Patient-Centered Medicine: Transforming the Clinical Method

Moira Stewart, Judith Belle Brown, W Wayne Weston, Ian R MacWhinney, Carol L McWilliam, Thomas R Freeman
Sage, £19.50, pp 267
ISBN 0 8039 5689 4

Many of the successes of modern medicine have been based on our understanding of the nature, classification, and causes of diseases and our ability to diagnose and treat them. Many of our continued problems are due, however, to the limitations of this approach, and doctors sometimes find it difficult to understand why patients often do not choose to continue the treatments that we prescribe or to adopt healthy lifestyles, sometimes seek alternative medical or non-medical care, and even occasionally complain about the treatment or information that they have received.

The concept of patient centred medicine is not new. At its core is the belief that to be fully effective doctors we must integrate our diagnosis of diseases with an understanding of our patients' experiences of life and their illnesses. Only then can we care for the whole person, give explanations and advice that are appropriate for that person, and share decisions and responsibilities for care.

The department of family medicine in London, Ontario, founded and led by Ian MacWhinney, who moved there from his practice in Stratford upon Avon in 1968, has described, researched, and taught patient centred clinical methods since that date, and *Patient-Centered Medicine* describes this major work.

In his chapter "Why we need a new clinical method" MacWhinney argues that there is a moral imperative for doctors to understand human experience, relieve suffering, and share with their patients the power that modern technology has given them.

The rest of the book divides the patient centred clinical method into six components: exploring the disease and illness experience; understanding the whole person; finding common ground regarding management; incorporating prevention and health promotion; enhancing the patient-doctor relationship; and being realistic about time and resources. It describes how these can be rated and taught, and marshals the considerable body of evidence which shows that achieving these components or "tasks" increases patients' satisfaction, reduces their concern, relieves their symptoms, and improves their physiological status.

So even in the climate created in medical schools by evidence based medicine there are both ethical and evident reasons for teaching medical students patient centred clinical methods. The book also describes a

learner-centred approach to teaching. A good start would be if every student was asked on the ward round: "What is the patient's understanding of their illness and what do they believe caused it?" "What are his or her feelings and fears?" and "What are his or her expectations of the doctor?"

—THEO SCHOFIELD, *department of public health and primary care, University of Oxford*

Stress, Catecholamines, and Cardiovascular Disease

David S Goldstein
Oxford University Press, £60, pp 539
ISBN 0 19 506538 7

"Stress is like obscenity. I cannot define it, but I know it when I see it." The opening quote of David Goldstein's book proves remarkably apposite for a text that draws both its literary and scientific strength from its scholarly mix of quotations and descriptions of catecholamine biology in cardiovascular disease. Just when general readers might themselves be sinking in the flux of catecholamine synthesis or metabolism, they are rescued by a tongue in cheek apologia for the biblical practice of trial by ordeal.

Three portraits (Dr Oliver Wendell Holmes, Sir Alfred Fripp, and Dr Oscar Clayton) from *The Doctors in Vanity Fair: A Gallery of Medical Men Who Appeared in Caricature between 1870 and 1914* by Alan H Sykes (ISBN 0 900811 27 7). As well as 53 caricatures the book contains the original legends plus an updated biography for

each entry, together with excellent notes and index. The main aim of the book, however, says the author, is "not history or biography but enjoyment." Copies are available from the author at Walthwaite How, Chapel Stile, Ambleside, Cumbria LA22 9JG, price £30 plus £2.85 postage and packing.

The medical interest in the topic lies in the scope for either explaining diseases in which catecholamine excess or depletion occurs, or for suggesting new treatments. Since the organs which have the highest density of catecholamines and their receptors are the heart and brain, the relevant diseases are cardiovascular and neuropsychiatric. The book concentrates on evaluating the stress contribution to cardiovascular disease, presumably because the author is fascinated by the role of the sympathoadrenal system in bridging psyche and soma.

The drawback of this is that recent therapeutic advances have been in the central nervous system, and it is a non-catecholamine, 5HT, which the Prozac swallowsers of the world are using as their antidote to stress.

