

The patient should be at the centre of health care argues *Bob Leckridge* in

Whose health is it anyway?

This seems a strange question. Isn't the answer obvious? Health is a very subjective phenomenon. If someone were to say "I'm not feeling very healthy at the moment" then who could say "Yes you are"? Yet our way of practising medicine assumes that the "doctor knows best". The "health expert" is someone with a specialised knowledge, someone with specialised skills and even a specialised language. Doctors and other health experts teach patients this new language, which involves giving more attention to the disease than to the patient. This results in patients being seen as, and even seeing themselves as, disease entities rather than individuals. I might ask a patient when I first meet them "Tell me all about yourself" and they may reply "I have endometriosis" or "I have Wilsons Disease". What does this tell me about this patient? What information do I now have about this person? How sad to have been trained to present yourself as a

disease subject. Having educated the people to see and present themselves this way the doctors can deal with all patients with the same label in the same manner.

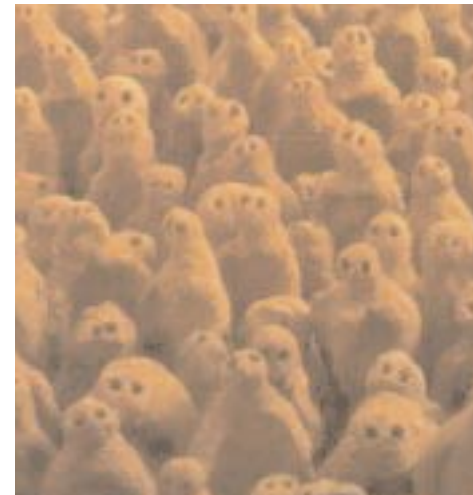
In fact, that is the "strength" of "evidence based medicine". This approach allows us to generalise, stripping out anything individual or particular and get to know what features there are in common between people with the same diagnosis. We can then ensure that everyone gets the same treatment. In fact that is a great demand – that everyone should get the same treatment. We are busy inventing "guidelines" and "national service frameworks" to ensure that everyone with the same condition is treated in the same way. But will this produce better health? Better health for whom?

Let's begin by thinking about what "health" is. If we are going to want to understand these phenomena we need to understand the language we are using. There have been countless attempts to define "health". One definition poses that it is "the absence of disease". The World Health Organisation defines it as "complete physical, mental and social well-being" but that rather substitutes one ill-defined phrase for another. What is "well-being"?

What do I mean by "health"? What I mean is "the freedom to make choices". I think this is fundamental to our concepts of health. In the middle of sickness we lose our ability to make choices. We are inhibited by pain or by loss of certain functions. The more we are able to make choices in the world, the healthier we are. This understanding of health means that you don't have to be free of "disease" to be healthy. In fact, once you have

a chronic disease, then you have it, but your life doesn't end. Sometimes the presence of the disease enables you to make choices you didn't feel you could make before. For example, if you were told you only had one year left to live, would you make any choices you're not making now? Would you be more able to make those choices?

This is a rather challenging view of health of course. We live in a society where we assume, on a daily basis, that we are not going to get sick and we are not going to die. We don't like to talk about death. But in fact, illness and death are inevitable. They are experiences we will all have. If that is true, then isn't it best to



be fully involved in the experience, to be able to not lose all your control to others? Does how you experience an illness affect its course? It seems that the evidence is emerging to show that it does – and crucially so.

What about the "other" state, that which is not "health"? That state which is known as "disease" or "illness"? Are these terms interchangeable? Are they the same? Cassell says in *The*

Healer's Art, "illness is what the patient feels when he goes to the doctor" and "disease is what he has on the way home from the doctor". In other words, "Disease then is something an organ has; illness is something a man has."

This is an important distinction. We cannot understand "illness" without understanding the person, the individual, and the human being within their context. How does this "disease" fit into this person's life? How does this person experience this "illness"? Weissmann says, "The challenge in scientific problem-solving...is to make clear that data from patients always have contexts."

This understanding is

These stories help us to understand how people get sick and how people get well. These are two of the great, poorly understood processes in human life. How do people get sick? And, how do people get well?

Arthur Frank, in *The Wounded Storyteller*, describes what he terms "the remission society". He points out that increasingly we have diseases from which we don't either just recover or die, but diseases that become part of our lives. This is true of all our chronic diseases, whether they be, for example, asthma, arthritis or cancer. With these chronic diseases we move back and forwards between "health" and "illness" – we go "into remission" as

stories". These are typical of modern, western medicine. Something is broken, fix it and I'll be fine. Such stories don't pay attention to origins or help the person to understand their illness. They are focussed on the fix, or the cure. This permeates all of our modern medical practice. Think of the highly popular TV series about doctors – why are so many set in casualty departments or emergency rooms? There have been great advances over the last 100 years in treatments of acute diseases based on this reductionist, rather de-humanising approach. We can rescue people from the jaws of death more reliably than at any other time in history. This is great news. It is a great advance. But it isn't enough, is it? To be rescued from your heart attack is great but it isn't the end of the story.

The second kind of story is "chaos stories". People who have just been diagnosed with a major disease often experience this. The symptoms, the experience itself is overwhelming and the person, the individual, is lost in the middle of it. We need to help people to find their way out of this chaos and this leads to the third kind of story, the "quest story". Frank calls it this because it is like the traditional story of the hero – there is a challenge – the diagnosis; there are obstacles and challenges to overcome – the investigations and the treatments; there are boons – lessons to be learned, new insights to be gained; and there is a return – moving into life changed, with new understandings and new choices.

