

# **Health Care in the 21st Century: A psychotherapist's perspective.**

COURTENAY YOUNG

## **Abstract**

An essay of exploration into a different perspective on an individual's health care and what might be meant by that; as well as examining how this might be extrapolated into a futuristic but more sustainable health care system.

## **Preamble**

This is a very 'hot' and topical issue in the USA at the moment as President Obama tries to create a new national Health Care system in the face of massive (and sometimes vitriolic) resistance, much coming from the Republican party and backed by the vested interests of the medical insurance companies. Surprisingly, most of the medical profession is relatively supportive. After years of dominance by the health insurance companies, and ever-increasing costs, even the concept of something universal and affordable is now almost unthinkable, despite the excellent examples of Medicare (for the poor), Medicaid (for the elderly), and the Veterans Administration health care system. People seem terrified of losing what they have got: despite the fact that – in the richest country in the world – 43 million people have got access to absolutely no health care.

The UK National Health Service (NHS), despite massive investment in the last few years, is not providing a shining example of a state Health Care system, even though – on paper – it is a lot better than many similar systems; though it has its own endemic problems, mainly that of too many managers and not enough medical staff.

Other European countries, especially those in France and Germany, seem to have very good health care systems, with a good social basis, and that are (mostly) affordable to the citizens. In other countries, there are basic state-run health care systems, some better, some worse, which seem to be seen as an essential part of the 'social contract' between the state and the citizen, but these health care systems also use up a fairly high proportion of those countries' resources (usually measured as a percentage of Gross Domestic Production (GDP)). This means that the health care system also competes within the country with education, roads, defence and development budgets and the cost of these is ever-increasing. The question then becomes – who pays for it, and how sustainable is it? And remember, this is just for the medical aspects of health care. As soon as the concept is extended further to 'real' health care, one realises that a different model, a different set of parameters, a total re-think, is really needed. This article doesn't solve

this set of problems, but it may – hopefully – stimulate some of the re-thinking process, particularly from the unique perspective of a psychotherapist, who is often a witness (possibly the only witness) to the problems of the individual in a complex society.

In a discussion with someone a few years ago on this topic, I found myself talking about a different model of general health care that tries to fit the issues that I see as important, from the perspective of being a UK psychotherapist, and one who works in the NHS. Quite naturally, he was coming from a somewhat different perspective, being a Japanese doctor and an acupuncturist. This topic seems to be of international interest. I do not pretend to have a solution to President Obama's problems, nor indeed those of the NHS, but I would like to try to widen the debate somewhat, as most of the present discussion centres around "medical" care, rather than the wider concept of "health" care.

But let me try to relate something of the theme of our discussion, and in particular what is meant by some of the terms involved. He had asked about the difference in the West between "medicine" and "health care", as he saw, from his perspective, 'Eastern' medicine as incorporating both 'treatment' and 'prevention', but in the West there is a massive effort put into diagnosis; treatment is predominantly either surgical or pharmaceutical, and there are only relatively minor efforts put into prevention, though some attempts are now being made towards better education, especially with respect to childhood obesity. My feeling was also that Western "medical care" focussed much more on seeing the people involved as either professionals (the empowered experts), or as patients (an essentially disempowered and often demeaned position); "care" was just going to the doctor and doing what he or she said; and a definition of "health" being the 'absence' of any particular illness: i.e. you were healthy possibly by luck, or by default.

Alternatively – and there is a big separation here – I personally see "health care" as something that usually happens outside of Western traditional medicine, and more often than not only in the field of what is called "Complementary" or even "Alternative" Medicine, though many of the disciplines in this field are also focussed on 'treatment', especially as they are usually individuals working privately and thus needing a succession of clients and payment for their services. However, in this field, the person is usually seen more holistically; there is a wider concept of "health"; "care" means more self-care; and because the person is paying directly for the service, there is more personal empowerment, so the recipient is seen more as a 'client' than a 'patient'. However, the 'system' (such as it is) is quite commercial and self-perpetuating, as the more 'illness' the practitioner discovers in their client, the more 'treatment' that person needs. This puts an economic premium on being accurate or ethical and on the client getting better.

