

INTRODUCTION:

UNDERSTANDING THE FUTURE OF MEDICINE

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THE PATHS TO THE PRESENT) — CAPS

This book, and the conference on which it is based, come at a turning point in the history of medicine. It is a time, we believe, when the profession has begun to direct its attention away from an almost exclusive concern with the body and is again focussng on the sick person.

The history of medicine is a story of changing customs and costumes, instruments and methods, explanations and theories. Throughout runs the common thread of attempts to understand what makes people sick and through that understanding to make them well again. We titled this book Changing Values in Medicine, but a better name might have been "Enduring Values in Medicine", for no sickness can be known apart from an appreciation of both the body and the person. It is strange that it should ever have seemed otherwise. Yet present day disease concepts, despite their obvious utility, are conspicuous for their impersonality.

How medicine came to where it is now, and how it was ever possible to forget that sickness always involves more than only the body, is in itself instructive. The history of medicine is often written as the story of a steady and

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determined growth of knowledge about human biology and disease, as if the development of anatomy, physiology, biochemistry, pathology and pathophysiology have all lead inexorably to our present scientific mastery. According to that scenario we are now in our finest hour--and better is yet to come. Some caution is necessary because in every era commentators on medicine have spoken of the brilliant advances of their time, often forgetting that the same praises were sung about medicine in other periods which, in retrospect, seem particularly sterile.

Medical history viewed as steps ever forward is not only not true, but also not very interesting. Vastly more exciting and productive is history read as twists and turns, as excesses and droughts along an uncertain road (if that implication of directionality is even a useful metaphor), profoundly influenced by prevailing philosophies and cultures. Medicine is always a part of its contemporary world, both shaping and being shaped by that world. But its goal has always been the same--the relief of sickness. And the the goal has always been elusive.

When one of us (EJC) graduated from medical school in 1954, excitement over burgeoning therapeutic effectiveness was everywhere. People really spoke about stamping out disease! As unbelievable as it may seem EJC was really concerned that everything would be cured and that no

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interesting diseases would remain. Of course, it turned out that solving some problems (primarily the big name infectious diseases) merely allowed new and unsolvable problems to take the place of the old timers. The goal of providing adequate care of the sick is elusive precisely because of the ever changing face of illness and the inevitable inadequacy of the physicians' knowledge.

In the world of today's doctors, the patients are older, their diseases are often incurable, and the society is undergoing some profound changes whose nature is not clear but whose effects are widespread. The public demands a more personal medical care governed by ethical strictures not dreamed of a decade ago, care in which the patient is seen as a full and knowledgable partner. At the same time, patients are suspicious of physicians and technology even while taking the effectiveness of both for granted. The paradoxes are numerous and depressing to contemplate. How did we get here, and where is medicine going?

The present era of medicine started somewhat more than a hundred and fifty years ago when the concept of disease as we know it came into being. Before the nineteenth century, patients presented themselves to physicians much as they do today-- "dropsied and asthma'd and joint racking rheum'd". But physicians looking at those patients did not see sodium retention, small airway

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obstruction, or synovitis. Nor did they see rheumatic valvular disease, chronic obstructive pulmonary disease, or rheumatoid arthritis. They observed only the symptoms themselves that could be heard or seen. To say that is merely to point to the truism that you cannot see what you do not know. Two factors impaired the ability of doctors to see beyond the obvious. First, they were overwhelmed by competing theories of how nature worked. Iatrochemists, vitalists, mechanists and others offered different explanations of the operation of the body; proponents of each position were able to see only those facts that supported their own viewpoints. (Present-day competing schools of psychology are similar.) Second, there was no cohesive nosology, or classification of disease, that could organize the phenomena of sickness out of the chaos of endless symptom manifestations and theoretical speculation.

Around the middle of the eighteenth century, Cullen in Edinburgh and Sauvages in Paris (among others) developed disease classifications based on symptoms alone. In Sauvages' classification there were 2400 "diseases" -- including, for example, 18 kinds of angina, 19 kinds of asthma, 20 of pleurodynia, 13 of cardialgia, 20 of phthisis, and so on. (Faber 1923) While those classifications were clumsy, they did represent a return to the actual phenomema of illness as a basis for the actions

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of physicians, a return to the bedside (in current jargon) and away from theoretical speculation. But as important as that empiricism was, it still lacked systematic guidance. The system that gave force to empirical methods and brought medicine out of chaos was the modern classification of disease.

