychiatry would do well to emulate its sister medical disciplines by finally embracing once and for all the medical model of disease.

But I do not accept such a premise. Rather, I contend that all medicine is in crisis and, further, that medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry. The importance of how physicians conceptualize disease derives from how such concepts determine what are considered the proper boundaries of professional responsibility and how they influence attitudes toward and behavior with patients. Psychiatry's crisis revolves around the question of whether the categories of human distress with which it is concerned

the physician is appropriate for their helping functions. Medicine's crisis stems from the logical inference that since "disease" is defined in terms of somatic parameters, physicians need not be concerned with psychosocial issues which lie outside medicine's responsibility and authority. At a recent Rockefeller Foundation seminar on the concept of health, one authority urged that medicine "concentrate on the 'real' diseases and not get lost in the psychosociological underbrush. The physician should not be saddled with problems that have arisen from the abdication of the theologian and the philosopher." Another participant called for "a disentanglement of the organic elements of disease from the psychosocial elements of human malfunction," arguing that medicine should deal with the former *only* (2).

The Two Positions

Psychiatrists have responded to their crisis by embracing two ostensibly opposite positions. One would simply exclude psychiatry from the field of medicine, while the other would adhere strictly to the "medical model" and limit psychiatry's field to behavioral disorders consequent to brain dysfunction. The first is exemplified in the writings of Szasz and others who advance the position that "mental illness is a myth" since it does not conform with the accepted concept of disease (3). Supporters of this position advocate the removal of the functions

new discipline based on behavioral science. Henceforth medicine would be responsible for the treatment and cure of disease, while the new discipline would be concerned with the reeducation of people with "problems of living." Implicit in this argument is the premise that while the medical model constitutes a sound framework within which to understand and treat disease, it is not relevant to the behavioral and psychological problems classically deemed the domain of psychiatry. Disorders directly ascribable to brain disorder would be taken care of by neurologists, while psychiatry as such would disappear as a medical discipline.

The contrasting posture of strict adherence to the medical model is caricatured in Ludwig's view of the psychiatrist as physician (4). According to Ludwig, the medical model premises "that sufficient deviation from normal represents disease, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement in individual patients" (Ludwig's italics). While acknowledging that most psychiatric diagnoses have a lower level of confirmation than most medical diagnoses, he adds that they are not "qualitatively different provided that mental disease is assumed to arise largely from 'natural' rather than metapsychological, interpersonal or societal causes." "Natural" is defined as "biological brain dysfunctions, either biochemical or neurophysiological in nature." On the other hand, "disorders such as problems of living, social adjustment reactions, character disorders, dependency syndromes, existential depressions, and various social deviancy conditions [would] be excluded from the concept of mental illness since these disorders arise in individuals with presumably intact neurophysiological functioning and are produced primarily by psychosocial variables." Such "non-psychiatric disorders" are not properly the concern of the physician-psychiatrist and are more appropriately handled by nonmedical professionals.

"nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on Biomedicine as the only approach to health care".

Resilience-based person-centred medicine

Targeting therapy to the needs of the individual
Conventional diagnosis is essential but is not adequate
for designing person-centred care

Susceptibility?

genetic or acquired factors that predispose to illness & disease

Triggers?

factors that provoke the symptoms and signs of illness &
disease

Buffers?

biochemical or psychosocial factors that contribute to
pathogenesis/salutogenesis and healthful or dysfunctional
responses