So it is only really with national, governmental schemes that there is any real financial ‘gain’ in the area of active health care prevention.

In contrast, I was told, Eastern medicine and many of the complementary and alternative therapies that have grown up recently in the West, see the person, not only as a patient, but less passively, looking much more towards any particular ‘treatment’ as helping that person become more involved (being pro-active) in a process of the restoration of the ‘balance’ of the different energy systems within that person. This takes us towards a very different – and more positive – model of ‘health’.

But the ‘doctor’ can also be proactive, if they are allowed to be. There is the apocryphal story of the Chinese doctor who is only paid when the patient is well: he gets a monthly stipend from each patient. If the patient falls ill, the doctor has to make him better – as quickly as possible – before he will get paid his stipend again.

Within the wider context, the person and their ‘problem’ can be seen much more holistically – maybe the ‘problem’ is encouraging the person to work something out on a different level – and any treatment, be it homeopathic or allopathic, conventional or alternative, or any consideration of mind, body and/or spirit is seen as being valid if, and only if, it restores the balance of ‘health’ within that person. This is a fairly simplistic, but (I believe) fairly accurate, overview. As soon as one starts to take this perspective as important, the issue of the prevention of illness becomes paramount. And a model of healthcare for the 21<sup>st</sup> century has to have this principle deeply embedded in it.

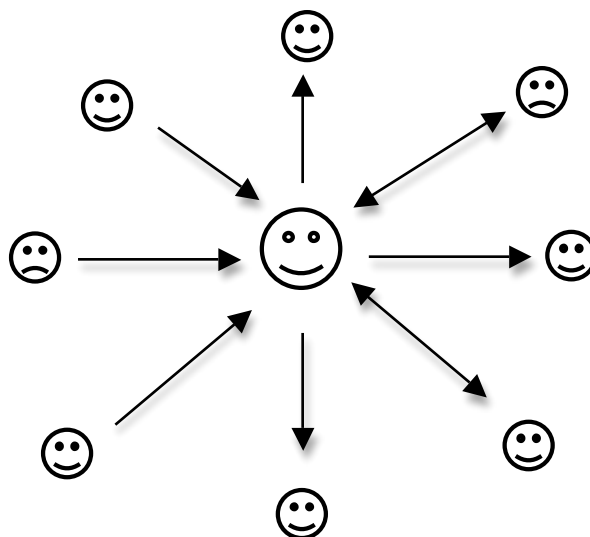
To go back to the example of America for the moment: in the present system, there is no interested party – apart from the recipients – that would really benefit financially from any significant level of preventative care. This is perhaps how and why the USA currently spends about 16% of its total annual wealth (Gross Domestic Production, GDP) on its medical system, which is more than any other country in the world. Most of the source of this money is from health insurance payments; and these are quickly becoming unaffordable for many people. So much so that decisions about where you live and what job you have depend on what the health care benefits in that state are, or what benefits go with the job. The money does not come from the US government, so if the US government were to start to fund health care properly and more universally, then they would become much more concerned about the ever-increasing costs. One of the current proposals in the USA is for the government to set up an ‘alternative’ health care insurance system that would compete with the current insurance companies and (hopefully) have the effect of providing a cheaper alternative. Yet the question then arises of who pays for this –

and how? Do people pay twice – through their taxes and through their insurance payments: hence a lot of the resistance to Obama’s otherwise very sensible policies.