The rise of modern nosologies, the classifications of disease that we use today, is detailed in a wonderful book by Knud Faber, Nosology, published in 1923. It is difficult to imagine the extent of the revolution in medicine that started in Paris in the beginning of the nineteenth century. At a lecture given by one of us recently, a student wondered aloud what physicians of 1815 saw when they saw tuberculosis. The one thing they did not see was tuberculosis. Because it had not yet been invented! They may have seen the pthisis in the lung, scrofula in the lymph nodes of the neck, kyphosis from a cold abcess of the spine, or any one of a number of other diverse afflictions--but not tuberculosis. The brilliance of Rene Laennec's contribution to medical progress was that he made it clear that all these things were but different manifestations of the same disease. He made that contribution by tying together what he saw in the living patient with what he saw at the autopsy, and by adding the essential element of physical examination. This is what we

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today call clinicopathological correlation. ^{Note that} ~~Why have we~~ ^{have} used the term 'invent' rather than 'discover'. We have done so to emphasize that when Laennec brought the various organ^a manifestations of tuberculosis together under one rubric, he ^{did not} ~~did not~~ merely uncover a truth that had been lying there all along, like finding a new species of violet in the forest, but rather made a major conceptual leap forward. It might have been possible to organize the reality that turned out to be tuberculosis in another way entirely. For example, the various presentations that we call tuberculosis, or the other afflictions presently known to be infectious, could have been viewed as diseases of malnutrition or social status, and in such a conception diseases would have included manifestations of the social being as well as the body. Such 'disease' constructions, while pointing to one set of causes, might have precluded the discovery of the mycobacterium. In fact, however, along with the concept of disease that developed in those years of ferment in Paris, came the belief that for each disease there was a specific etiology. Thus, the revolution that started in the early 1800s with the concept of disease, coupled with the belief in specific etiology, opened the way for science to be brought to bear on the problems of medicine with the resultant spectacular success of which we are the beneficiaries.

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Thus, in a brief period, disease classification, diagnostic methodologies and the search for specific etiologies entered into medicine, turning it on its head. Stanley Reiser details these developments in his recent book, Medicine and the Reign of Technology (1978). Taken together, Faber's Nosology, and Reiser's book constitute an excellent way of understanding the recent past of medical history and providing a basis for predicting what the next major trends will be.

During the 19th and early 20th century the challenge was diagnosis. Treatment was decidedly secondary. Dr Lain Entralgo, in his book Doctor and Patient (1969), tells a story of the great clinician Skoda making rounds. Skoda held forth at the bedside of a patient displaying his usual diagnostic brilliance. At the the end, when one of the assistants asked him what should be done for the patient, Skoda brushed the question aside as of no importance! He, like other great physicians of those decades, felt that science had been the salvation of the profession. A new discipline (for Skoda anatomical pathology was the base of medical knowledge) had entered medicine that saved it from the sloppy, unfounded and uncontrolled therapeutics of purges, poultices and phlebotomy. That was what treatment was and that is why treatment was of no interest. Thus to the moral discipline of responsibility to the patient and

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to the profession handed down through millenia, science added an equally valid cognitive discipline. Medicine, like the remainder of humankind had entered the era of science and technology.

During the last forty or fifty years medicine has again been turned inside out by the exploding therapeutic effectiveness with which we are all familiar. The fact that change is still going on hardly requires comment except to point out that one of the most recent major advances is the large scale controlled therapeutic trial which is little more than a decade old.

CURRENT PROBLEMS

The effectiveness that blesses our hands would not have been possible were it not for the disease classification introduced in the early 19th century. But there is a circularity built into the system that prevents us from seeing its inadequacies. The disease classification is based on pathology--alterations in structure. Even though disease definitions that are primarily biochemical or physiological have recently become acceptable, the basic thinking is still oriented around the structural alterations of disease. Consequently the therapeutic effectiveness of which we are justly proud is also oriented towards diseases. Thus it should be no surprise that our care of the sick is out of balance. If some aspect of an illness is not included in the definition of the associated

