Patient centred medicine: reason, emotion, and human spirit? Some philosophical reflections on being with patients

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The ideal of patient centred medicine remains only partially realised. Within modern Western society, the highly individualistic culture and religious decline linked with medicine's reluctance to relinquish an outmoded form of scientific rationalism can act as reductive influences, stifling conceptual development. Some examples of the recent literature on communication skills in medicine are analysed to discern the underlying philosophy. A rationalist stance invites an examination of the possible nature of rationality. Another example accepts the need to accommodate the emotional and the unconscious. Issues of human suffering with an inherent spiritual dimension seem to remain excluded. The need to move beyond a duality of reason and emotion to embrace the existential and spiritual is suggested as a theoretical prerequisite for developing a more inclusive concept of patient centred medicine, which only then may be realised. Some brief examples are considered of the sort of notions and types of discourse that might effectively inform "teaching" of communication skills.

Patient centred medicine has a large and expanding literature yet still seems to remain a theoretical ideal rather than practised reality.¹ In reflecting on this disparity it may be fruitful to take a closer look at what we mean by the concept of patient centredness, its nature, and how this relates to the teaching of this to doctors. This can also not be undertaken without taking some account of the nature of medical culture informing the communication skills methods and the larger culture of Western society which embraces the patient/doctor relationship. It will involve first, briefly tracing the historical roots of some major influences that still constrain the Western medical paradigm; a form of scientific rationalism in the context of an individualistic and secular Western culture. The focus on patient centred medicine will take some examples from the recent literature on communication skills in medicine to discern the underlying philosophies. One example taking an overtly rationalist stance invites some reflections on the possible nature of rationality through the eyes of some philosophical thinkers. These also help inform the assessment of another example that recognises the need to

expand the concept to accommodate the emotional and the unconscious which, though plausible and convincing, remains problematical when facing an issue such as human suffering with its unavoidable spiritual dimension. Conceptual development of patient centredness beyond a duality of reason and emotion, or of the conscious and the unconscious—to embrace the existential and spiritual dimension, however difficult—seems appropriate when consultation modelling and communication skills discourse may struggle or fall silent. This question may help inform the differential diagnosis of why the practice does not match the theory: to overcome the compartmentalised view that places the spiritual and existential problems of life outside the modified medical model, we may need a richer and more inclusive form of discourse, which can be typified by some examples from a spiritually informed philosophical viewpoint.

"Medicine in industrialised countries is scientific medicine".² The quotation opening John Saunders's account of the art and science of medicine illustrates a compartmentalised view of medicine—the "art" of medicine being restricted to the moral dimensions of care centred on the human faculties of the doctor: "... the ability to listen, to empathise, to inform, to maintain solidarity: for the doctor, in fact, to be part of the treatment".² Saunders suggests the "art" of medicine extends further, indeed that "... the art and science of medicine are inseparable, part of a common culture. Knowing is an art; science requires personal participation in knowledge".²

This reminds us how contemporary medical thinking and practice remains heavily influenced by a nineteenth century view of scientific rationalism, "... sometimes thought of as [one of] the last bastions of Enlightenment thinking".³ Modern biomedicine, with its roots in a Cartesian and dualistic mechanical view of mind and body,⁴ through its scientific and technical success could be viewed as determining not just the knowledge, but skills, attitudes, and even moral values deemed necessary in the good physician. In a population selected for convergent thought⁵⁻⁸ an overly reductionist view of modern medicine⁹ may sit quite naturally. Yet on this view our humanistic and moral concerns in an increasingly secular society can appear as a separate domain, and the connections to the medical model sometimes unclear.

REDUCTIONISM

Reductionism in this context is that pattern of thinking whereby different explanations or accounts of something are arranged in a hierarchy.

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They are seen to run in a linear manner from the superficial to the more fundamental; from the “softer” to the “harder”; sociology may be reduced to biology; biology to chemistry; chemistry to physics. This tends to assume the “harder” more fundamental explanation is closer to reality, and thus being more “real” is accorded the status of a more complete and final answer. This logic thus imputes a measure of unreality to explanations at a higher level, implying they are little more than approximations that could in principle be reduced to a more “scientific” one; the implication also being that such reduction may in some sense render the higher level obsolete. In this way the reductive assumption subtly extends its instrumental effectiveness to imply a certain type of worldview. The seductive nature of this view does not depend solely on its record of success in the field of modern science. Many writers point out^{10–11} that this draws on the imagery of atomism, which has endured from the origins of Western civilisation in Greek thought. The atomistic vision results in a search for ultimate simplicity and completeness. It promises a final answer by breaking things down into ultimate units. This atomistic doctrine has informed the reductive project of modern science on the one hand, and the social atomism of individualism on the other. The way these two strands of thought have complemented and reinforced each other is examined at length by Midgley.¹⁰

This paradigmatic view may no longer constrain thinking in the “hardest” science of physics¹² yet, though increasingly recognised in medical circles, it remains a subtly persistent influence. This can be seen in the way these patterns of thought can limit not just the way medicine is perceived, but also the scope of ambition in those that wish to alter this perception. We can explore this in relation to patient centred medicine, what it means, and how it is approached through communication skills programmes.