Goldstein is right to regard catecholamine biology as the meeting place of mind and matter. Nothing could be more organic than a pheochromocytoma, but most of the patients beating a path to our clinics with symptoms (and, often, plasma adrenaline concentrations) indistinguishable from those of a pheochromocytoma suffer from no more than—correction, a little more than—releasing two standard deviations above the mean adrenaline response to “stress.” Concentrations of adrenaline in the blood can vary 100-fold, quite unlike those of other hormones (or the more closely regulated release of the neurotransmitter, noradrenaline).

It is tempting to think that this range is what would be expected of the emergency “flight and fight” hormone, although the lack of close regulation could equally be regarded as evidence that the adrenal medulla is vestigial in humans, its role subsumed by noradrenaline.

It is the role of catecholamines in cardiac disease which is central to Goldstein's thesis. This seems to be that stress responses of the sympathoadrenal system have evolved through natural selection, which as we all know, stops working after the reproductive age, when heart diseases kill. Questions of primacy then arise, which can be neatly resolved by concluding that sympathoadrenal activation exacerbates rather than causes the disease—for example, adrenaline causes the ventricular fibrillation which prevents some patients from reaching hospital after myocardial infarction, but is not itself the cause of the myocardial infarction.

Those wishing to complete the circle through various endocrine systems will find all the ammunition they want here. But Goldstein admits that β blockers have had a less than dramatic impact in preventing cardiac death and, as in the central nervous system, it may be that other amine, 5HT, or indeed many other mediators, at which we should be looking. Or it could be chance, or it could be genetic variation in the receptors and cell signalling events within cardiac myocytes. However, the value of *Stress, Catecholamines, and Cardiovascular Disease* is not

in answering the author's or reader's more philosophical questions, but in providing in an attractive and readable manner the wealth of information about the topic which enables others to test their own philosophy without first needing to rediscover the wheel.—MORRIS J BROWN, *professor of clinical pharmacology, University of Cambridge*

Wrong Medicine: Doctors, Patients, and Futile Treatment

Lawrence J Schneiderman, Nancy S Jecker
Johns Hopkins University Press,
£21.50, pp 200
ISBN 0 8018 5036 3

Medical futility—the idea that doctors ought to refuse demands for treatment that is unlikely to work, or that merely prolongs states of permanent unconsciousness or dependence on intensive medical care—is an *idée fixe* for Lawrence Schneiderman and Nancy Jecker. The concept has been criticised for packaging an uncontroversial claim, “patients can't demand treatments that won't work,” with a controversial one, “unconscious life or life dependent on intensive care is not worth preserving.”

I hoped that *Wrong Medicine* would both respond to critics and develop the concept of medical futility more fully. I was disappointed on both counts.

The book is a mere rehash of previously published material on medical futility. I was puzzled by many of the cases selected to illustrate its thesis. Of the 12 cases discussed, only four involve patients' or families' demands for so called futile treatment. Inexplicably, the authors include four cases of families' demands for withdrawal of treatment. For example, *Wrong Treatment* opens with the story of Nancy Cruzan, a woman maintained in a persistent vegetative state for seven years against parental wishes. The moral lesson of the Cruzan case—doctors ought to respect the wishes of patients and their families—runs counter to the book's message.

The legal analysis in the sixth chapter is deeply flawed. The authors claim that doctors have little to fear when refusing to provide “futile” treatments. They observe that “there has never been a single civil judgement against or criminal conviction of a physician for withdrawing life-sustaining treatment.” They fail to mention that the legality of such withdrawal is based on the refusal of treatment by either the patient or the family. The courts have shown profound reluctance to allow doctors to withdraw life-sustaining treatment against the wishes of the family.

Ultimately, *Wrong Medicine* is based on a false picture of medical practice. The authors believe that without the concept of medical futility patients and their families can “choose any treatments, even irrational treatments.” This is simply not true. The US President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) points out that a “health care professional has an obligation to allow a patient to choose from among medically acceptable treatment options...or to reject all options. No one, however, has an obligation to provide interventions that would, in his or her judgement, be countertherapeutic.” The fact remains that even without medical futility doctors have an ethical and legal basis for refusing demands for treatments that fall outside standard medical practice. *Wrong Medicine's* title is truer than the authors intended.—CHARLES WEIJER, *clinical trials research group, McGill University, Montreal, Canada*

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