

GUEST EDITORIAL

Healthcare Reform: Values: the elephant in the room

Brian Broom MBChB MSc (Immunology) NZ Regd Psychotherapist MNZAP FRACP^a,
Johanne Egan BSc(Hons) MBChB Dip Paeds PG Cert ClinEd FRNZCUC DHSc^b, Brigid
O'Brien MBChB MPH MPHTM FNZCPHM MFTM RCPS (Glasg) DTM&H^c, Shamsul Shah
MBBS MRCP (UK) CCST (UK) (Palliative Med) FACHPM^d and Karen Lindsay MBChB BSc
MRCP (UK) FRACP^e

a Consultant Physician (Clinical Immunology); Psychotherapist & Adjunct Professor, Department of Psychotherapy,
Auckland University of Technology, Auckland, New Zealand

b Emergency Medicine Specialist, Waitemata District Health Board, Auckland, New Zealand

c Public Health Physician, Whole Health Medicine Institute Postgraduate Certificate, Auckland, New Zealand

d Consultant in Palliative Care & Palliative Care Co-ordinator, Department of Medicine, University of Auckland, Auckland,
New Zealand

e Consultant in Rheumatology, Clinical Immunology and Allergy, Auckland City Hospital, Auckland, New Zealand

Keywords

Active listening, biomedical model, clinical context, clinical knowledge, compassion, cultural context, disease care, doctor patient relationship, dualism, evidence, healing, narrative, New Zealand Health and Disability System Review, objectivity, patients as objects, patients as subjects, person-centered care, reductionism, science-based medicine, spirituality, subjectivity, technological advances, values, whole person care

Correspondence address

Dr. Brian Broom, Department of Immunology, Auckland City Hospital, 2 Park Road, Grafton, Auckland 1023, New Zealand. E-mail: bandabroom@xtra.co.nz

Accepted for publication: 3 July 2019

Introduction

In 2019 The New Zealand Coalition Government instituted a wide-ranging Health and Disability System Review [1]. During 2018, a group of thirteen medical specialists has been meeting monthly to share common interests in whole person-centred care. We work in diverse disciplines, including immunology, rheumatology, infectious diseases, emergency medicine, sexual health, transplantation medicine, palliative care, ophthalmology, pain medicine and public health.

All of us have established careers and deep emotional investments in clinical medicine, in public and private practice. We value our training and the modern science-based treatment modalities that, historically, we have been privileged to offer to our patients. None of us wants to turn our backs on useful medical interventions that we regard as valuable, indeed essential. But we have a deep concern about the current state and direction of the dominant model underpinning the health system. We feel that healthcare, or to be painfully accurate, *disease care*, is massively and increasingly oriented to patients as *part-persons* or *objects*, no matter the spin we read from health managers. There is a slow-burning crisis, due to a profound imbalance in the values underpinning healthcare provision. All of us,

patients and clinicians, and Society generally, suffer as a result of this imbalance.

We believe that if the proposed reform process results in a mere tweaking of the current system on the basis of its current and implicit values, we will continue to see wasteful expenditure and rising levels of inequity. We will perpetuate the current, blindly hopeful beliefs in about-to-arrive, 'miracle' technological advances, some of which have benefit, often only for a few, and many that turn out to be illusory. Carrying on in the same old ways, albeit sanitised by expensive and time-absorbing reviews, carries an escalating risk to the economy and to patients, particularly to the poor. The risk to Society is somewhat analogous to that due to the inertia around climate change. The issues are complex, but we feel the problem needs to be more clearly articulated.

A subgroup of our larger group has attempted to identify and crystallize what we believe to be the relevant issues: firstly, the key values underpinning most of modern healthcare, and then, secondly, the identification of the values we regard as crucial to what we ourselves call *whole person-centred care* [2] and which forms the basis of this Guest Editorial.

The biomedical model

The crucial driving force behind the current healthcare crisis and a perceived need for reform is the dominant model of care, widely known as the *biomedical model*. Most patients are not familiar with this term, nor, strangely, are many clinicians. It refers to the deeply engrained assumptions underpinning clinical practice - in reality, the 'truths' we clinicians live by and are meant to practice. For decades this model has been harshly critiqued by patients, social scientists, philosophers and many clinicians. Our group, as medical specialists, are in fact deeply invested in the deployment and financial implications of the biomedical model. Thus, we can be considered 'insider' critics.

But why does the biomedical model attract criticism? Firstly, one of the central characteristics of the biomedical model is that it is *reductive*. Virtually all critics lament that in this model the 'person' of the patient, *as a whole*, is reduced, moved aside, and, as technology burgeons, is increasingly irrelevant. A simple example is the assumption driving the more extreme expectations concerning the development of robotic medicine; essentially, that human to human relationship is irrelevant in the healing process [3,4].