COMMUNICATION SKILLS AND PATIENT CENTRED MEDICINE

Training in communication skills is now an established concept with a sophisticated literature. The field grew from a liaison between doctors, psychologists, and educationalists. The range of models suggested over the last few decades may differ in perspective and emphasise different elements, but what they all seem to share is the aim of patient centred consulting.

The *doctor centred style* at one end of the spectrum can be characterised by the paternalistic, autonomous doctor as the expert, whose clear role is to extract the relevant information (relevant for the doctor) from the patient, apply the biomedical (lately biopsychosocial) model to come up with the correct diagnosis and appropriate treatment (judged by the doctor). This package of care is delivered to the patient.

The *patient centred style* might be seen as a more genuine dialogue. Its initial aim is to access, and take account of, the patient’s subjective experience, not just for exploration of symptoms in pursuit of diagnostic accuracy, but also to gain an understanding of his/her hopes, fears, expectations, thoughts, beliefs, and life context—that is, to get to know the other as a person, as another self, as a fellow human being. The literature in this field over the last three decades attempts to move along the spectrum.^{13–17}

WHY PATIENT CENTRED? A SPECTRUM OF AMBITION

The value of the patient centred style depends on its aims, which can lie along a spectrum of ambition. A modest aim could be to achieve effective consultation as judged by health outcomes in biomedical terms. This aim seems broadly accepted, with much research addressing the question of when this style is effective and how far it need be taken.¹⁸ A more ambitious middle range may address the wider psychosocial dimensions with less regard to direct outcome

measures. At the far end the aim might be to know the other in order to respond as oneself, to gain as full an encounter between whole persons as one can. This moral encounter, and the responsibilities that spring from it (for both parties), can then provide the framework *within* which any effective consultation takes place. We can now view this expanding concept of patient centred medicine in relation to some of the more recent literature.

An approach by Kurtz and colleagues¹⁸ takes an overtly evidence based line. They focus on skills rather than attitudes, supporting this with evidence of the effectiveness of these skills. They state in their introduction: “Communication is not a personality trait but a series of learned skills”¹⁹ yet remain ambivalent, conceding that: “Communication skill is closely bound to self concept, self esteem and personality . . . we have to work with our own and others’ feelings in studying this subject”.²⁰ Their approach is pitched as a direct appeal to what is seen as a rationalist core running through both biomedicine and evidence based medicine, and even if the authors themselves recognise the limitations, they clearly see more ambitious aims as having to be mediated through this rationalism; primacy is given to this rationality.

A more expansive view can be found in the work of Salinsky and Sackin, who feel the “missing pieces” of this sort of “best practice” approach can be addressed “. . . by paying attention to what the doctor is feeling rather than what he/she knows”.²¹ Thus they see emotion as the counterbalance to complement the rational, providing crucially important insights. Yet this account does not exhaust the potential of the patient/doctor interaction.

This is recognised by Misselbrook²² who suggests that “. . . the need to be patient centred has been well stated, but what this means is still largely uncharted”.²³ He feels the case for patient centred medicine is won and concentrates on exploring what he sees as the main block to its development in practice. We are urged to make diagnoses in physical, psychological, and social terms, and yet the evidence based medicine (EBM) that is currently promoted either restricts itself to physical evidence alone, or casts such evidence at the top of a hierarchy that tends to devalue any evidence “lower down”. While the problematic nature of what counts as evidence remains very much alive, serious exploration of what we mean by being patient centred will inevitably reopen the “case for”; perhaps we must push the conception of the doctor/patient relationship beyond the confines of a descriptive model. This widening process could take account of philosophical and spiritual perspectives, without which the issue of human suffering in the patient/doctor relationship seems to be difficult to approach. In what follows I intend only to suggest how conceptions of the patient/doctor relationship may limit themselves—intentionally or otherwise—partly through pride and confidence in our human rationality which is sometimes misplaced, and partly through fear and lack of confidence in the human spirit required to deal with our own and other people’s suffering, which again may be misplaced. Through drawing on some potentially helpful examples of thought in this sphere the intention is to suggest the central importance of addressing the patient/doctor relationship in terms of a wider range of human capacities—rationality, emotion, and human spirit.

RATIONALITY

You see, gentlemen, reason is a good thing, that can’t be disputed, but reason is only reason and satisfies only man’s intellectual faculties, while volition is a manifestation of the whole of life . . . life frequently turns out to be rubbishy, all the same it is life and not merely the extraction of a square root.²⁴

The moral philosopher Midgley has explored, amongst many themes, the relation between reason, emotion, and the

motivation of human behaviour. Her earliest work *Beast and Man: The Roots of Human Nature* is a call for the integration of our human capacities without denying our essentially animal nature.²⁵ It was written at the time of a polarised debate, between on the one hand “social scientists . . . still insisting that human nature did not exist at all. Human beings were pure products of their culture, originally indeterminate items, infinitely malleable . . . shaped only by education”²⁶ and on the other hand the sociobiologists whose reductive claim, based on “genetic determinism”, proposed to “reshape, displace and finally cannibalise the entire social sciences and humanities”.²⁶ Midgley attempted to bridge the divide.

