TEACHING HEALING IN AMERICAN MEDICINE: A VIEW FROM OUTSIDE

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Medical education is focused on the technology of modern medicine, and rightly so. The techniques of curative medicine can be taught, the results proven. But healing is more difficult to teach, and approaches to it are more value-laden. Can it be taught? In this lecture I want to talk about healing and how it differs from treating because I think this distinction will draw us into the core of why medical education exists.

Healing means being made whole - "wholeness" and "health" share the same Greek root word. **Treating** is doing something to arrest a disease. Healing has a broad focus and looks for a certain result - "wholeness". Treating has a narrower focus - a particular disease, and looks for a narrower result - getting rid of the disease. I will use my experience as a framework for this lecture, especially in light of my own recent retreat from the activities of healing to the those of treating. I hope my own story brings to light some values implicit in graduate medical education.

One of the reasons I chose to study Family Practice was because I wanted to learn about healing. Family Practice, as I understood it, was a way to coordinate the advances of American medicine after World War II. But even more, it was a response to - and a reaction against - the depersonalizing and compartmentalizing effects of those advances. By the end of the 1960s technology and specialized medicine had increased so much that not only was primary care at risk, healing itself was as well. Family Practice was more than just a way to upgrade the old GPs and give them respectability in an environment where Board certification was more and more important. It was a return to seeing a patient not just as a bag of organs, but as a "whole person" living in a family which could contribute to a disease and also influence its outcome. I felt Family Practice would give me the opportunity to study, in Paul Tournier's phrase, "the healing of persons"[1].

Implicit in my thinking was this: specialized technical medicine was becoming very good at fine-tuning the diagnosis of disease, as well as treating those micro diagnoses. I had respect for those treatments, but sensed that treatment was not always accompanied by healing[2]. I knew people could be "cured" yet not "made whole". I even knew people who were "whole" - ie content, well-integrated, and healthy - even though they had a condition or disease that hadn't been cured. In other words, I knew that though there was an important overlap between *treatment* and healing, they weren't the same thing. My hope was that Family Practice training could give me an overview of treatment skills, while at the same time showing me how to use them for healing.

At least now, looking back, that's what I would want from a Family Practice program. At the time I think I assumed that simply by mastering the primary treatment skills of all the specialties, including psychiatry, and by offering them to everyone in the family, I'd have a better shot at healing. I think twenty years ago my program assumed the same thing, and they gave me that overview.

We did not talk much about "healing", though. Family Practice was only seven years old then, and it was important in that first generation to define the curriculum and gain academic credibility, all in terms the medical establishment understood. But we weren't outsiders trying to get in, we were the medical establishment. So naturally we built Family Practice in terms we understood: technical diagnosis and treatment terms, not "healing" terms. To us, then, adequate diagnosis and treatment was healing.

Let me add here, parenthetically, that medicine does not have, nor should it have, a monopoly on healing. There are many "healing arts", many professionals involved with helping people become whole. We in Family Practice understand especially the approach of other scientists, ie, social scientists such as psychologists and social workers. But we dare not delegate to them the entire task of making people whole. Their sphere of influence is almost as narrow as ours. Pastors and spiritual directors can have a very deep influence in helping some people become whole - but only some people. Wise friends and relatives can be remarkable healers - but only some friends and relatives. Actors, singers, and writers can profoundly affect a journey toward wholeness - sometimes. Even an entire culture can be one that encourages either health and wholeness, or dis-ease and fragmentation.

But if medicine is one of the healing arts, how intentional are we in helping our patients become whole? Are we satisfied with diagnosing and treating the bio-medical parts of their disease, and letting counsellors and pastors help them live with, or fight off, the dis-ease? And do all of our treatments aid in healing, or could some of them actually be counter-productive in bringing wholeness? I shall return to this shortly.

When I completed my Family Practice training I began practicing in Maynardville, the county seat of Union County. There

my wife and I worked in what might be called an ideal place for Family Practice. We saw entire families and provided them with the whole range of out-patient services, admitting them to St. Mary's Hospital for in-patient care. We lived in the community and occasionally made home visits, so we saw our patients' dis-ease in its context. As Medical Examiner and jail doctor, I even had an inside look at the seamier side of life in Union County. We worked closely with the Cherokee Mental Health system, and so had immediate access to professional counsellors. Our first employer was the Public Health Department, giving us an official link there. We were not just "organ doctors" or "body doctors"; we weren't even restricted to being "Family Doctors". We were, in some senses, "community doctors".

In all of this activity, were we involved in healing? It's not a question I asked at the time. Mostly we treated our patients and were happy when they "got better". I was taken then by the ideas of "community health" more than "the healing of persons" - but I think we did do more than just treat; I think we did try to heal. Beyond the three-ring circus of services we provided or arranged for, we entered some people's lives. We struggled with them as they tried to get rid of an affliction, or more often to live sanely with it. Here and there and now and then, sometimes because of all the "ancillary" services, and sometimes relying on techniques we'd been taught, but often using only the personality and common sense God gave us, we worked to help people become whole.