The focus of the clinician working within the biomedical model is the disease, the diagnosis, the clinician's (or robot's) expertise and methodologies, the latest technology or medication or intervention. This is top-down and physicalist. Yet much of it is very useful and crucial. But, note, there is an overwhelming preoccupation with the physical or physically measurable aspects of the person. Thus, the patient is ultimately less than a whole person; he/she is reduced to a heart, a skin, a brain or a system (e.g., immune system). Ask patients who are shunted from one narrow specialty to another about what they think of this (!) Secondly, the biomedical model is profoundly *dualistic* - that is, it assumes a strong separation between body and mind. Within the model we have over-valued objects, categories, objectivity and detachment. In practice, this means that a body, that physical aspect of a person, can be treated without much attention at all to mind, to the patient's story, to relationships, to family, to culture, to poverty, to trauma and abuse, and much more. We treat patients as *object-bodies* [5].

Patients as object-bodies

There are surely many personable clinicians, but the system is deeply oriented to *object-bodies*, and it is to this emphasis that money is allocated, even as resources become ever more constrained. And so, despite the large amount of evidence that physical ill health and disease are profoundly related to social deprivation, alienation, poverty, abuse, loneliness, poor social networks, lack of purpose and meaning, patients' adverse personal stories, and more, such considerations are constantly sidelined or rendered invisible by the overwhelming commitment of the biomedical model to its underpinning object-body values.

And such is the commitment of clinicians and the healthcare system to the biomedical model and to the financial reward system built around it, that there is precious little room or finance to address these other beyond-the-physical-body factors [5].

A further difficulty is the way in which *evidence* is organised in healthcare. It is much easier to do quantitative (measure things) rather than qualitative (explore experiences) studies of causes of physical illness. It is likewise much easier to study groups of supposedly similar people with the same label, the same diagnosis, than it is to study *single individuals as a whole*, and in this way to gain the attention of evidence-rating authorities. The uniqueness of each individual has consequently become essentially erased and, in consequence, the unique emotional, cultural, relational and social stories of each individual or subject in the study become erased. And, in our passion for objectivity and rationality, we have not only erased the patient as primarily a person, we have developed a culture of scepticism about anything that has to do with these aspects of persons as being in any meaningful way relevant to disease. Indeed, we have excluded mind from bodily disorders, except for a few 'psychosomatic' disorders.

Emotional and subjective factors are not generally the concern of many clinicians and are typically not considered when it comes to understanding why people get ill and why they do not get better. We have armies of clinicians who fundamentally work as if a physical intervention is always the answer. Physical interventions do tend to work well for acute and traumatic conditions, but not so well for chronic conditions. And yet the chronic co- and multimorbid conditions are defining medical issues of the current Century [6-9].

There are, of course, other factors at work maintaining this general pattern. The careers of millions of clinicians and academics are built around this biomedical value system. In both private and public health provision the business model is now pervasively co-dominant. Of course it is easy to blame 'Big Pharma', which actively utilizes and promotes the biomedical model, but it is a mistake to reduce the problems down to the real or apparent iniquities of the pharmaceutical industry and technology corporations. Nevertheless, it is a truism that the biomedical model value system, with the primacy it allocates to technology, constantly acts to feed the commercial goals of these corporations.

The 'technologisation' of medicine

We cherish the idea that good healthcare should be available to all and be sustainable through the generations. But the extreme 'technologisation' of medicine has fostered the search for more and more 'breakthrough' therapies, the costs of which are increasingly beyond our budgets and are thus becoming increasingly unavailable, resulting in a growing inequity. Put more bluntly, scarce resources are more and more channelled into low-return, often over-inflated treatments. The industrialisation of care has led to a day-to-day healthcare management emphasis on production-line efficiency, key performance indicators,

outputs rather than outcomes, and a correlating minimisation of person-centred values.

Clinicians experience all of this and many have become burdened, disenchanted, hardened, alienated, burned out and less effective with patients [10,11]. Moreover, the rising incidence of burnout and suicide in the medical profession is alarming [12,13]. The current system exerts a form of moral injury whereby whole person-oriented doctors are forced to work in a dualistic, biomedical way. The media and popular magazines, in a form of co-dependency with the established system, keep tantalising us with the next 'new answer' deemed to be just around the corner. Typically, after gushing reportage of an exciting new development, we hear that the new treatment, if found effective of course, will not be available for another 5-7 years or more. Does such reportage emerge because of a background push for research-funding? Such a question merits attention.