The emergent view was of a rationality grounded in our biology. Midgley demonstrates the way Reason has usually been sharply opposed to Feeling or Desire in the philosophic tradition, extending back to Plato, whose view of evil as something alien to the soul involved ascribing a necessary subservience of animal desires to human reason: the “Beast Within, whose only opponent is the Rational Soul”.²⁷ This opposition, running through the history of Western thought, supports her claim that “Fear of and contempt for feeling make up an irrational prejudice built into the structure of European rationalism”.²⁸

Rationality arose, in evolutionary terms, in response to the pressure to choose between conflicting desires; and these desires are in this sense prerational, forming part of our biological nature. The point emphasised is that the conflict is not between man’s reason and his more primitive desires, but between those desires themselves. These conflicts “ . . . are not the result of thinking; more likely they are among the things that first made him think . . . conceptual thought formalises and extends what instinct started”.²⁹

The examples of justice and honesty show how rational reflection could not work without some sort of “unevenness for it to get a grip on”—that is, a pre-existing balance and structure among the motives. Both justice and honesty were important and valuable elements of human life taken to imply that

. . . impulses to be fair or truthful have a special value. Reflection recognises this and does not create it. Conscience is not a colonial governor imposing alien norms; it is our nature itself, becoming aware of its own underlying pattern. It does not invent a new set of priorities; it sees those that are called for. It is not free to make up the rules of the value game.³⁰

What is emphasised is the “late arrival” of rational thought onto the scene of animal (including human) behaviour, even that which has tended to be credited to specifically human rational thought, such as behaviour serving the welfare of the community as opposed to the individual. The author quotes Lorenz on this misperception.

Not only is this opinion erroneous, but the very opposite is true. If it were not for a rich endowment of social instincts, man could never have risen above the animal world. All specifically human faculties, the power of speech, cultural tradition, moral responsibility, could have evolved only in a being which, before the very dawn of conceptual thinking, lived in well-organised communities.³⁰

We need to accept the essential role of our feelings in motivation, not as a subsidiary phenomenon, but as central in guiding our behaviour. They are the raw material without which our rational faculties would serve no purpose. In one sense, as Wordsworth puts it, “. . . our thoughts are the representatives of our past feelings”.³¹

In highlighting what could be described as the “unnatural” opposition of thought to feeling Midgley attempts to draw attention to a more integrated view of human nature, and in so doing points out the damaging flaws in the Enlightenment view of rationality that has served as a basis for modern science, and more importantly in this context, for modern medicine.

This evolutionary view of rationality is developed and articulated usefully by Nozick³² in *The Nature of Rationality*. In his lengthy exploration he claims that instrumental rationality, though not exhausting the concept of rationality, remains central to all theories, and manages to provide a detailed and plausible account of this instrumental rationality from an evolutionary and thus biological perspective. He realises that this account itself, depends, in part, on reason supporting evolutionary theory in general, and this application in particular, in that though it grounds reason in facts independent of reason this cannot be accepted independently of our reason. These are Nozick’s words, more or less, which I take to mean that it is the acceptance of evolutionary theory on rational grounds that is required over and above the inherent rationality of any theory’s construction whether acceptable or not—that is, acknowledging that should evolutionary theory be scientifically “overturned” this would affect the argument and so this grounding of rationality cannot be accepted independently of reason. As such “. . . the account is not part of first philosophy; it is part of our current ongoing scientific view”.³³

Nozick contrasts the evolutionary hypothesis with the perspective put forward by Kant. Observing that the rationalist argument could provide no convincing reason why supposedly independent facts and reason should correspond, Kant proposed that (empirical) facts were not an independent variable, and that objects must conform to our knowledge, to the constitution of the faculty of our intuition. Thus our knowledge is not of “things in themselves” but only an empirical manifestation or representation. But another alternative is that reason is the dependent variable, shaped by the facts, accounting for the correspondence, and it is just such an alternative that the evolutionary hypothesis presents.

Nozick considers rationality as a biological adaptation, and explores its function very fruitfully. For example, he tempts us to try out the following hypothesis.

The list of philosophical problems that thinkers, without evident success, have long struggled with—the problems of induction, of other minds, of the existence of the external world, of justifying rationality—all mark assumptions that evolution has built into us.

. . . it was never the function of rationality to *justify* these assumptions that embodied stabilities of our evolutionary past but to utilize these assumptions in order to cope with changing conditions and problems *within* the stable framework they established.³⁴

Returning to Kant, and to his attempt to make principles the sole guide to behaviour at the expense of individual desire, Nozick argues that “. . . principles are [partial] devices . . . formed to function in tandem with already existing desires, some of which were biologically instilled . . .”.³⁵

As such, Kant is mistaken in divorcing rationality so clearly from the emotional nature of man. Midgley points out that in equating morality essentially with reason, he took for granted an emotional background he did not notice—his own natural empathy and a passion for justice.³⁶

Thus we arrive at a view which accepts “. . . the embedded, and embodied, nature of our rationality”.³⁷ This gives a picture of rationality embodied in our biological reality and embedded

in our evolutionary history. In placing the context and limits on rationality in this way, Nozick draws comparisons with similar themes of other writers, (Wittgenstein, Dewey, Heidegger, Polanyi), "... who also, for different reasons, see rationality as embedded within a context and playing a role as one component along with others, rather than as an external, self sufficient point that judges everything".³⁵

This notion of rationality would always have to take account of the "given" nature of biological desires as providing the "biological starting point", and would always question the assumption that by definition these desires are rational.

