

ANALYSIS



ESSAY

How medicine has exploited rationality at the expense of humanity: an essay by Iona Heath

Iona Heath argues for a rebalancing of the two sides in every clinical consultation, championing that for which evidence based medicine has no answers

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In 1876, George Eliot wrote, “Attempts at description are stupid: who can all at once describe a human being? Even when he is presented to us we only begin that knowledge of his appearance which must be completed by innumerable impressions under differing circumstances. We recognise the alphabet; we are not sure of the language.”¹

In just such a way, evidence based medicine tempts us to try to describe people in terms of data from biomedical science: these are not, and will never be, enough. Such evidence is essential but always insufficient for the care of patients. It gives us an alphabet—but, as clinicians, we remain unsure of the language.

Most clinicians are not scientists; they have a different responsibility—to attempt to relieve distress and suffering and, to this end, to enable sick people to benefit from biomedical science while protecting them from its harms.

Each patient has unique values, aspirations, and context. More fundamentally, history and experience alter how each body works through many mechanisms, and socioeconomic inequality and the directly consequent unequal distribution of hope and opportunity often play out in premature disease and death.

Clinicians must see and hear each patient in the fullness of his or her humanity in order to minimise fear, to locate hope (however limited), to explain symptoms and diagnoses in language that makes sense to the particular patient, to witness courage and endurance, and to accompany suffering.

No biomedical evidence helps with any of this, so a rift runs through every consultation. On one side, evidence has a huge part to play, assuming it is free of bias; on the other side is the substantive role for humanity. Clinicians must constantly bridge the rift, because as Kleinman writes, “Physicians are poised at the interface between scientific and lay cultures.”²

Disease and illness

To make sense of the world the human mind simplifies experience and denies much of its complexity. The reductive

nature of biomedical science and our relatively crude disease taxonomy is part of this process. It has led to enormous progress in clinical medicine but devalues individual experience.

The disjunction is also between the body as an object and the body lived as a subject. The rift tempts us to offer easy technical solutions to the insoluble existential challenges of ageing, death, and loss.³ Miké has proposed an ethics of evidence with two clear imperatives: the creation, dissemination, and use of the best possible scientific evidence as a basis for every phase of medical decision making and the need to increase awareness of, and come to terms with, the extent, and ultimately irreducible nature, of uncertainty.⁴

Uncertainty is inevitable whenever we apply evidence from studies of populations to individuals. This evidence can only inform us about probabilities; it can never predict what will happen to an individual because “trials . . . are deliberately aimed at showing average efficacy in a diseased group rather than optimum management for individual patients.”⁵

Yet these trials are used to construct clinical guidelines that, despite all the well meaning caveats, are too often used to coerce behaviour at the level of individual patient care through, for example, the financial incentives of payment for performance.

And worse, the evidence based medicine movement has never taken proper account of the warning of one its pioneers, Dave Sackett: “The two disciplines [preventive and curative medicine] are absolutely and fundamentally different in their obligations and implied promises to the individuals whose lives they modify.”⁶

Curative medicine is uncertain enough, but preventive medicine has become almost ludicrously so. The populations of the richest countries in the world are healthier by objective standards now than ever before yet they report relatively more illness than those living in poorer countries.⁷ People live longer than ever before but feeling fearful and ill, labelled as subject to ever more risk factors and exposed to endless health scares. And the

Two sides of the consultation

- Disease versus illness
- Objectivity versus subjectivity
- Technical versus existential
- Population versus individual
- Utilitarianism versus deontology
- Normative versus descriptive
- The map versus the territory
- Numbers versus words
- Quantitative versus qualitative
- Reason versus emotion
- Science versus poetry

effectiveness of most preventive interventions is hugely overestimated. How much have doctors colluded with that misplaced optimism? How much have doctors created it?

Utilitarianism and deontology

Health service policy in general, and particularly evidence based medicine, is founded on the values of utilitarianism—seeking to achieve the greatest benefit for the greatest number—or those of egalitarianism—recognising equal rights to healthcare throughout society—or, most often, a rather confused mixture of the two. However, the task of clinicians is to engage with the needs and values of each patient and their moral obligation is to do the best for that particular patient, and so the values of clinicians inevitably become primarily deontological. This commitment is poorly understood and little appreciated by policy makers, whose priorities relate to population or societal levels. Yet, without this foundation in deontology, patients would find themselves unable to trust clinicians, with less efficiency at societal level.

This leads to another rift—between society and the individual. At the societal level our notions of health and disease are crude, reductive, and normative, while at the level of the sick individual, the clinician needs to pay attention to detail and description.