Essentially, we are limping along hoping that new technologies in the hands of clinicians will save us, with newspaper and magazine columnists continually feeding that hope. This hope is, however, largely illusory - as illusory as the idea that we do not need to do something about the way we consume resources in order to avoid the worst outcomes of climate change. Why is it illusory? Because it pins all of our hopes on a technological fix and ignores a huge area of human functioning relevant to disease. Currently, we are all caught in this complex multilayered web of interlocking or circular reinforcements. Our politicians are ultimately guided by the dominant clinical way of doing things. A political attempt, *via* the Health and Disability Review [1], to change dysfunctional patterns is encouraging, but we fear that the same old biomedical model, with its powerful protagonists, will prevent anything but tinkering.

We do not eschew the benefits of biomedicine, but argue that it should be expanded and based on a wider set of values, which more closely represent the realities we are dealing with. What is this reality? What are these values? To answer these questions let us consider the nature of care. Organised, professionalised healthcare, as we know it, is mostly enacted between *persons*: between patients and clinicians. The patient is a person and so is the clinician. Persons are not merely object-bodies to be diagnosed and treated. They are *wholes*. Wholes are not fundamentally divided. We, as clinicians, divide them into mind and body, into this or that organ system, into separate diseases, into our specialty interests. We impose our focus of interest onto the whole. We fragment the whole. We have based a myriad of medical and other specialties on these fragments. Yet these fragments are all indivisibly connected and dependent on each other. The human infant is actually born a physical and subjective whole. These two elements were never originally divided - it is we who have done the dividing [cf.14]!

Discussion

In short, it is absolutely bizarre to treat persons as if their minds, emotions, relationships, families, traumas, experiences, stories, cultures, spiritualities, and more, may be reasonably disregarded in our considerations of the emergence and treatment of illness. And yet we constantly, habitually, implicitly and systemically practise as if that is so. Indeed, if healthcare is enacted between *persons*, it follows that healing is a matter of enactment (physical and non-physical) between persons, or persons and their context. In this view, what happens in the relationship between the clinician as a person and the patient as a person is as crucial as the biomedical intervention. It is *both/and* rather than *either/or*. More specifically, all persons develop their personhood (with physical *and* non-physical dimensions) in relationship with parents, siblings, relatives, cultures and with the physical world and ecologies. Persons are constituted in relationships. Healing is enacted in this wider, richer framework. Healing should not be abstracted from this framework into an illusory self-contained and limited physical world of manipulation of objects [5,14].

The reality we need to consider is that, on their own, better, cleverer, more sophisticated and extremely costly technological manipulations will not ultimately bring about the healthcare outcomes we need and want. If as professionals we persist with the delusion that they will do so, we are feeding the public with false hopes, if not lies. We must cease ignoring the 'story' of the patient and cease treating the patient as just a diagnostic problem, cease undervaluing the crucial ingredients of good relationship in the clinical space. Rather than defaulting, always defaulting, to more investigations, more costly interventions, more drugs, more anything technological, we must start attending to that which is missing - expanding our repertoire to consider the *whole*. There are many caring clinicians working in our healthcare system, but the truth is that relational healing values are mainly ignored in the conceptualisation and practice of healthcare [15-17].

What, then, are the values undergirding this whole person-centred or relational healing framework? We must learn to use our biomedicine inside, as part of, and along with a listening/healing ethos. We must listen carefully to our patients rather than just compartmentalising them into our diagnostic codifications - we can do that too(!) We must be open to the patient's story. Mind is not separate from body, however awkward that might be to those who are not accustomed to listening to these aspects of a patient's reality. We need to be open, and curious, and empathic. We must understand that the patient's story may be hard to reveal, hard to listen to, hard to bear, but that it may be the most important thing for us to understand why this person got ill, and why they are not getting better. And it may be the most important thing for the patient to understand, not just the clinicians in their clinical expertise [15-17]. For all of this, willingness, generosity, warmth, compassion, connection and presence are needed. These are skills that are not prioritised in our training, but

urgently need to be [18]. We are not alone in these concerns. There are certainly voices around the edges of biomedicine for compassion and mindfulness, but generally the biomedical framework remains solidly honoured and dominant.

Whole person values for healing and healthcare are strongly congruent with those of Māori tikanga. *Whanaungatanga* - relationships, belonging, family, community, connection; *Manaakitanga* - kindness, *aroha*; *Kotahitanga* - unity; *Rangatiratanga* - leadership; *Tino rangatiratanga* - self-determination, empowerment; *Wairuatanga* - spirituality; *Kaitiakitanga* - stewardship. But it is not good enough to tack these Māori values onto the biomedical model as some kind of optional post-colonial extra for the few, while still fundamentally subscribing to and resourcing the narrow biomedical model for those of us who are not Māori. These values are crucial to healthcare wherever it is situated [3,15].