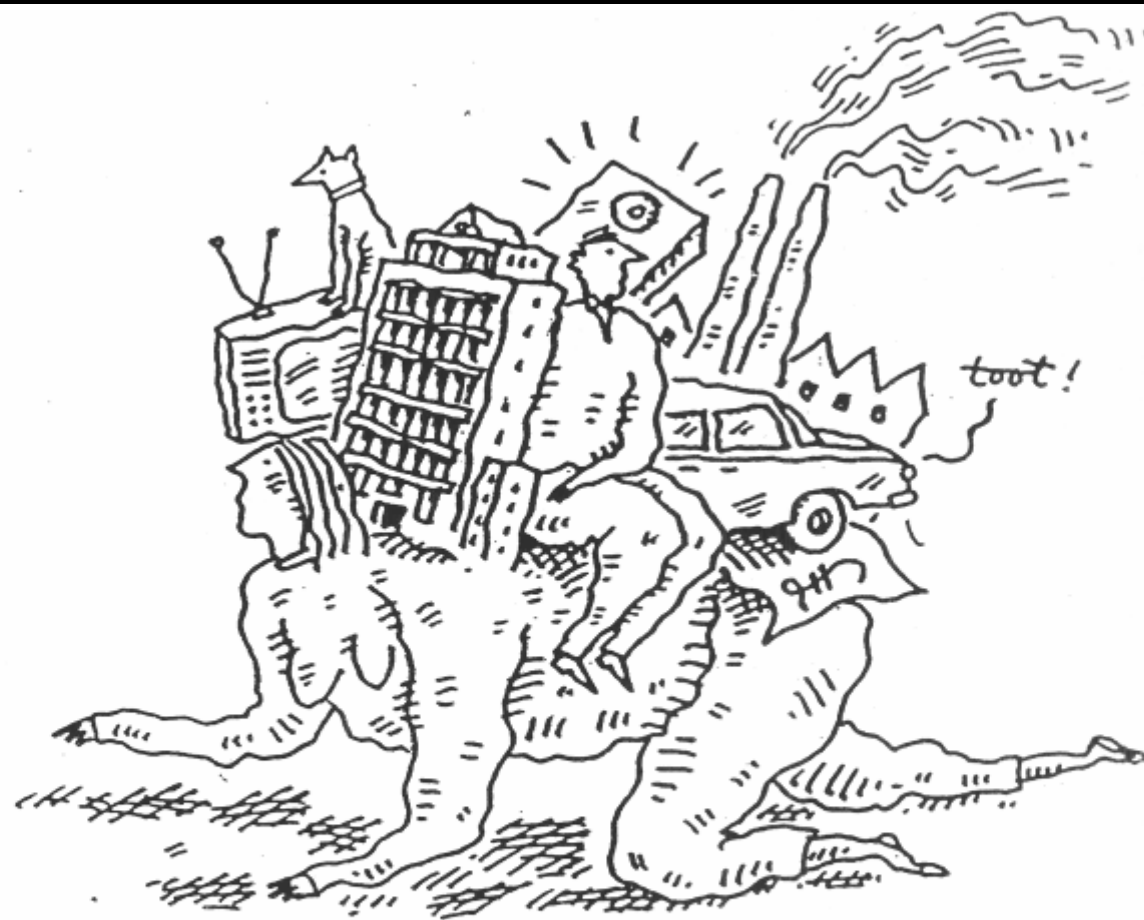
Resilience-based person-centred medicine

Working with mind, movement and metabolism

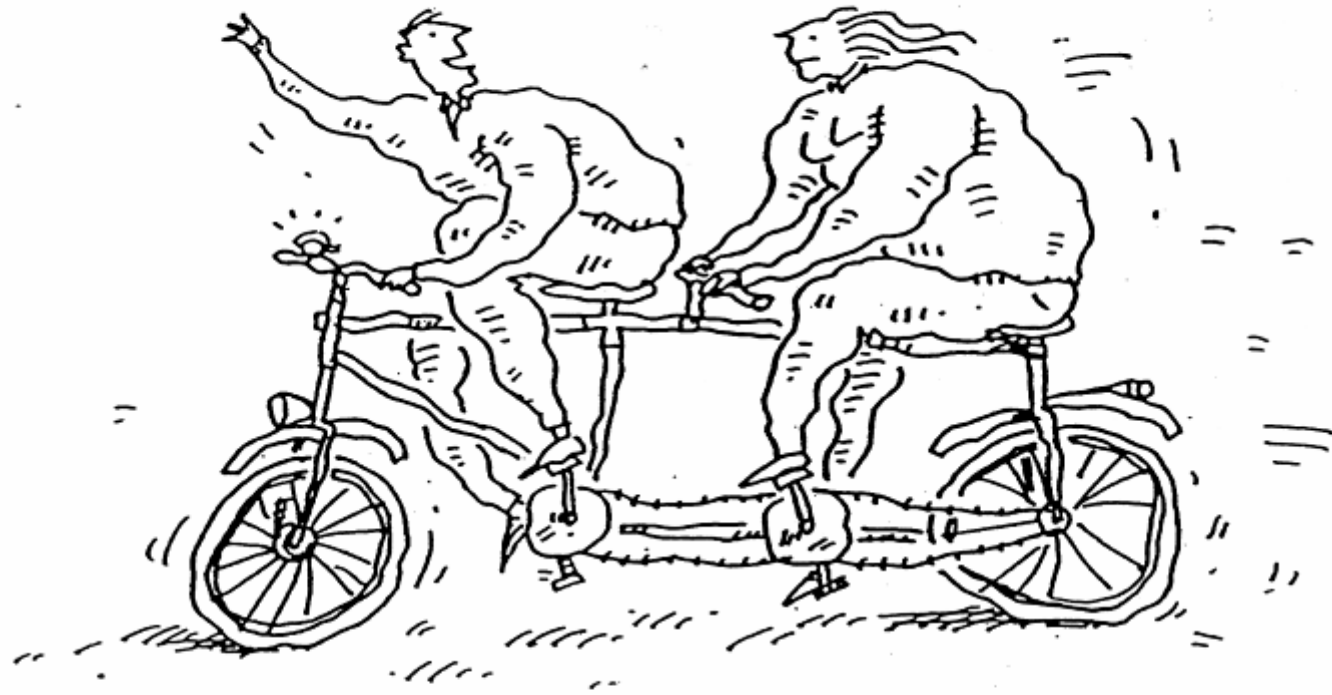
Lifestyle, temperament and diet (and environmental factors) can predispose to illness & disease, provoke symptoms. But they can also reduce the activity of biochemical mediators