Perhaps this marks a limit to our rationality, the fact that we are creatures. We start with certain desires and predispositions; although we are not forever stuck with exactly these—we can modify and transform them in various ways—we will always be at a place reachable from there.³⁸

It is this prior starting point for any rational process that seems to fade from view. Indeed the rational process itself, to some extent, tends to encourage a distorted valuation of its role, and its goals; as if, once given life, it attempts complete autonomy by covering its tracks—a form of "parricide" that Isaiah Berlin observed,³⁹ as new scientific disciplines emerge from their less tidy philosophical and historical origins. Rationality can appear to become the vehicle of salvation in an attempt to transcend the limits of the "given", a self contained world capable of serving as a source of value. Yet as Weber would argue:

[the] instrumental rationality on which modern Western society puts so much store . . . the ends [political, economic, social] . . . are ultimately non-rational and "arbitrary" or "conventional" . . . they derive their legitimacy from value decisions whose ground is anterior to instrumental decisions.⁴⁰

all forms of rationality, in particular the "instrumental" and "absolutist" rationalities [Man] had used as his compass points, were ultimately grounded in subjective values, whose sources and wellsprings were non-rational, charismatic, affective and intuitive.⁴¹

Accepting a scientific view of rationality based on our evolutionary biology means also accepting that our values may not emerge from a rational source; nor can they be simply added to a rational base; they serve as the motivational context within which rationality has an important but limited and instrumental function. In relation to patient/doctor communication Kurtz *et al*, promoting an evidence based approach at the level of skills in preference to dealing with personal attitudes and values, seem to reflect some of the limitations mentioned earlier (overconfidence in rationality, diffidence over the non rational aspects of human nature) thus echoing the deeper, persistent influence of Enlightenment rationality on medicine in a wider sense.

EMOTION

I agree that two and two make four is an excellent thing; but to give everything its due, two and two make five is also a very fine thing.²⁴

The limitations of a purely rationalist, skills based approach to doctor/patient communication are recognised by Salinsky and Sackin.²¹ They take a Freudian psychoanalytic line from the psychiatrist Balint⁴² who, in the 1950s, pioneered the idea

of the therapeutic effect of the doctor himself—"doctor as drug"—and the value of the doctor using his own emotional activity during encounters with patients both in a diagnostic sense and as an essential element of the doctor's development. Balint proposed that for most doctors trained in conventional "history taking" a deeper form of communication was called for: "... [T]he ability to listen is a new skill . . . in learning to listen to patients the doctor begins to listen in the same way to himself . . . [which requires] a limited though considerable change in personality".⁴³

Salinsky and Sackin propose various unconscious defences in the doctor, built up through a combination of professional and personal circumstance that by rising to conscious awareness allow control leading to improved communication. This essentially focuses on problematic or difficult doctor/patient relationships in order to uncover the unconscious emotional stumbling blocks. They are right to point out the lack of depth in the skills approach, with its narrow rationality and rightly argue for attention to the non-rational, emotive aspects of a doctor's behaviour. Exploring these emotional aspects in sufficient depth (and this is where Balint style work has been criticised as only for the highly motivated minority due to the large personal investment required) would then provide the missing ingredients to complement the skills approach.

Salinsky and Sackin's early discussion concerning the development of self awareness and our capacity for empathy is encouraging. The "illusion" of a professional self that remains unaffected by human emotions while keeping our personal selves out of the interaction is seen as unsustainable: "... we soon realise that the professional self is only a specialised part of the personal self".⁴⁴

This recognition of the inseparability of personal and professional development certainly acknowledges the need for a much wider conception.

Once we learn to listen, our clinical method requires us to attend to the emotions in every case. It cannot do otherwise. We will no longer be able to live with the affect-denying clinical method that dominates our medical schools.

. . . listening is at the same time *a skill, a state of mind and a way of being* a physician . . . without the intrusion of distracting thoughts and emotions we can respond to suffering with authentic feelings and acts of compassion (my emphasis).⁴⁵

Yet I would suggest the challenge of responding to suffering from an authentic way of being is not met from within the psychoanalytic perspective—there is something of a conceptual withdrawal. The defences, seen as necessary in the context of the "... physical, mental, and spiritual suffering of our patients"⁴⁶ can only be brought under conscious, and thus more rational, control; the price paid being "... a loss of some capacity to experience something of oneself and the other".⁴⁷ This tradeoff could be seen as returning to a rationalism that lacks "negative capability"—that is, "... the ability to endure absence, uncertainty, partiality, relativity, and to hold at bay the desire for closure, coherence, identity, totality".⁴⁸

