The Qualitative View of the Patient

Abstract: The current medical model has a disproportionate emphasis on quantitative aspects of the patient. This essay explores its effects on the doctor-patient relationship, doctor and patient satisfaction, and the healing process. The value of subjective, qualitative, non-quantifiable patient characteristics is brought into focus, leading to a new practical clinical approach, following patients' qualitative characteristics as a guiding principle. This is a radical departure from the current model, leading to the possibility of truly patient-centered medicine. Philosophical bases of the current approach are questioned. A possible practical solution, a method known in psychology as client-centered therapy, is proposed as a possible first step in the direction of transforming today's medical model. Possible obstacles and ways of implementing this approach, with its possible risks and benefits, are briefly discussed.

As scientific progresses have brought us greater and greater achievements in almost every aspect of the mastery of the physical world, medicine has become more of a science and less of an art. Our admiration for the powers of quantitative analysis inexorably leads to the quantitative view of the patient as well.

The patient coming through the doors of our offices is more and more a conglomerate of various quantitative characteristics, and less and less a human being with non-quantifiable qualities. The patient has certain height

and weight, body mass index, blood pressure, blood glucose and cholesterol levels, hemoglobin and left ventricular ejection fraction, serum creatinine, etc. The patient may have a certain quantifiable degree of stenosis in various blood vessels and heart valves, there is a number for visual and hearing acuity, and there are quantifiable degrees for disease severity. Quantification has expanded into the area of human function; we quantify physical and mental capacity. In addition to being applied to the physical characteristics of organ systems, functional status, and disease severity, we are now quantifying the innately subjective aspects of human existence. Pain scales and depression scales have become a part of a routine physician practice.

This trend seems inevitable, since all of our diagnoses and treatments are guided by numbers. The unfortunate downside of this trend is an increasingly mechanical view of a patient who is seen as a complex biological mechanism that can be controlled through better ability to quantify it. The non-quantifiable aspects, such as personality for example, are seen as annoying byproducts of this biomechanism, byproducts that often interfere in our otherwise perfectly appearing system of numerical manipulation. Today's quantitative approach is rooted in the philosophy that views only the quantifiable as real. This philosophical approach divides the world into subjects and objects. Only what is objectively quantifiable is seen as real, objectivity being defined as a consensus of subjects about the quantitative characteristics of an object. Limitations of this philosophical approach have been demonstrated in quantum physics, where subject-object indivisibility was recently re-discovered.[1] By applying quantitative approach indiscriminately in medicine, we may be severely limiting our

ability to understand the nature of human being, and with it, the nature of health and illness.

It is not surprising that patients feel more and more alienated and sometimes hostile toward their doctors. To a patient, whether he can put his finger on it or not, today's physician, to a large extent, has a disposition of a rigidly programmed robot. Questions are directing the patient to produce numerical responses (i.e. how severe is your pain on the scale from 1 to 10), answers are given in terms of numerical probabilities (i.e. you have a 50% chance of five year survival). The so called 'chit-chat' is now taught in some medical schools as a technique that helps the 'real business' run more smoothly.

Fear of litigation, financial pressures, ever more numerous guidelines, all make it more difficult to have an attitude other than that of efficiency. In addition, an ever growing array of drugs and treatments with their accompanying fragmentation of care, further loosen human connection between a doctor and a patient. Thus the patients' frustration is analogous to the frustration most of us experience when calling our bank, and instead of a friendly voice of a teller, hearing computerized recorded prompts that ask us to speak to them in order to guide us along the pre-determined algorithm.

Yet, any therapeutic action applied to the patient (except for those that are done in true emergencies on semi-unconscious patients) depends on the trust and understanding between the doctor and patient. A patient will not take a medication, nor submit to life-saving surgery, if this trust is not established.[2] It is not a surprise that we now have an army of patients who are labeled with poor adherence, and those who are receiving the

modern ‘wonderdrugs’ while continuing to engage in self-destructive behavior. In order to adhere to the treatment, one must believe that the treatment has value and is worth the troubles that come with accepting it. There are fewer and fewer patients who will blindly obey the doctor’s authority and just ‘do what the doctor says’. This perhaps is the only good effect of the dehumanizing process of quantification. It has prompted patients to re-evaluate their dependency on the authority of the doctor, giving them an opportunity for growing up. Indeed, today’s efficient doctor can hardly be viewed as a caring father.

What is a qualitative view of a patient and why is it valuable? The qualitative picture of the patient includes all of the person’s non-quantifiable attributes without any attempt at quantification. They are inherently subjective. Being boundless by nature, the qualitative characteristics cannot be easily defined, but yield themselves to understanding through subjective and poetic terms.