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disease, treatment will not usually be directed at that feature of the illness. The concentration on disease and technology has left the more personal and human aspects of sickness less well understood and poorly cared for. Growing awareness of that lack and widespread desire to find a remedy are part of the reason behind the Conference on Changing Values in Medicine and this volume. However, the search for a more balanced medicine is by no means new. There is a certain irony in the fact that Rudolph Virchow, who provided the strongest evidence for the structural basis of disease, and in so doing helped bury humanism in medicine for a hundred years, was himself a committed humanist. In 1848 he wrote "Our task is an educational one, we must train men capable of fighting the battles of humanism" (1848, ^{p.274} ~~Medizinische Reform 1848, p.274~~). It is in this century, however, that the deficiencies of an orientation to disease alone have become increasingly obvious. The March 19, 1927 issue of the Journal of the American Medical Association carried the now famous paper by Francis Peabody, "The Care of the Patient", which states the problem posed by concentrating on disease as clearly as it has ever been written.

Over the past two generations, certainly since the 1950's, medical educators have attempted to shift the orientation of medical education and medical practice away

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from an almost exclusive concern with disease and technology and towards a greater concentration on patients themselves. The phrase 'treat the patient as a person' has been around so long that it has become cliché. Note that although the phrase 'a coin lesion of the lung is carcinoma until proven otherwise' has also been around for a long time, we do not call it cliché but rather a dictum. The difference between the two statements is that the one about the coin lesion not only provides a direction for action but rests on a substantial base of knowledge and recorded experience. In addition, the language of description for the lung and its lesion is by now held in common by physicians over the entire world. By contrast, 'treat the patient as a person' is an imperative that rests on the common humanity of physicians and patients; it is largely unspoken, uses no universally agreed upon "professional" language, and provides no unambiguous basis for action. (Indeed, the phrase itself is somewhat ambivalent since it literally means that a patient should be treated as if a patient were a person; as in "when treating women with cancer of the breast one should remember that they are also persons".)

It is not surprising, therefore, that these attempts to reorient the direction of the profession have not been very successful. In fact, there are even some who feel that

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the problem has actually gotten worse. Those commentators point out that in recent decades medicine seems to have become increasingly technological and scientific, and consequently more impersonal. According to that view, we take into our medical schools the most compassionate, concerned and bright young people and turn them into "autotechnicons". While that may be a somewhat harsh viewpoint, it is certainly true that it is difficult to compete in the students' list of priorities with biochemistry, or learning to do technical procedures or to read CAT scans.

During the same period as our disquiet with medicine has been growing, the world around has been in upheaval. The last two decades have seen our culture's view of science change from the source of salvation to the source of difficulties. Scepticism has replaced the former sense of trust. A distinct antitechnological drift exists, paradoxically, alongside a continued love of new products and is accompanied by the increased distrust of physicians noted earlier. It is startling these days to find that patients who have been seriously ill with infections often attribute their post-illness fatigue to the the antibiotics that cured them, instead of the illness. The drug has become the enemy, not the disease. While that may be a natural attribute of an extraordinarily healthy society, it

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is also an indicator of the cultural milieu.

There have also been a marked changes in the traditional attitudes of Americans to their government and to authority in general (including physicians), and even in the concept of the individual--so vital to American political history. The word 'individual' (the Constitution of the United States speaks of persons in the same sense) which once meant primarily someone who is equal before the law, has increasingly come to mean someone who is his or her own person--"me, myself, and I". Sameness is no longer the salient characteristic; instead, differences are the crucial feature of the concept of the individual. This is not the place to explore the profound conflicts that a change in the cultural meaning of the word 'individual' from a term of egalitarianism to one standing for uniqueness introduces into American political life. It is apposite, however that this conference addresses an exactly parallel problem in medicine and in medical science. The Social Medicine movement of the 1930's addressed itself to the problem of providing all sick persons with equal care regardless of their of race, ethnicity or socioeconomic status. And those are still important concerns. But now, in addition, the patient is seen to be unique and it is because of its contribution to that sick person's illness, its treatment, to that person's life itself as lived, that

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the idiosyncratic mix of features that we know as person has come to demand attention. It is clumsy to write that because there is no synonym for person, the meaning resides in the word, and the meaning has changed in the last twenty years. All those intertwined changes, technological, cultural and political have created the setting in which the Conference on Changing Values in Medicine took place.

