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Editorial

A Radical Idea: Making Medical Practice 'Health-Effective' Is the Future of Medicine

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A great deal has changed in medicine over the last fifty years. In economically developed nations, chronic illness has emerged as a more significant cost to society than acute disease; both illness and good medicine have been recognized as deeply biopsychosocial rather than merely physical; the scientific basis of chemical and behavioral treatments has developed beyond recognition; the necessity for translational science has been recognized; and we have come to acknowledge, grudgingly, the inability of purely technological solutions to meet human medical needs. Slowly, the practice of medicine is being forced to adjust to these far-reaching changes.

It seems unarguable today that an essential mark of a civilized society is that it has prosocial medical services: i.e., services that are provided free or affordably for all members of that society and that are maximally effective in turning sick people into healthy people. A society with such services has surmounted the conflict between the needs of society (globally and individually) and the self-seeking of its providers. Today, we see the USA struggling with this very challenge; the sight of insurers and clinicians alike resisting change due to personal greed can only be called morally offensive. Yet even President Obama's insurance-based solution is inadequate, as my own experience has shown in organizing medical services for people with HIV and degenerative neurological disease in the insurance-based Dutch and German systems.

Simply having free medical services does not guarantee that they are prosocial: the British National Health Service with its antiquated model of ineffective, costly, physician-centered, and management-dominated services is an unfortunate warning against such an assumption. To be prosocial, a service must also ensure it maximizes the health of the individuals who seek the services. By health, I mean the same as the 1948 definition of the World Health Organization: i.e., a state of complete physical, mental, and social well-being, and not merely the absence of physical diseases. This conception of medicine accords substantially with that of the Islamic clinicians Al-Razi and Ibn Sina in the 9^{th} - 11^{th} centuries CE or 3^{rd} - 5^{th} centuries AH. If we have known for so long what health is, why does medical practice fail to recognize it today?

The problem lies in the model of medical practice. To recognize and ensure the primacy of health, a model of medical services is required that puts each patient's needs at the very center, where the physical, mental, and social aspects of illness are addressed conjointly. Seeing the

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patient as a whole person is the core idea of both biopsychosocial and, indeed, of classical medicine. But it has been extremely difficult to develop a way to implement this form of practice in modern medicine: not only has there been resistance from physicians who want medicine to remain physician-centered, and from managers who understand money more than medicine, but also, until recently, the science of behavioral, mental, and social medicine, of the technologies of assessment, and of the design of integrated systems have been insufficiently mature to envisage an alternative, health-effective form of medical practice. However, as a result of the development in scientific practice over the past 60 or so years, from simply reductionistic to systemic approaches, the necessary technologies have now developed. We see parallel changes in the shift from neuro-anatomy to neuro-systemics, from reductionistic genetics to epigenomics, and so forth.

Yet medical practice itself has progressed little. This is mainly because biotechnology has progressed so greatly, maintaining the costly—but unsustainable—approach of providing simplistic, reductionist solutions to complex, human illnesses. It is clear that no society—no matter how wealthy—can keep paying for increasingly expensive 'magic pills' for biopsychosocial illnesses: treating the infarctions and cancers but not the addictions and environmental contamination; treating the metabolic disorders but not the poor nutrition; treating HIV, TB, and malaria but not the behavioral risks and the social inequalities. Contrary to the opinion of some, no single type of clinician can possibly have all the expertise necessary to provide competent, comprehensive treatment, yet in spite of the development of medical professions other than that of physician, medicine has not changed its form of practice significantly in centuries.

From the scientific evidence, it is clear that in order to be maximally health-effective in addressing the primary causes of morbidity and mortality in developed societies, medical practice needs to change fundamentally. Just as science has matured into systemic, multi-disciplinary practice, so must medicine mature from physician-centered biomedicine to systemic, multi-professional medicine. Whether one likes it or not, providers' solutions are influenced by what benefits them more than what benefits the people in need, particularly when patients' needs are too distant from providers' own experiences. A good example is Wagner's and Bodenheimer's Chronic Care Model where patient-centeredness is simply a veneer over the old, physician-centered model of practice. If medicine is to be evidence-based, providers can not pick and choose from that evidence to suit their own preferences without demonstrating the same sort of greed among providers that we see today in the USA.

Of course, it is difficult to change culture; without clear, scientific measures of progress, an obsolete culture has a way of reasserting its hold. To this end, illness needs to be assessed differently and comprehensively, creating a benchmark for treatment that refers to health rather than the absence of physical disease-markers; this requires an integrated treatment-plan to which all clinicians subsequently refer and on the basis of which they integrate their individual treatment-plans. In turn, this requires nurse-led multi-disciplinary practice and case-management. Subsequently, it requires an assessment of clinicians' and administrators' ability to create health-defined outcomes, which itself requires the development of performance-based data related to each individual patient for the purpose of medical governance. Such practice requires the participation of the patients not only in treatment but also in medical governance; this promotes patients' responsibility while ensuring providers' accountability so that the focus

of services remains on patients' health and not on providers' preferences. Not insignificantly, it also protects against the ravages of patient-consumerism in medicine, which drives costs up.

Many elements of such an outline are readily recognizable, the primary difference lying in how it is formed into a system that can embrace scientific progress in practice while remaining focused on the single goal of long-term health for each patient. This has fundamental consequences to medical practice. Not surprisingly, even less-comprehensive approaches than this have shown significant cost-savings over the physician-centered model of practice: work by the Cummings Foundation in the USA, for example, has shown that relatively crude integration in medical practice can create sustainable offsets of more than 60% in utilization-costs in general practice. The design outlined here refers to a rigorous model of medical practice presented online recently within a consultation paper on participative medical governance published by the Tuke Institute. It is also similar to the model for participative translational medical research, developed by the author, and adopted in March 2010 by the British Department of Health for its national clinical trials framework.

In this era, we are at a cross-road where real progress can be made. It may be called a form of 'akhlaq' (أخلاق) for each clinician to promote real change in the way medical practice is defined, designed, and delivered so that it meets the needs of the patient first and foremost and prevents the intrusion of providers' self-seeking. Any society that is fortunate enough to be able to provide free or truly affordable services should protect that privilege by making them as health-effective as possible. The Kingdom of Bahrain is in an enviable position to be a world-leader in this progress.