Then after seven years, we left to work in Africa. There were many reasons, most unrelated to our work as healers because "the healing of persons" was not in the center of what we did. But our leaving did give us a chance to take a fresh look at Family Practice, and indirectly at healing.

Family Practice intended to provide cradle to grave, minor to serious, medical and surgical health care for everyone in the family - or at least to "orchestrate" that care. The idea was that such a broad view would reduce fragmentation of services by having them better coordinated, with a single manager, or "tour guide" through these services. Underneath, I think, was the hope that that single manager would be in a better position to help the patient heal[3].

Our experience, though, was different. Instead of "coordinating" care, we found ourselves squeezed between the minor and serious. The increasing standard of care required that, for most of our hospitalized patients, we consult specialists, and they tended to take control of the patient care. We didn't orchestrate, we listened. And with the other "end" of care, the common minor conditions, we found that nurse practitioners and physician's assistants did an excellent job in caring for these patients. Sometimes they did even better than we did, because, frankly, we eventually found some of that work boring. We were still the tour guides through our caring circus of services, but healing and wholeness became more elusive.

I mentioned above that I was "taken" by the ideas of community health - suggesting that I was in a "phase" that I would eventually "get over". That doesn't quite get it. It's true that my first job in Africa was mostly in community health, and that I do not have the same involvement in community health as I used to. But the healing of communities is not a phase; I think it is an integral part in the healing of persons.

What I found difficult was to do both at the same time - and so for a while I did only community health. My experience was like that of a nephrologist being asked to care for someone with renal failure - who also had heart disease and significant emotional and family problems resulting from the diseases. To accurately diagnose and prescribe for the kidney disease requires one set of skills; to care for the patient's emotional and social problems requires a different attitude and different set of skills. Likewise the healing of persons requires a different attitude and set of skills from the healing of communities.

I see that now. But first in Union County, and then in Africa, my question was less "which set of skills do I have?" than "which task is more important?" - or rather "which task is more important to me now?" I knew that prevention, or maintaining health, was preferable to trying to repair it once it had been disturbed. I felt too that the restoring of health had a better chance of being effective when people in the community were involved in the process. Any healing, I thought, should be the offering of a remedy and the active reception of that remedy. Passive recipients - whether individuals or communities - may be cured, but only active recipients could be healed. That belief led me not just to the discipline of public health, but to the approach called community health.

Community health, however, proved far more difficult than I first envisioned. Perhaps that is only a reflection of the difficulty of any healing. There are plenty of public health remedies - vaccinations, public pipes or private latrines, homemade rehydration solutions for diarrhea, mosquito nets, and so on - but more often than not we impose these remedies on communities. More often than not people are passive rather than active recipients. More often than not communities are "cured" of their health hazards without being made whole.

Gradually we let go of community health; more and more in Africa we were asked to practice "individual" medicine. And as we did we discovered that two things were happening to us:

1) we were getting better at the craft of medicine, and

2) we were no longer attempting to heal.

Each requires some explanation.

Western scientific medicine in Africa is, in some ways, the medicine of Osler: the careful use of history and physical examination to diagnose illness. It is in other ways the medicine of the American 1950s and 1960s: basic X-ray and laboratory to aid diagnosis, and basic medicine and surgery to treat most conditions. It is, of course, also the medicine of the 1990s: there are CT scanners and fiber-optic scopes and sub-specialty surgery available in big cities, and even small rural mission hospitals have ultrasound machines and - sometimes - samples of the latest drugs.

But in much of the Third World there are no automated chemistries, no culture and sensitivities, no respirators, no renal dialysis, no intensive care units, no medical or surgical sub-specialists. Family doctors and general surgeons - but often just "GPs" - are the end of the line, and mostly see only referrals from PA- or nurse-level primary providers. Far from being "squeezed" for work by boredom on the one side and specialists of the other, family doctors are the specialists - but without the technology of American specialists. And without the expectations America lays on them.

The result is that we must rely more on our hands and ears and eyes for diagnosis, and that we must treat with ingenuity. Cost-consciousness is not a style of practice that can be rewarded by an HMO; it is the only way to practice. African medicine and surgery rely far less on technology simply because it's not there. Yet the amazing thing is how often we can diagnose accurately and treat adequately without high technology. We become better clinicians - even by Western standards - precisely because we lack the technology characteristic of Western medicine.

After some time of practicing this medicine in both Tanzania and Kenya, I began to think about what had been obvious all along: that I was not building long-term relationships with my patients. I was like an American surgeon or ICU nurse: I got to know the sickest patients very well while they were ill - but then they would either die or go home, and often I would not see them again. Most of the poor health in Africa is from acute infections or trauma; little is chronic and degenerative as in America. I was not building long-term relationships with people because of the nature of their disease and my role as the one being referred to. I was doing more extensive diagnosis and treatment than in America, but was no longer thinking about long-term therapy and change... or healing.

And, in a way, I didn't have to. I may have been the "end of the line" for Western medicine, but no one saw Western medicine as the end of the line. People came to our hospitals for "treatment" without, I think, ever expecting "healing". Healing was still a matter for traditional healers and culture and family. Even the bulk of Africans who had joined a religion from "outside" - Islam or Christianity - saw in that religion the ultimate provider of healing. Doctors are viewed as craftsmen, not artists; as technicians, not healers.