We can experience these subjective characteristics most vividly when we fear, hate, or love. A love poet is not inspired by the perceived mathematical harmony of the geometrical shapes of the beloved, but by the simultaneous subjective perception and knowledge of the rapture and expansion of being that the union with the beloved promises. This knowledge is simultaneously so deep and grounded, so high and transcendent, and so certain, that for the lover it overcomes all the gloom-instilling boundaries of the world.

This brings us to the question of the nature of a human being. I would not attempt to answer this question here, except to assert that a human being seems to be infinitely more than the sum of its calculable

characteristics. I also would like to propose that a person's non-calculable aspects are far more central and essential to one's nature and experience as a human being.

Our training tends to instill fear of the subjective as something that carries a double risk of having us lose control of ourselves and of losing our efficiency of operation in the concrete world. This fear prevents us from developing these subjective modes of functioning. It is not surprising that we then feel impotent at addressing patients' subjective needs, hiding, so to say, behind the numbers. Having never developed the capacity for subjective perception of another person, we remain partially blind in this respect, unable to connect with the patient (and often even with our loved ones), and as a consequence, unable to clearly see what the patients' subjective needs are.

This subjective view comes rather spontaneously within the open perceptiveness of love. For that reason, paying attention to what the patient's loved one may share usually provides important clues as to the patient's subjective needs. Developing one's own capacity for unconditional love is a sure way of becoming highly aware of the patient's subjective needs. This may appear difficult given the demands for high practice efficacy. We become wary of emotionally needy patients, since they seem to devour our time with little to show for it in terms of our usual numerical results. In fact, the new 'pay for performance' system of reimbursement implies that if we had not put the patient on the recommended set of medications, had not obtained the right set of labs, and had not achieved a certain numerical result, we would not be performing well and are not worthy of a full payment for our services.

Feeling dissatisfied with the status quo of today's quantitative approach to the patient and sensing patients' dissatisfaction, I have embarked on my own process of exploration. In my search for what exactly is the qualitative view of the patient and how to use it in practice, I discovered that the field of psychology, and particularly a psychologist Carl Rogers, had formulated in the 1960s the ideas that were only vaguely circulating in my mind. In psychology this approach is termed *client-centered therapy*.[3]

While most of the current psychological approaches appear to be rooted in the same limited model as somatic medicine, this approach appears to offer the first step out of the presumed inferiority of the subjective. Client-centered therapy, apparently highly successful in the field of psychology, is based on the faith in the patient's ability for self-determination, constructive change and development in the direction of a fuller, more satisfying life, as defined by the patient.[4] Our current medical approach, for the most part, seems to be based on the opposite belief, a belief that the physician must take over the responsibility for the patient's health.

Further, the practitioner of client-centered approach is advised to make the sincerest effort of adopting the patient's internal frame of reference to gain the center of the patient's own perceptual field and see the world through the patient's eyes.

While many of us, who are not psychologically inclined, might find such a concept straining, its implementation in the everyday medical practice is quite simple. One simply needs to let each patient, who is mentally competent according to the usual criteria that we use for

assessing mental competency, determine the course of his own treatment. This allows the patient's subjective hierarchy of health priorities to emerge into the center of the therapeutic interaction. While the patient may not be able to discover whether he has cancer, he can surely tell us whether he is interested in discovering it. He can tell us whether he wants to deal with the uncertainty issues, diagnostic tests, their side-effects, and treatments with their inconveniences.

In spite of appearing risky at first glance, such a practice may prove to diminish the risk, from both legal and clinical perspectives. I think this approach is worth the attention specifically because of its practicality. It does not require spending additional time with a patient, but there is a price.

The price is in giving up all of the medical guidelines as being primary guiding principles of treating the patient. The price may be, perhaps, in not getting 'paid for performance', since each individual patient cannot view good performance in the same way.

Caring disposition, described by this psychologist in terms of empathic ability of perceiving the world through the patient's eyes, should guard one against frustration and abandonment of the patient. Instead, it may lead to more efficient care. This may mean not following some of the guidelines, or waiting until the patient is ready to address certain aspects of his health, without the slightest pressure and with a full recognition that certain important aspects of health are not addressed. It means allowing the patient to develop interest in his own health within a warm doctor-patient environment, and respecting the patient's wish to remain ill. Allowing the patient to assume responsibility for his health and illness may

have significant benefits and therapeutic effects. While such a view may appear like a great leap of faith, our current leap of faith in the patient's inability for self determination has never been substantiated.

Will such an approach increase patient longevity? The answer to this question cannot be derived within the constraints of a double-blind, randomized clinical trial. Perhaps only epidemiological studies, with their inherent weaknesses, can be applied to practices that involve the non-quantitative nature of the human mind as an important medium of health. Yet I believe that such an approach may bring important improvements—increasing patient longevity, and improving both patient and physician satisfaction. In my personal experience I am already finding this to be true.

Reference:

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