The psychoanalytic perspective might itself be viewed as another manifestation of Western rationality.⁴⁹ Webster points out how all significant movements in the history of Western rationalism (which he lists as "Cartesian dualism, Platonic idealism, Aristotelian rationalism, apocalyptic reductionism, beast angel dualism, or even Christianity"⁵⁰) are underpinned by a dichotomy, which a scientific evolutionary view contradicts, between "... two separate but interconnected entities—a mind which is pure and a body which is relatively impure". The rational mind seeks dominance and control over

the body. The way this umbrella of Western rationality does seem to cover the psychoanalytic approach of Salinsky can be seen in a Balint Society lecture quoted at the end of the book.⁴⁹

Much of our medicine is blind and silent and frightened about subjective feelings; yet these are nothing new—they have always existed. They and defences against them have, however, been in *blind* use. What *could* be new is the deliberate study of their nature and ubiquity, in the hope of a more disciplined use.⁵¹

Here it's possible to picture medicine, much like the ever more secular and individualist post-Enlightenment society which it inhabits, "in the dying moments of our emaciated and shrunken humanism . . . huddled for warmth . . . [as] Freud's rationalism is less icy and less cold than many other kinds".⁵² Yet rationalism it is.

PHILOSOPHICAL SPIRIT

You can hold back from the suffering of the world, you have free permission to do so, and it is in accordance with your nature, but perhaps this very holding back is the one suffering you could have avoided.⁵³

A broader, more ambitious concept of patient centred medicine invites a move beyond integration of the rational and the emotional, or even recognition of the unconscious, to allow a form of Freudian reclamation.⁵⁴ Ways of being in the presence of suffering seem to stretch the limits of standard discourse in the medical literature; in fact general public discourse seems unable to find a meaningful place for such concepts which thus tend to be relegated to the realms of the private self or religion.^{55 56} In a sense medicine, not without some apprehension, is becoming aware of the central importance of a deeper appreciation of the human interaction between patient and doctor; the importance of recognising needs which require a different form of discourse, beyond the language of models and skills. What follows is merely a reflection on some of the types of discourse that need to feature in deepening the conceptions we as health professionals embody in practice—not an exhaustive analysis, but suggestive examples to contrast the methods, ambition, and discourse of mainstream medical communication skills programmes with those that we may require.

Buber's philosophical anthropology and philosophy of dialogue provides one useful example. He is most famous for his formulation of the I-Thou concept as a mode of being distinct from I-It where "The primary word I-Thou can only be spoken with the whole being. The primary word I-It can never be spoken with the whole being".⁵⁷

The I-Thou is characterised by mutuality, directness, presentness, intensity, and ineffability with regard to relationship in this mode, and Buber has a lot of useful ideas on the nature of genuine dialogue. He saw the "interhuman" as more than simply the space where the psychology of two people meet.

When two men converse together, the psychological is certainly an important part of the situation, as each listens and prepares to speak. Yet it is only the hidden accompaniment to the conversation itself, the phonetic event fraught with meaning, whose meaning is to be found neither in one of the two partners nor in both together, but only in their dialogue itself, in this "between" which they live together.⁵⁸

What might be helpful is his notion of "making present". This, in Buber's terms, is a mutual confirmation between partners, which happens to a certain degree wherever men come together. Unlike Rogerian affirmation as unconditional acceptance, or the familiar psychotherapeutic term "unconditional positive regard", Buber is keen to emphasise confirmation of the other person, in his being as himself, as the judgementally neutral ground on which to relate in a genuine way, which need not involve passive non-judgemental acceptance or approval of everything in the other. Buber puts it thus:

The chief presupposition for the rise of genuine dialogue is that each should regard his partner as the very one he is . . . I accept whom I thus see, so that in full earnestness I can direct what I say to him as the person he is. Perhaps from time to time I must offer strict opposition to his view . . . but I accept this person . . . I struggle with him as his partner, I confirm him as creature and creation, I confirm him who is opposed to me as him who is over against me.⁵⁹

This conception seems to encapsulate a level of commitment attainable within the context of one's own authenticity, a more feasible and appealing prospect in practice than the Rogerian conception. Friedman neatly states the concept of "making present" in his introductory essay.

Making the other present means "to imagine the real", to imagine quite concretely what another man is wishing, feeling, perceiving, and thinking. This is no empathy or intuitive perception, but a bold swinging into the other which demands the intensest action of one's being, even as does all genuine fantasy . . .⁶⁰

This rather daunting commitment makes even professionally empathic and sensitive practice appear sometimes less than authentic—more "seeming" than "being".