The discussion that my friend and I had focussed around the ‘role’ of the doctor or practitioner, who often is considered, or considers themselves, as central in the health care system. My friend had an idea that there should be a ‘network’ of interested people, but then we started to argue about labels. I found myself saying that if he called his concept of a network, “Medicine in the 21st Century” (as he originally thought he would), this would exclude myself, as I am not a doctor, but a psychotherapist, and it would also exclude many other practitioners in the complementary medical field. If he used the title, “Treatment in the 21st Century”, this might continue to promote an allopathic view and give the medical profession the feeling that they should be the only people really involved, given their somewhat confined perception of their work, their training and their efficacy. Whereas the title, “Health Care in the 21st Century” would be much more inclusive, and would also sound the note that we both wanted to sound – that the ‘patient’ needs to be facilitated and ‘empowered’ to take much more care and responsibility for their own health and treatment, and the ‘practitioner’ would therefore become something more of a facilitator. This is a fairly radical role reversal, and I would like to explore this concept a little further.

It was at this point in this discussion of fairly similar ideas, that I more fully understood several concepts that have been behind much of my early work and thinking in complementary medicine, and as a psychotherapist, and also my dissatisfaction with present health care systems. The basic model looks something like this:

Diagram 1.



**The model:**

The position of the ‘person’ (I won’t call them a ‘patient’) needs to be seen as being absolutely central to the model. Then all the people around them: partners, family, friends, neighbours, employer, colleagues, doctor, psychotherapist, practitioner, teacher, lawyer, priest, etc. – who are all to varying degrees affected by the ‘health’ of that person – can also all (in their own ways) reflect back to that person perspectives about that person’s health and these views will differ from certain aspects of their perception, their knowledge, and their ‘insight’ into about that person.

Now, this is where my perspective as a psychotherapist begins to show. If that person has a problem in life – be it medical, legal, behavioural, psychological, general health, or whatever – there will then be many different views on that problem. The process of reflection of these views back to this person is a very important part of the ‘diagnosis’ and maybe even part of the ‘treatment’ or ‘therapy’, but it is also done from the perspective that the person has, and can, express valid views about themselves and others around them. It is done from the perspective that the person does not, ever, empower someone to ‘cure’ them, and thus dis-empower themselves from being proactive in any betterment of their situation. It is also done from the perspective that the person involved does not really need to have a ‘problem’ or an ‘illness’, in order to get help.

Maybe it is not a ‘problem’ (or an ‘illness’) that is the issue, but a form of ‘survival technique’ that is now somewhat counter-productive or dysfunctional. If our parents believe ‘this’ or ‘that’, or act like ‘this’ or ‘that’, then – as a child being dependent on them – we adopt ‘this’ or ‘that’ in order to survive, irrespective of whether it suits us or not. These become a habit, sometimes a life-long habit: but they don’t always work when we become adult ourselves. Maybe the person’s environment has changed considerably (especially from when they were a child), and thus the ‘survival techniques’ need to adapt appropriately. Maybe they do not fully realise the impact that these patterns of behaviour and perception are having on other people, or other people are too polite to say what they think or feel.

Modern society, even though it is hectic, even though there are masses of people, even though there is almost instantaneous communication, can be very isolating, and people often feel alone and quite desperate. We are often not very happy. We are sometimes encouraged by advertising to consume too much of cigarettes, alcohol, or fatty or sweet food to make ourselves feel better: all of which we also ‘know’ are bad for us. We are sometimes encouraged to believe that we really ‘need’ a new ‘something’ in order to feel happy. If we feel upset or threatened, we are encouraged to believe that ‘they’ are the enemy, and that our life will become better if we

‘win’ against ‘them’: even though somewhere we also know this not to be the case. ‘People’ are often seen, especially by governments, as needing to be ‘controlled’ for their own good: ‘people’ cannot decide things for themselves: “we”, the politicians, doctors, psychiatrists, trade union. or experts, will decide what is best for you, the ‘patient’ or the “little man”.<sup>1</sup> I have used somewhat extreme examples, but this pattern persists throughout modern society and can be seen in our lives at many different levels and in a thousand different ways.