A person's beliefs about health and illness are critical to self-care and will influence both behavioural and physiological responses to illness & disease

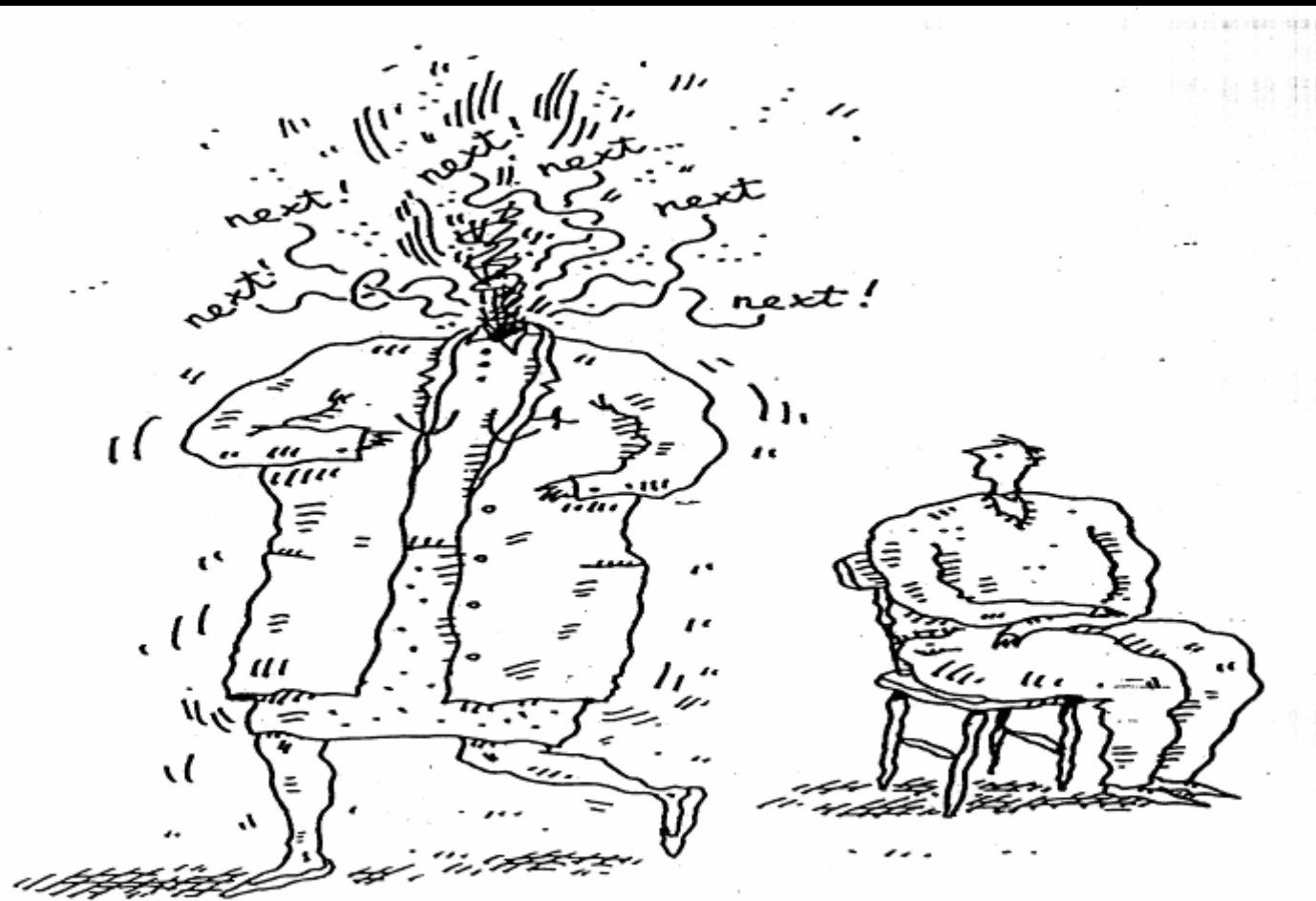
Enhancing self-efficacy through information, education, and the development of a collaborative relationship is important in all clinical encounters because perceived self-efficacy is an important mediator of healing processes