Buber goes on to develop his duality of "being" and "seeming" which he sees as the central problem in the sphere of the interhuman. He arrives at the idea that whatever "truth" may mean in other realms, in the interhuman

. . . it means that men communicate themselves to one another as what they are . . . This is a question of the authenticity of the interhuman, and where this is not to be found, neither is the human element itself authentic . . . to yield to seeming is man's essential cowardice, to resist it is his essential courage . . . one can struggle to come to oneself—that is, to come to confidence in being.⁶¹

Enlarging the notion of the doctor/patient relationship to accommodate this degree of authenticity, as a real element of practice for the physician to call upon, requires more than the acquisition of a set of skills. This is not to say one might not learn to adopt them—good physicians do so. There is, however, a difference between, on the one hand acknowledging the need for commitment to authentic human communication which may *include* learning new skills; and on the other hand, abstracting a set of skills from what is deemed effective consulting, to isolate these from the potentially threatening and less clearly teachable "attitudes", in pursuit of the credence given to an evidence based rationality. Even should one gain some mastery over one's emotional defences, without the confidence in one's essential being and what one is trying to be, without the sense of moral identity guiding one's actions, then such authentic human dialogue seems unlikely. Pirsig, responding to his son's inquiry about the ability to take

care of something in an authentic way, when asked whether it was hard wrote: “Not if you have the right attitudes. It’s having the right attitudes that’s hard”.⁶²

Another writer worth reflecting on is Tillich, in *The Courage to Be*.⁶³ In a similar vein to Midgley, when she bemoans the consequences of a violent divorce between reason and emotion, Tillich points to the unfortunate consequences of the intellectualisation of man’s spiritual life, including the loss of the word “spirit” and its replacement by mind or intellect. Tillich characterises it thus: “. . . Man was divided into a bloodless intellect and a meaningless vitality [biology]. The middle ground between them, the spiritual soul in which vitality and intentionality are united, was dropped”.⁶⁴

A few pages earlier he reflects specifically on medicine in relation to anxiety and religion. Here he prefigures the “integrated” conception of medical humanities⁶⁵ that potentially has much to offer in beginning to address such issues as suffering.

The medical faculty needs a doctrine of man in order to fulfil its theoretical task; and it cannot have a doctrine of man without the permanent cooperation of all those faculties whose central object is man. The medical profession has the purpose of helping man in some of his existential problems, those which usually are called diseases. But it cannot help man without the permanent cooperation of all other professions whose purpose is to help man as man. Both the doctrines about man and the help given to man are a matter of cooperation from many points of view. Only in this way is it possible to understand and to actualise man’s power of being, his essential self affirmation, his courage to be.⁶⁶

Tillich’s main concern was to identify the universal human source of the courage to be in the face of non-being without calling on the sort of faith that has divided opinions and beliefs down the ages. He views “theology” itself as part of the problem to be transcended, his intention being to bring the spiritual aspect of humanity back into the arena of serious thought, by questioning our categories of thought—opening, or reopening doors to what many may have forlornly thought to be closed episodes in our human “progress”.

In the broader context of our human existence as a whole his distinction of “existential anxiety” from “pathological anxiety” is interesting, in that existential anxiety he sees as irremovable due to its ontological character—that is, the anxiety of existing in the face of unavoidable non-existence, namely our own mortality. As such, this existential anxiety must be “taken in to the courage to be”; the “courage to be” must face and incorporate it. Pathological anxiety, in failing to take on board this anxiety, leads to

... self affirmation on a limited, fixed, and unrealistic basis . . . [producing] unrealistic security [in the face of death] . . . unrealistic perfection [in the face of guilt] . . . unrealistic certitude [in the face of doubt and meaninglessness].⁶⁷

Analysed in this way pathological anxiety is the price of a form of cowardice, disguised (consciously or unconsciously), as short term “solutions”. These solutions may have superficial appeal to a view of medicine rooted in Western rationality. Even paying attention to the emotions, conscious, or unconscious, we still need a moral if not spiritual strength to “... squarely face the misery and the pain . . . accept each other’s hopelessness and freely share the sadness about their helplessness”.⁶⁸ This mode of being suggested by Salinsky must draw on something like Tillich’s conception of courage that has absorbed a level of anxiety on the existential plane; a

type of spiritual confidence that does not arise merely from a narrow scientific training; a spirit perhaps more dependent on ways of thinking, rather than content of thought; genuine education rather than training; development of personal qualities rather than acquired techniques: a completeness or fullness of human being.

It is at this whole existential level of being, of human existence, that our interpretations of what patient centred medicine might mean seem to falter, as does the language used. Yet there is increasing recognition of the need to move beyond them; beyond Balint towards an engagement of our “true and whole selves”,⁶⁹ even encompassing our spiritual values^{70 71}; beyond the empathic as a skill⁷² to empathy as embracing “the whole inner world of the speaking voice”⁷³; beyond the requirements of adhering to models or codes of practice towards a philosophy of practice that comes from within the practitioner,⁷⁴ from first of all being “a good human being”.⁷⁵ We perhaps now need to move from a biopsychosocial anatomy towards an “existential anatomy”,⁷³ acknowledging the increase in self knowledge required to meet patients at this level in some measure.

PATIENT CENTRED MEDICINE RE-VIEWED

The communication skills literature can now be viewed as trying to widen the narrow medical gaze of the doctor to embrace conceptions such as we have reflected on—but without really debating *why*, relying on the *how* of medical effectiveness; ultimate purpose and meaning are left to emerge from method and means.