As an example, let us consider a man, who might have been demeaned as a boy, and only given emotional warmth and approval for his achievements. He is quite likely to become a ‘workaholic’ and may well also be something of a perfectionist. He may not trust people very much, only position, status or ‘achievements’. He is relatively successful, and yet is ever driven to ‘do’ more. He can get passionate about work, about politics, about the future; and, emotionally, he is quite remote, quite cut off. As a result of this mix, after a while, from the general stress of life and work, the absence of intimate relationships, and these inner pressures, he develops (let us say) an inflamed duodenum, and later, malignant hypertension (high blood pressure).

Does one just prescribe Zantac (for the inflammation) or Atenolol (for the hypertension)? Will beta-blockers really help this person to ‘slow down’ and become more ‘laid back’ and relaxed? We might consider something like Autogenic Training – especially if anti-hypertensive drugs like Valsartan or Bendroflumethiazide are contra-indicated? Maybe even Shiatsu (a form of treatment), or Tai Chi (a form of self-discipline), could help to reduce this particular person’s background build-up of stress. And these are also short to medium-term levels of treatment for these particular symptoms.

We might even consider encouraging this person to enter into psychotherapy, which could help him understand – not his “neurotic patterns”, but the way that he survived as a child in an emotionally remote family. He can start to: understand his desire to please people - his (achievement-orientated) parents, so that he can begin to change these patterns and approve of himself more: gain a greater sense of self-esteem; the ability to feel content with “good enough” achievements; a realisation that his parents actually loved him, despite being somewhat misguided in their demonstration of that love; this could all assist his process. He might open up a little more to friends and partners; he might soften towards his children; he might relax with his colleagues and be able to hear ‘feed-back’ without hearing it as criticism.

Any of the more traditional treatment perspectives could have originally involved a process of demeaning the person in some way – making him ‘sick’ or ‘ill’, instead of supporting him and encouraging his personal growth: it is important not to demean him (the patient) in any form of treatment whereby he is encouraged to feel that something is ‘wrong’ with him, or that he

is helpless or ill, before we (the professional) deigns to cure him. We often cannot avoid this if we put ourselves in the position of ‘doctor’, ‘healer’ or ‘therapist’ and the person in the role of the ‘patient’ needing treatment.

Not only do we need to find another set of roles here, but there are further disadvantages to this perspective. Any one-on-one position in a health care situation will often have the fundamental positioning of [client/patient] saying, “*I don’t know what is wrong with me*” and the other [health professional] saying, “*I (think I) know what you need to do.*” This is a hierarchy of experience, intelligence or perception. It intrinsically is capable of demeaning the person in their “I don’t know” state, and elevates the other into a “knowing” position.

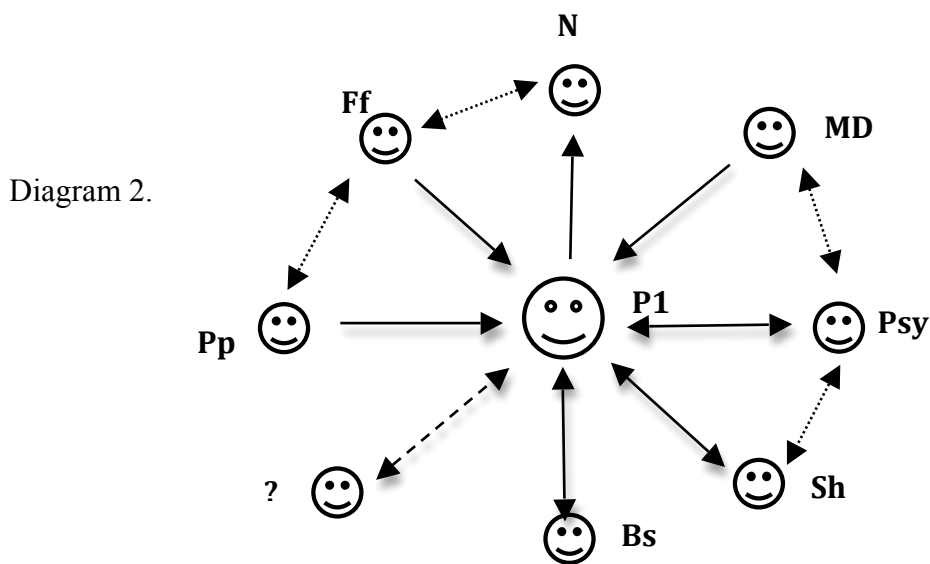
There are many other hierarchies, of knowledge, training, and experience that usually have a more obvious mal-effect. We all know the dangers of institutionalisation of long-term hospital patients: this is one of the extreme positions. I also happen to think that it is very rare and difficult for a one-on-one practitioner to avoid this position unless they are very aware and extremely careful of the ‘therapist-client’ / ‘doctor-patient’ relationship.