To say it another way: more is expected of each doctor because there are fewer doctors, but less is expected from the profession as a whole. We are expected to be good technicians, as in America, but we are not expected to be able to prevent every death. A bad outcome in America means a lawsuit because there is nothing beyond medicine when medicine fails. A bad outcome in Africa is a tragedy with spiritual, not legal, implications. There is always something beyond medicine - and for that reason, we are not expected to heal, but only to treat.

Now we must return to American Family Practice and ask whether or not my original expectation - to learn about healing in a Family practice training program - was reasonable.

To summarize the problem: American sub-specialty technological medicine is very good at diagnosing and treating, but has been accused of neglecting the "whole person". More than this: the more a health care system uses technology, the less it depends on human or "natural" resources for healing. It can even suppress "natural" healing in the same way that continued high doses of corticosteroids can suppress the "natural" production of endogenous corticosteroids[4]. But the biggest effect of high technology medicine is that by focusing on biomedical treatment, it ignores the question of healing altogether.

Scientific medicine in Africa, on the other hand, employs less powerful technology and has not yet eliminated the healing forces of the culture. Therefore, when scientific medicine in Africa ignores the question of healing, as does its American counterpart, the consequences are very different. The treatment paradigm is the same, but it is at work in an entirely different culture.

American Family Practice intended to address the problem of fragmentation by asking one cadre of doctors to oversee health care for the entire family: to recommend preventive activities, diagnose and treat the majority of their illnesses, and efficiently connect them with the correct technology and specialists for more complicated disease. The assumption was that proper training in common illnesses, together with a broad understanding of what "high tech" medicine can offer, would provide a doctor with the tools necessary for complete treatment, which was assumed to be the same as healing.

But this third decade of Family Practice has taken a twist that we didn't expect, though perhaps we should have. The "high tech" medicine that we coordinate is very expensive, and we long ago chose to not let that be a factor in deciding whether and when to use that technology. It was a matter of ethics: life and health were at stake, and we could not endorse a lesser level of health, or at least treatment, based merely on money. We would offer - or "prescribe" - the best to everyone, and it was up to

the patient, or the insurance company, or the government, to find the money to pay for it.

They did - for a while. And in the process "they" gained control of our medical system. Now they have told us there is simply not enough money to pay for all the latest technology for everyone, so they - the ones who pay - have changed the way we practice. And since their concern is economic, their changes are based on economics. The healing versus treating debate disappears from the agenda.

For Family Practice, the change is this: We first became a specialty, in part, to reduce fragmentation and treat the whole person. Now we are being told that we are "gatekeepers", suggesting that *real* treatment occurs only beyond the gate. We originally were given extra training so that we could do more than "general practitioners" and treat patients *without* referring them. Now we are given extra training in diagnostic procedures so we can treat patients by referring them. The focus is shifting from treating the whole patient to navigating that patient through the whole medical system.

This does not mean that we no longer treat patients. But it does mean that our center of gravity is changing, and what is distinctive about us as a specialty is different than it used to be. Twenty years ago we were developing the expertise to manage clinical problems in the huge "overlap" area of body, mind, and family. Now we are more able to select out those few patients in this overlap needing "definitive" organic treatment, but less able, it seems, to manage the whole problem. The fallout for healing is obvious.

But then again, is it fair to ask Family Practice to attempt what neither African nor American scientific medicine does? Can any scientific curative system be expected to help make people whole - especially when the culture they come from is fractured? Is health care really the sphere for healing?

It's a difficult question. If healing is the business of Family Practice, we need to make major changes in our curriculum, recruit a different kind of new doctor, and try to reclaim what Western medicine lost centuries ago. On the other hand, if healing is beyond the scope of Family Practice, then Family Practice is off the hook - and all of American medicine is on the rack, tortured by a people in need of healing and seeking it from a system set up only to cure.

I read the last half of this lecture to my wife, who squirmed until I came to the last few paragraphs. I had been asking the wrong question all along, she said, hoping for Family Medicine to teach me how to heal. Of course medicine can't heal, she said. She, a board-certified Pediatrician, who also passed the boards for Family Practice, a "generalist" who can do major surgery on a patient with a twisted bowel and have him well and home in less than ten days - she said without hesitation, "Only God can heal."

Now, how can we convince the American public?

Notes

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[1]The 1965 English title of his first book, published originally in Switzerland in 1940. In the epilogue he refers to World War II, and indeed his first-hand experience of it, as the background for taking a new and more complete look at healing.

[2]Arthur Barsky calls this "the paradox of health", that in our society "substantial improvements in health status have not been accompanied by improvements in the subjective feeling of healthiness and physical well-being." ("The Paradox of Health", *NEJM*, vol. 318, no. 7, Feb. 18, 1988.)

[3]Keeping costs down was another benefit, but I do not remember it being strongly emphasized in the first decade of Family Practice.

[4]This negative feedback of our medical system is the main subject of Ivan Illich's 1975 book, *Medical Nemesis*.

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