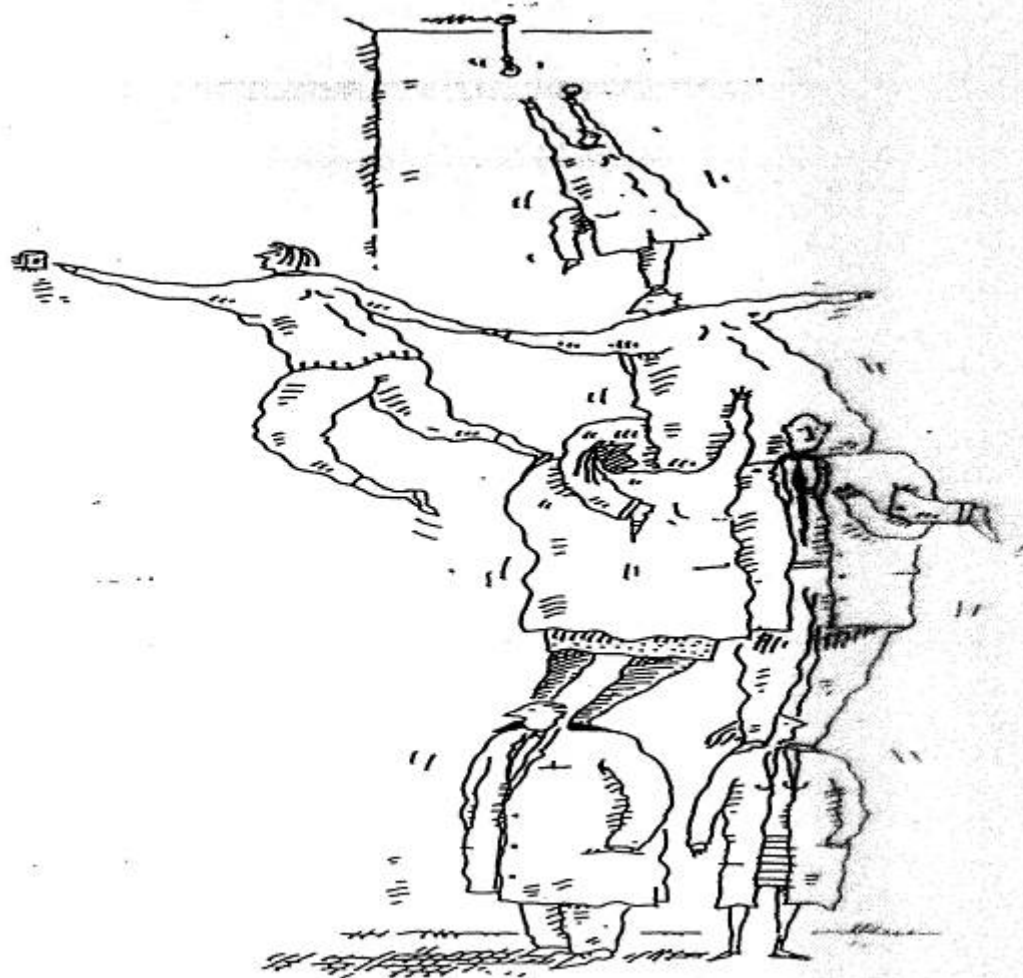
Caring in context.



Empowering the client.



Sustaining the care-giver
- avoiding burn-out.



Working collaboratively

"We are not tinkers who merely patch and mend what is broken....we must be watchmen, guardians of the life and health of our generation, so that stronger and more able generations may come after."

Dr Elizabeth Blackwell (1821-1910) the first woman doctor

"We are not tinkers who merely patch and mend what is broken....we must be watchmen, guardians of the life and health of our generation (and our planet), so that stronger and more able generations may come after."

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