A profound problem is that the map of biomedical science only roughly matches the territory of human suffering. The American physician Eric Cassell, writes, “We all recognize certain injuries that almost invariably cause suffering: the death or suffering of loved ones, powerlessness, helplessness, hopelessness, torture, the loss of a life’s work, deep betrayal, physical agony, isolation, homelessness, memory failure, and unremitting fear. Each touches features common to us all, yet each contains features that must be defined in terms of a specific person at a specific time.”⁸

Yet these potent sources of suffering are largely absent from the map of biomedical science? We can bridge this aspect of the rift only with the help of different arenas of knowledge and understanding. Kleinman recommends ethnography, biography, history, and psychotherapy to “enable us to grasp, behind the simple sounds of bodily pain and psychiatric symptoms, the complex inner language of hurt, desperation, and moral pain (and also triumph) of living with an illness.”²

Numbers and words

At its starkest, the rift is between numbers and words. Numbers have seductive beauty and purity that suggest solidity and certainty. Words are infinitely malleable and adaptable but can communicate much more. We try to define disease using

numbers, but this has separated the map from the territory even further. Words are essential to help patients to understand what is happening to them and what might help. Only with words can we forge trust, relieve fear, and find meaning. Yet as Feinstein reminds, “Most of the research devoted to patient care has been more mathematical than clinical.”⁵

We need words to acknowledge and respond to emotions, which are just as important in the care of patients. And this is why clinicians will always need the insights of qualitative research alongside the quantitative, and why clinical journals should publish both.⁹

Reason does not hold a monopoly on truth, as George Eliot explained in *Daniel Deronda*: “Suppose he had introduced himself as one of the strictest reasoners: do they form a body of men hitherto free from false conclusions and illusory speculations? The driest argument has its hallucinations, too hastily concluding that its net will now at last be large enough to hold the universe.”¹ She could have been writing about some of the excessive claims for evidence based medicine.

Yvor Winters, American poet and critic, proposes poetry as the necessary link between reason and emotion: “The artistic process is one of moral evaluation of human experience, by means of a technique which renders possible an evaluation more precise than any other. The poet tries to understand his experience in rational terms, to state his understanding, and simultaneously to state, by means of the feelings we attach to words, the kind and degree of emotion that should properly be motivated by this understanding.”¹⁰

Clinicians need to be just this—experts in the feelings we attach to words—otherwise our efforts to communicate with our patients will oscillate between the tedious and the cruel.

Science and poetry

The American poet Robert Frost described poetry as “the shortest emotional distance between two points: the writer and the reader.” And this is so often the intensity of connection that doctors need to help people experiencing suffering and loss.

W H Auden wrote, famously, “Poetry is not concerned with telling people what to do, but with extending our knowledge of good and evil, perhaps making the necessity for action more urgent and its nature more clear, but only leading us to the point where it is possible for us to make a rational moral choice.”¹¹

He provides another bridge across our rift and a much needed defence against the many people who want to tell patients and professionals what to do. Poems ask us to think, and most of us, when ill, want a doctor who is prepared to think. I long for a day, when instead of guidelines, doctors are simply given summaries of evidence, with clear indications of the limitations

and extent of uncertainty, and always acknowledging possible harm. This would encourage clinicians to think instead of telling them what to do.

So in the end my rift comes down to one between scientific evidence and literary humanism. And as long as we are spared from evidence based poetry, music, or art of any sort, these aspects of human understanding will remain dependent on genius.

As Seamus Heaney has pointed out, “The world is different after it has been read by a Shakespeare or an Emily Dickinson or a Samuel Beckett because it has been augmented by their reading of it.”¹²

Literary humanism allows us to find new sense and meaning in the world. And all too often, clinicians try to help their patients see a terrible world differently and to find meaning in it.

I am not arguing for just one side of this multifaceted rift but for a rebalancing. Medicine needs to approach each patient in the fullness of their humanity and so must draw on knowledge and wisdom from across the full range of human understanding.

It seems that we may have exploited rationality at the expense of humanity. The Dutch philosopher Annemarie Mol proposes a way forward: “Instead of either pushing professionals back into their cage, or allowing them to do whatever they like, it is better to open up and share the crucial substantive questions publicly. How to live well, what to die from, and how, thus, to shape good care?”¹³

Let me end with a different Eliot. In his 1944 essay on Virgil, T S Eliot wrote, “In our age, when men seem more than ever prone to confuse wisdom with knowledge, and knowledge with information, and to try to solve problems of life in terms of engineering, there is coming into existence a new kind of provincialism which perhaps deserves a new name. It is a provincialism, not of space, but of time; one for which history is merely the chronicle of human devices which have served their turn and been scrapped, one for which the world is the property solely of the living, a property in which the dead hold no shares.”¹⁴

Today, evidence based medicine is used to drive definitions of clinical quality that involve insufficient doubt, and this has become difficult to question because the aim is so worthy. Nonetheless, such unidimensional means are damaging because they propagate an intensely normative and objectifying view of what it means to be healthy and of what human life and healthcare should be. We need more breadth, more balance, and more doubt, and only then will our consultations cohere.

This essay was inspired by Iona Heath’s keynote talk from *The BMJ* and Centre for Evidence Based Medicine’s Evidence Live conference in 2015.

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Biography

Iona Heath was a GP for 35 years in an inner London practice in Kentish Town and president of the Royal College of General Practitioners from 2009 to 2012. She wrote a regular column for *The BMJ* until 2013.