FOCUS OF THE CONFERENCE

Although this Conference is certainly not the first time these issues have been addressed, it does represent a fundamental change in approach to the problem of attending to persons in medicine. That approach is based on several beliefs. We do not think that doctors turn away from the personal within their patients because doctors do not care, or that students opt for technical means because they lose their concern and compassion. Both students and doctors act the way they do because their knowledge and skills--all hard bought--are primarily disease oriented. When they do not attend to the "personal" aspects of illness and patient care, it is simply because they do not know how. They do not have the knowledge or the skills because they were not taught. In fact, beyond providing role models and the moral imperative to treat the person, faculties of medicine do not know how to teach the special skills required by the change of medicine's focus toward the sick person.

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The Conference and this volume are more than a restatement of the need for a medicine concerned primarily with the sick person and they go beyond simply another cry for more humanism in medicine. Rather, these papers are based on the belief that gaps in knowledge and understanding, (technical problems in one sense of that word) and not a lack of humane impulse are what stand in the way of progress. Further, the papers reflect the conviction that these difficulties will give way before the sustained application of intellect and concern, just as have the afflictions of the sick in previous times. That our knowledge is inadequate, that the path is obscure, merely joins us to all of the history of medicine. To redress these deficiencies, to acquire the necessary knowledge and skills, individuals must make this intellectual area their primary academic concern. And for that to happen, new sources of support must be made available and medical schools must honor the endeavor. With appropriate effort we believe that those changes can and will take place. It is our hope that this volume will point to some of the many areas of research that are necessary.

PATHS TO THE FUTURE

Even if we could agree about the problems of today's medicine, we would still be a long way from being able to propose solutions. Lack of agreement about what are the main difficulties with modern medicine, however, has not

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stemmed the tide of proposed solutions. Holistic medicine is an example of a prescription for better medical practice that has taken hold as a small social movement. The proponents of holistic medicine, however, like most critics of current medical practice, are much clearer about what they do not want medical practice to be than about what physicians should do in the future.

What are the major barriers to understanding the future of medicine in a time of change? Of the many issues identified by the authors in this volume, we believe that three stand out. First, there is the change in the status of the individual noted above. This expresses itself in medicine as a tension between two different ways of viewing the patient. In one, roles and relationships assume primary importance: the patient is regarded as someone who relates to others, the disease, the environment, the physicians, and who cannot be seen or treated apart from those relationships. In the other view, of more recent vintage, the patient is considered primarily as an autonomous possessor of immutable rights that override every other consideration.

The second barrier arises from the science that has been fundamental to the development of modern medicine. In science the objective is to understand the individual occurrence by means of a general law. But in medical

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practice, knowledge of what is generally the case does not tell the physician how to treat this particular patient. The problem of how to proceed from the prototypic case to the individual instance remains to be solved in a systematic manner.

The third, and perhaps most important, source of difficulty is that many of medicine's basic concepts are assumed to be so widely shared and understood that definition and analysis are unnecessary. The strength of Otto Guttentag's essay (indeed, of his life's work) is his realization that we stumble not because of failures to understand the complex, but because we fail to stop and analyse the obvious and the simple. Professor Guttentag forces us to attend to the rarely articulated but fundamental question, "Who and what is medicine all about?" Speaking from the perspective of the attending physician--the patient's doctor--Guttentag re-examines the most basic issues of all of medicine: what is a patient, what is care, what is sickness. Step by step, and diligently, he looks at every concept in the central medical equation. His paper is a distillation of the work of decades: each of its major themes--the central role of the attending physician, the physician-patient encounter, and the single disease concept, or clinical entity--has been the subject of previous papers. His complex essay can

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most profitably be approached through the references provided at the end of his paper.

The rapid and profound transformation of medicine by scientific and technological advances over the past 50 or so years seems to have changed the role of the physician--to have made romantic but obsolete the notion of a single doctor taking care of a single patient. In assessing these developments, Walsh McDermott contends that far from diminishing the centrality of the patient's own physician, the new technology has actually thrust the doctor into an even more pivotal role. Because the use of technology begins at the bedside, a return to the centrality of the attending physician is no mere romantic idyll, but is increasingly essential in order to control the use and cost of technology. Hence McDermott calls for the development of a more "discriminating medicine" with the personal physician as the key to its success.