Yet taking the conceptions on offer, what are the “ideas, concerns and expectations”¹³ of the patient if they are not a form of existential knowledge? What are her “health beliefs”?¹⁶ From where does her “narrative thread”¹⁸ emanate? How can one be seriously as “patient centred”¹⁷ as McWhinney suggests without such knowledge? In a “meeting of experts”,¹⁴ are we not relying on genuine self knowledge, on both sides? Can the “inner consultation”¹⁵ have any meaning without such knowledge? Kleinmann certainly appreciates the “existential commitment” required in being an empathic witness⁷⁶ as do Brown *et al.*⁷⁷ Yet doctors are encouraged by communications gurus to adopt these techniques largely on evidence of effectiveness, the moral and philosophical framework being assumed (though there are signs of change).^{78 79} Making such assumptions in the context of medical training seems unreliable, and to forgo the challenge of analysing, debating, and attempting to shape the values and goals of medicine for the easier reductive route to technical method appears to promise only limited solutions, as evidenced by the disappointing performances documented.¹ It would also seem less than abundant in the qualities of courage and honesty that are embodied in the foundations on which we depend, and in which ultimately physician, patient, and society must place their trust.

Of course, medicalisation can be taken to unrealistic and unnecessary lengths. Perhaps the doctor should confine himself to interventions based on evidence of effectiveness and leave the existential and spiritual aspects to someone more suitably qualified. This view seems supported by the dearth of medical literature in this field, as Yawar shows,⁴ yet as he acknowledges, “spiritual considerations are absent from few consultations”. Any attempt to confine the medical consultation to an evidence based rationality would seem to lead only to the unrealistic securities and certainties of Tillich’s limited self affirmation. This may be an understandable reaction against the “. . . aspects of medicalisation [that] make doctors miserable. The bad things of life: old age, death, pain, and handicap are thrust on doctors to keep families and society from facing them. Some of them are an integral part of medicine, and accepted as such. But there is a boundary beyond which medicine has only a small role. When doctors are forced

to go beyond that role they do not gain power or control: they suffer".⁸⁰ It may be that society and families, of which we doctors are a part, feel unable to face the bad things—perhaps partly through lack of "spiritual intelligence".⁸¹ Yet if doctors are to "... become the pioneers of demedicalisation [and] hand back power to patients, encourage self care ... resist the categorisation of life's problem as medical"⁸² can we with any moral justification continue to restrict ourselves either to maintain[ing] control, or to avoiding the suffering entailed in a wider conception of the doctor/patient relationship for which, admittedly, we have been "... largely unselected and only partially trained"?⁸³ Do we, perhaps, need a form of "philosophical spirit" to transcend some of the limitations of our enlightenment heritage to begin the demedicalisation of society? If so we must develop courage of a type Kant refers to: "... the courage to avail yourselves of your own understanding—that is the motto of the enlightenment".⁸⁴

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- Tonks A. A summary of responses (What makes a good doctor? How can we make one?—theme issue) *BMJ* 2002;**325**:715. The responses from within the profession were notable in strongly recognising the importance of the human qualities: "... to be a good doctor, you first have to be a good human being".
- Kleinmann A. *The illness narratives: suffering, healing and the human condition*. New York: Basic Books, 1988: 54: "... empathic witnessing ... existential commitment to be with the sick person and help build narrative to make sense of and give value to experience".

- 77 **Brown J**, Stewart M, Weston W, eds. *Challenges and solutions in patient centred care: a case book*. Oxford: Radcliffe Medical Press, 2002: 122. The use of "motivational interviewing" is described by Miller W and Rollnick S in *Motivational interviewing—preparing people to change addictive behaviour*. New York: Guilford Press, 1991, where "acceptance of people as they are seems to free them to change . . . more than a set of techniques . . . it's a way of being with clients". They also accept that "to suggest one can remain uninvolved . . . especially in the encounter with suffering . . . is a fallacy [and that to] . . . recognize accurately the pain of the patient . . . takes courage, a fact that often goes unacknowledged": 142.
- 78 **Tate P**. Does thinking make us stupid? *Education for Primary Care* 2001;12:461. "Practising patient centred medicine is in fact pretty easy if you want to do it . . . but . . . models of educational behaviour, tasks, strategies, and skills . . . [have led to] agonisingly slow changes in actual behaviour . . . the first and fundamental step is the change in attitude."
- 79 **Neighbour R**. On consultation skills. *Br J Gen Pract* 2002;52:965. "Maybe some complexities are best left undeconstructed, some pretty jigsaws left intact . . .".
- 80 **Leibovici L**, Lievre M. Medicalisation: peering from inside medicine. *BMJ* 2002;324:866.
- 81 **Zohar D**, Marshall I. *SQ—spiritual intelligence: the ultimate intelligence*. London: Bloomsbury, 2000: 243. A spiritual "dumbness" that "isolates knowledge and focuses on small areas of it . . . isolates knowledge of things from a wider knowledge of people, processes and life . . ." where self awareness gets a low priority.
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BOOK REVIEW