Conclusion

Sadly, our dominant Western cultural emphasis on objectivity, object-bodies and object manipulation has led to a systemic and profound loss of mindfulness of the person as a whole and persons-in-relationship and almost a complete loss of understanding of physical illness as in some way an expression of the whole. Ironically, we see a profound loss of healing and therapeutic opportunity. We are unlikely to make much headway while the dominance of the ideology of the biomedical model and its underpinning values remain the unacknowledged elephant in the room. Its dualistic, body/mind separation and exclusiveness, as well as the vested interests supporting it, are preventing us from making the changes that many individuals and groups increasingly desire. It seems we are on a healthcare pathway rather akin to the climate change pathway. We can see it happening, but the forces maintaining it make it hard to acknowledge its reality and for us to change it. We do hope there may be room in the upcoming Health and Disability System Review for these considerations not only to be aired, but actually listened to.

Conflicts of Interest

We declare no conflicts of interest.

References

- [1] New Zealand Health and Disability System Review. (2019). Available at: <https://systemreview.health.govt.nz/>.
- [2] www.wholeperson.healthcare.
- [3] Broom, B.C. (2007). *Meaning-full disease: How personal experience and meanings initiate and maintain physical illness*. London: Karnac Books.
- [4] Broom, B.C. (1997). *Somatic Illness and the patient's other story. A practical integrative approach to disease for*

doctors and psychotherapists. New York/London: Free Association Books.

- [5] Broom, B.C. (Ed.). (2013). *Transforming clinical practice using a mindbody approach. A radical integration*. London: Karnac Books.
- [6] Miles, A. & Asbridge, J.E. (2016). The chronic illness problem. The person-centered solution. *European Journal for Person Centered Healthcare* 4 (1) 1-5.
- [7] Bennett, J.E., Stevens, G.A., Mathers, C.D., Bonita, R., Rehm, J., Kruk, E., Riley, L.M., Dain, K., Kengne, A.P., Chalkidou, K., Beagley, J., Kishore, S.P., Chen, W., Saxena, S., Bettcher, D.W., Grove, J.T., Beaglehole, R. & Ezzati, M. (2018). NCD Countdown 2030: worldwide trends in non-communicable disease mortality and progress towards Sustainable Development Goal target 3.4. *Lancet* 392 (10152) 1072-1088.
- [8] Horton, R. (2019). Time to radically rethink noncommunicable diseases. *Lancet* 393 (10184) 1922.
- [9] Marmot, M. & Bell, R. (2019). Social determinants and non-communicable diseases: time for integrated action. *British Medical Journal* 364, 1251.
- [10] Hall, L.H., Johnson, J., Watt, I., Tsipa, A. & O'Connor, D.R. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS One* 11 (7) e0159015.
- [11] Ranjbar, N. & Ricker, M. (2019). Burn Bright I: Reflections on the Burnout Epidemic. *American Journal of Medicine* 132 (3) 272-275.
- [12] Patel, R.S., Bachu, R., Adikey, A., Malik, M. & Shah, M. (2018). Factors Related to Physician Burnout and Its Consequences: A Review. *Behavioral Sciences (Basel)* 8 (11) 98.
- [13] McFarland, D.C., Hlubocky, F., Susaimanickam, B., O'Hanlon, R. & Riba, M. (2019). Addressing Depression, Burnout, and Suicide in Oncology Physicians. American Society of Clinical Oncology Educational Book. Available at: DOI: 10.1200/EDBK_239087.
- [14] Broom, B. (2016). Naming what we do. *European Journal for Person Centered Healthcare* 4 (2) 265-270.
- [15] Broom, B.C. (2011). Meaning-full Disease, Psychoneuroimmunologie, and the Mindbody Clinician. In: Schubert: *Psychoneuroimmunology and Psychotherapy*. Stuttgart: Schattauer GmbH.
- [16] Broom, B.C. (2009). Health, Illness, and the Patient's Personal Story. In: *Health and Well-being in Aotearoa New Zealand. Australia & New Zealand*: Oxford University Press.
- [17] Broom, B.C. (2000). Medicine and Story: a novel clinical panorama arising from a unitary mind/body approach to physical illness. *Advances in Mind/Body Medicine* 16 (3) 161-207.
- [18] Broom, B. (2016). Training clinicians in whole person-centered healthcare. *European Journal for Person Centered Healthcare* 4 (2) 402-408.