But what are the qualities and characteristics that define a good physician? In searching for a common core of meaning, Hans Jonas found that "at every turn there waited either the bane of the obvious or the taunt of the indefinable". The obvious is technical knowledge, that is, the 'good' in good doctor starts with the acquisition of medical facts. Unfortunately, much of medical education seems based on the premise that the mastery of facts is the

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end of the matter. Jonas goes on to explore the equally necessary but difficult to define virtues of judgment, nerve, empathy, and moral character. These are often considered to be arts, or inborn qualities, as if it were not possible to teach them. However, such characterizations may simply reflect the fact that we have not yet learned how to teach these requisites of the good physician, and not that they are inherently unteachable. From the essay^s by Professor Jonas and Dr. Guttentag, it is clear that basic conceptual questions --e.g., what is a good doctor? what is judgment? what is a person?--must be addressed by medicine. That these issues have been the concern of western philosophy since its beginnings should give one pause, but it is not hubris to insist that they be tackled anew. Even if these key questions again prove resistant to satisfactory answers, the attempt should provide some new understandings. As in the treatment of alcoholism, partial success is not failure.

Pedro Lain^y Entralgo, writing about the meaning of the word "good" in "good patient", and James Childress in his commentary, bring us directly to the center of another of the issues critical to understanding the future of medicine. For Professor Lain the good patient is not only a person altered by sickness, but someone who has religious, moral, and social duties which are a necessary part of the

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equally necessary will to be better. These duties, and the obligation to try and get well again, entail certain attitudes towards the physician, the patient's own self, and the surrounding society. In the totality of these duties, obligations and attitudes, one finds the "good patient". Written with Lain² Entralgo's characteristic richness and penetrating insight into patients, doctors, and medicine (which should entice many into the rewards of reading his other work), his essay places more emphasis on the duties of the patient than on his or her rights. This picture is not changed by his closing insistence that to be a good patient requires a good physician.

James Childress counters these views with arguments increasingly familiar to American physicians (although seldom so well expressed). Professor Childress takes Lain² Entralgo to task for overemphasizing the patient's duties as a patient and undervaluing the individual's rights and freedoms that, he believes, are in no way diminished by the fact of patienthood. Childress vigorously argues the position that is sometimes called "radical autonomy": nothing must diminish patients' rights to make autonomous choices. To speak about the will to be cured represents a kind of moral paternalism in which the value of health is seen to have priority over other goals such as freedom. Even the use of the term 'good patient', he

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suggests, introduces an unnecessarily moral tone to the argument and he offers as a substitute 'responsible patient'. Although more articulate than most, James Childress' plea has found many voices of late, even among physicians. That this argument also has adherents in nursing is shown by Sally Gadow's eloquent statement towards the same end.

This issue resonates in the other papers in the volume. In the discussions of Mark Siegler, Eric Cassell, Otto Guttentag, as in the conversations of virtually all physicians, no matter what their stated position on patient autonomy, some necessary relationship between patient and doctor is presumed. Even Edmond Pellegrino, who is a forceful advocate of patient autonomy, points out that both the illness and the relationship with the physician alter the almost absolute primacy of autonomy that seems to be pictured by Childress and Gadow. Pellegrino, however, resists Al^aisdair MacIntyre's characterization of the problem. With his usual elegant clarity, MacIntyre goes to the heart of the matter and contends that the person pictured by the radical autonomy view is, simply stated, a myth. No person exists apart from all of his or her roles, as well as the social setting and matrix in which they are found. Autonomy, for MacIntyre, "...is not...a property of every rational agent. It is an achievement and a social

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achievement, as is rationality itself." It follows that the actions of physicians and the image of medicine they value and project will have a profound effect on the patient's ability to achieve and maintain autonomy. Does the depersonalizing bureaucracy of doctoring, done in the name of efficiency or cost control, further enmesh patients or set them free? Will doctors be owners of the power of magic or sharers of knowledge? Is the patient an object of scientific attention or a sick person to be cared for? ^aAlasdair MacIntyre explores all these questions and their implications in rewarding detail.

As MacIntyre unpacks those issues, and indeed in many of the papers, it becomes clear that certain kinds of knowledge and information which seem essential to medical practice are far from the scientific generalizations about the body and disease usually considered medical knowledge. Mark Siegler convincingly argues that clinical medicine, in contrast to research medicine, cannot be understood solely in terms of its body of scientific knowledge. He makes his point by showing that the nature and limits of clinical medicine are defined by what is, in its essence, a personal encounter between doctor and patient. The evolution of the encounter is traced from its beginnings in the patient's decision that something is a "medical" problem to a developed relationship between doctor and patient. Dr.