The Gift: New Writing for the NHS

Edited by D Morley. Stride, 2002, £7.95, pp 261. ISBN 1–900152—1

The Gift is an anthology of writing, prose, and poetry, commissioned by David Morley, who heads the Warwick writing programme at Warwick University, in the United Kingdom. It includes 114 pieces, some from professional writers, others from National Health Service staff who took part in writing workshops with the editor, and one from the editor himself. The professional writers include Dannie Abse, Hanif Kureishi, Doris Lessing, Fay Weldon, Tom Paulin, and many others. Much of the work is excellent. It is arranged thematically, progressing from birth, through growth, and the process of illness and death. It was produced as a joint project with Birmingham Health Authority and a copy given to every member of National Health Service staff in Birmingham, UK—31 000 copies in all. This, according to the preface, was to "celebrate the NHS workforce in Birmingham, to acknowledge the role they all play in this endeavour that is so much part of all our lives". Ironically, less than one year after the publication of the book, the Birmingham Health Authority ceased to exist, having been amalgamated, in the most recent NHS reorganisation, with neighbouring authorities in Dudley, Solihull, Walsall, and Wolverhampton to make one of the new Strategic health authorities.

David Morley describes the book as "writing as an act of community, even solidarity" and this is a book with aims and objectives, with purposes. This may be fitting for a project involving the management of the National Health Service, but as with so many products of NHS management, when you try to probe the mission statement for meaning there is a slightly uneasy sense of things half glimpsed, half grasped in the gloom, but slipping away from you without ever quite revealing themselves, never quite taking form. What kind of community is it that consists of 98 writers, ranging from the poet laureate to a specialist nurse in Birmingham, and who come from all over the UK, and from North America, France, Germany, Pakistan, Guyana, and Australia?

What kind of solidarity do such people share? How much do they have in common, other than the fact that they write? In a sense, of course, being a writer is sufficient to make one a member of a community, of writers, and to invite one to express solidarity with one's fellow writers, but I suspect that was not quite the kind of community or solidarity that David Morley was trying to claim.

At first sight, one is led to believe that a substantial proportion of the book will be by people who work in the NHS. Morley tells us that the contributors include "not only authors such as Doris Lessing, Fay Weldon, Hanif Kureishi and Les Murray, but also staff in the health service . . . Writers in the NHS worked with me on new writing . . . in workshops at Warwick University or via email". Morley sings their praise: these NHS writers, "they are a force: read their writing" he tells us. But they are a pretty small force—on closer inspection we discover that of the 98 contributors, only nine could be described as not being professional writers, but simply part of the NHS workforce. Of the 89 professional writers, many names are familiar, some not so. But from the biographical notes supplied, it is clear that their collected novels, plays, and volumes of verse would fill a decent library and their collected prizes and awards would make a substantial trophy cabinet. We have the poet laureate, we have "one of the greatest living British poets", we have "Australia's leading poet". And we have, necessarily, a different kind of book.

This is a book with a mission, a purpose, and ideas. The first purpose is "to produce a book of literary merit that stands on its own". There is no doubt that the content has merit, each piece by itself, but whether the book as a whole has sufficient merit to stand on its own, and whether it is a whole, is more difficult. And the problem is that it also has other purposes. "The second [purpose] is celebratory"—the book is to celebrate the 50th birthday of the NHS and to look forward to the next 50 years. And still more purposes—"the book wants" (if a book can have "wants") to give the NHS workforce "something which is serious, entertaining, permanent, meaningful, and articulate", that might "inspire medical workers to reflect on how people who use their service feel and think about their experiences" and encourage them "to find little or big things that they can do or change to make a difference to the

human dimensions of the NHS". It may sound uncharitable, but reading this my heart sank and, metaphorically at least, I wept for all these fine writers commissioned to produce what turns out to be propaganda, one more tool in the quality assurance strategy, an instrumental good, a means to an end. There is a clue in the Preface, in which Alan Wenban-Smith, the (then) Chairman of the (then) Birmingham Health Authority, tells us that in 2001 "the government asked all who work in the NHS to spend time finding new ways of thinking through how to ensure that the service develops and grows to fit the requirements of a new Century as set out in the National Plan for the NHS (the exercise was call Local Modernisation Review)". This book was one outcome of that activity.

Much of the work in the collection is very fine. At times the connection to the National Health Service is very direct and obvious, at other times it is tenuous to the point of obscurity, but that is as it should be. In a real and important way, the NHS is superfluous to the writing in this book. If it is good writing, that is because it engages with some experience of life and succeeds in communicating that experience, with some force, to the reader. But health and wellbeing are so central to any literary account of the experience of life that to justify it, as Wenban-Smith does, on the grounds that "much of the quality of people's experience of the NHS . . . is about the human dimensions of giving and receiving care" and that creative writing can encapsulate this in a way that is "more meaningful than managerial exhortations!" is rather to miss the point. Almost anything could encapsulate the quality of human experience and the human dimensions of giving and receiving care more meaningfully than managerial exhortations—be it Proust or Thomas Mann, or Agatha Christie, *Casualty* or *EastEnders*. The paradox is that to take a piece of literature or a work of art and turn it to some purpose is to turn it, in that context, into something else, of (supposed) instrumental value. The fine writing in *The Gift* thus seems reduced by the act of compiling it and giving it to all the people working in the (former) Birmingham Health Authority. Each piece on its own is fine but the book becomes just another managerial exhortation.

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