There are certain key questions that can lead us out of such a situation: (“leading questions” if you like). For example, “*What do you experience as going wrong?*” instead of something like “*What’s the problem?*” indicates that, as a professional, (a) you see the person in front of you as having important information, and (b) also that you see the person as being in a process of increasing imbalance. In the second question; you are much more likely to get the answer back “*That’s what you should be telling me!*” or the inner response, “*Me. I’m the problem.*” This deprives the practitioner of an incredibly powerful resource – the patient / client himself or herself. Let us give them a little credit: things may not be good at present, but the person has survived 20, or 30, or 40, etc. years in the school of hard knocks: possibly more so even than you, the professional, educated and privileged practitioner.

Let us instead consider the (more appropriate) reality of a many-to-one situation. It is relatively rare that a person only has one single point of contact with the world and that only with their therapist, practitioner or doctor. They are usually part of a sociological ‘complex’ or matrix, connecting, home life, work life, social life, individual interests and the person’s health. Family, friends, workmate, bosses, partners, and others that they consult, all will have a view or insight on the person’s state of health, or on their ‘problem’. Often the other people in this person’s life might demean their own perspectives, as they don’t consider themselves as competent, or as a professional. However they also see aspects of that person that the therapist, or doctor, practitioner or priest, never sees. They see that person’s tenderness (or coldness) with their partner, or their

children, for example. They observe their confidence or ability at work and lack of it in their home, or in emotional situations, or visa versa.

So none of these views are complete. They cannot be complete. No-one, however skilled or wise, can completely know another person, and thus know what they really need (and this is very different from what is ‘wrong’ with them), and thus no-one will be able to tell them what they need to do. The person must find out all this for themselves, and this is the process of personal development (“Know thyself”) and personal empowerment (“Do it” or “Carpe Diem” – ‘Seize the Day’) and of personal healing. With this sort of insight can come – albeit slowly – a degree of self-regulation, discrimination, and even wisdom.



So, in this new model of healthcare (see Diagram 2), any (and perhaps every) Person (P1) has around them a team: (for example) a partner (Pp), friends (Ff), neighbours (N), a doctor (MD), a therapist (Psy), a Shiatsu practitioner (Sh) and a somewhat enlightened boss (Bs). There is also “that which is as yet unknown” (?). So we have a series of views of that person, each view giving (say) a 10-12% insight on that person - once it has been checked out and affirmed.

Let me elaborate a little on this last point. I might think that I can see something of a person. If I share this with them – and if it is done in a compassionate or empathic way that can be heard – and if the person can receive it relatively clearly – and if it is reasonably correct and confirmed – then we can say that this bit is part of our consensual reality. It’s clear, it’s open, it’s acknowledged, it is probably accurate, and then it can be worked with. But this is not the whole story. If the different perspectives can be ‘shared’ a little, or coordinated a bit, then one can build

up a 75-85% accurate picture of the person's dynamic or pattern. This is probably as accurate as we can get.