It's easy to see how different types of stories are relevant in different circumstances and how an individual must be enabled to tell their story if they are going to improve.

The clay figures (detail) in Anthony Gormley's Field for the British Isles symbolise the paradox of the individual within a group

leading to an upsurge of interest in what is termed "narrative based medicine". This means placing the patient's story at the centre of the process. Stories of course are highly individual. No two stories are the same, so this approach is recognising that the individual, the whole person, the particular experience is crucial to understanding their illness. This, of course, is at the heart of the homeopathic method.

"survivors" of a particular disease. They become a part of our lives, a part of who we are. This significantly affects how we experience them and what our outcomes will be. Frank goes on to identify three typical styles of storytelling in illness. Everyone might tell their stories in one of these forms or in different forms at different times.

The first of these he describes as "restitution



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So, your health is your story. It is unique and individual and should be at the core of the health care process. You should be at the core of the health care process.

Is this how things are? Sadly, not much. The dominant model is “evidence based medicine”. This sounds like common sense but how it is applied and how it impacts on our health is determined by what we accept as evidence.

There is an accepted hierarchy of evidence that places large group studies at the top and individual experience at the bottom. This leads to recommending treatment choices that are the best for the average person in a group. But who is average? Funnily enough, most people are not. This leads to experts telling us what is best for us. This can lead to astonishing arrogance with the expert assuming that they know what the best choice is for the patient. But isn't it the patient who can make the best choice for them? Doesn't the patient require to be fully informed and helped to make choices? In fact a lot of evidence is emerging to show that patients who are fully involved in their own care and their treatment choices have the best outcomes – this has been shown in cancer sufferers and in AIDS patients for example. By outcomes, I mean years of quality life.

One of the reasons for this dominance of randomised control trial evidence is the benefit that such work brings to the treatment of acute disease. In acute disease the range of patterns of the disturbance is small. The individual features are not the most important ones. However, once the acute event is survived and the illness becomes chronic then the individual experience becomes much more important

than the group one. We all bring our own unique ways of coping, our own unique life experiences into the story of our chronic illnesses. In such circumstances individuals can only be helped by fully understanding their individuality – not what they have in common with large groups. So, guidelines for chronic diseases are of no value if applied blindly without consideration of the individual situation, the individual context, of this person's values, attitudes and choices.

In the *British Medical Journal* recently, Marmot and Wilkinson argue that “social dominance, inequality, autonomy and social relations have an impact on psychosocial well-being and are among the most powerful explanations for the pattern of population health in rich countries.” Who somebody is, how they experience their life, how they relate to others is crucial to understanding the patterns of their illnesses and the outcomes of their treatments.

Perhaps even more significantly we are beginning to describe how such mind-body and contextual factors

are determinants of illness and of recovery. For example, Marmot and Hemingway in the *BMJ* in reviewing some of this literature in the context of coronary heart disease show that depression and social support are significant factors in both the occurrence of heart disease (the aetiology) and the outcome (the prognosis).

These ideas are not new. “Every affectation of the mind that is attended with either pain or pleasure, hope or fear, is the cause of an agitation whose influence extends to the heart,” William Harvey wrote in 1628. However, if we want to provide real health care that is of value to people through the whole of their lives, then we need to rediscover and restate these principles.

We can learn much from what we have in common but only I can experience my health. I am the one who needs to make the choices. I am the one who needs to be informed. When unwell I want to be cared for and cared about. I don't want to be treated as a waiting list statistic or a unit in a randomised trial. I want to be helped to understand what is going on, to make sense of it,

To understand a person's illness you have to see them in the context of their own world



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and as Richard Rorty the philosopher says of poets, “to make life anew”.

The homeopathic method is ideally designed to cope with these challenges and to meet these needs. It is a method that places the individual and the individual’s story at the centre of the care process. It is a process that requires a holistic understanding of the patient within the context of their families, of their work of their place in society. It is a method, which enables people to understand their lives better and to understand their health better.

Whose health is it anyway? It’s your health and it’s your right to be understood, to be cared for and to be empowered to make choices about your health care. It’s time to reclaim our lives from “experts”. It’s time to reclaim our health.

This article is based on the themes of the first Ronald Livingston Memorial Lecture which was given by Bob Leckridge at the Royal Society of Medicine on 11 June.

The BHA is grateful to Mr Harvey Shulman for sponsoring this lecture.

Dr Douglas Ronald Livingston was born in 1915 into a medical family and qualified as a doctor in 1940. He served in the Royal Navy as a medical officer and after the war went into general practice. He became interested in homeopathy and qualified as an MFHom in 1958. In 1960 he moved with his family to Poole in Dorset where he set up a private homeopathic practice. A great enthusiast for homeopathy, he wrote several books including *Evergreen Medicine and Homeopathy: Born 1810, Still Going Strong*. He was an inspiring teacher and a dedicated physician, much loved by his patients. He died on Christmas Day, 1999.



Bob Leckridge FFHom is President of the Faculty of Homeopathy, and a specialist at the Glasgow Homoeopathic Hospital. He qualified as a GP in 1978, and began his training in homeopathy in 1982.