In this perspective, no one particular view dominates. Malignant hypertension - the view from MD - is just one part of the person's process. The person is getting support from, and maybe also giving support to, their friends (Ff), who (or one of whom) are in contact with the person's partner (Pp); their partner, who knows the person quite well, has also witnessed some of the original parental reactions - either directly, or transferentially. The therapist (Psy) provides some help in expressing the person's unexpressed emotions; has perhaps met the partner once (with the person); and perhaps can help the person to see how they adopted this (relatively) successful strategy - it was successful: they survived; though now it is counter-productive. The Shiatsu practitioner (Sh) helps the person get more into their body, feel what is happening there, and maybe helps them to line up their energy systems. There may even be some professional communication between the doctor (MD), the therapist (Psy) and the Shiatsu person (Sh). The person's boss (B) has been communicated with, understands they are not just malingering (or something), and has come to realise that the person has pushed himself or herself too hard, is too much of a perfectionist, and is possibly even on the way to a really serious break-down or crack-up, which could then seriously disrupt the business of the company. S/he realises that his person has value and needs to be cared for. The person themselves, in the centre of all this, can build up an accurate(ish) picture of a large part of themselves by this sort of process. They need to, as they are the one who is going to change.

Each perspective from the people around can help reflect these basic concepts back to the person involved. This will: (1) not only help them see themselves more clearly, both good points and bad points; but (2) often have with it a piece of the possible solution, or at least the tools to help find it. The doctor can provide a regimen of Zantac or Atenolol (if it now seems necessary). and can also check to see that there are no signs of a deeper or more serious problem. Their partner can provide some of the unconditional love and acclaim that the person needs, and soften the effects of this protestant work ethic on their children. Their therapist can help the person to forgive their parents and look for self-esteem within themselves. The complementary practitioner can help the person re-build their pattern of health, and their boss can put them into a more supervisory role (perhaps for a while), which takes off some of the pressure to produce, and uses their perfectionist talents to the best advantage, as well as using their experience and skill (say) to it's best advantage in instructing or supervising others.

What I am trying to promote is a perspective on health whereby it is seen as an on-going, interactive process, without any judgement, just observation and feedback. We are all probably

less 'fit' than we would like to be; probably slightly more overweight than our 'ideal' BMI<sup>2</sup> rating (less than 30); and then there are lots of other indices of health risks: high blood pressure (hypertension); high LDL-cholesterol ("bad" cholesterol) v. low HDL-cholesterol ("good" cholesterol); high triglycerides; high blood glucose (sugar) levels; a family history of premature heart disease; the degree of physical inactivity; cigarette smoking; alcohol intake above reasonably 'healthy levels (14 units p.w. for women; 21 units p.w. for men); and so forth. But ... when did you last have all these checked? Even if your 'scores' were all good, does this mean that you are "healthy"? And, if so, for how long?

### **Implications**

However there is a further aspect to this model. As can be seen in the diagram, various parts of the person become 'known' through this sort-of group interactive process. Whether this happens through a consultative or community process over time, or through some sort of "case conference" process, is a matter of choice, as long as there is reasonable communication and clarity. So far, all that has been determined is the diagnostic stage. Through this process the person involved should have acquired a fair degree (about 75%) of information about what is happening with them as regards their 'wellness' or 'illness'. They should also have had some positive feedback and some pro-active help towards resolving any imbalances.

Now, there is also a process of maturation and growth. Many of the major illnesses and traumas can, and perhaps should, be seen in this light. They do not *have* to be seen negatively, as illnesses or disasters; they *can be* seen as opportunities to look at, and even re-look at, what is not working in our lives. Growth and change can happen in many weird and wonderful ways. The psychotherapist and philosopher, Pierrro Ferruci (2009) studied the lives of many famous people and discovered a 'peak' experience in every single one of them – many times it was directly connected with a major illness, trauma or potentially negative life-event.<sup>3</sup> Illness does not therefore *have to be seen* as bad.

Before I leave this particular perspective, I want to emphasise the importance of the 'unknown' area in the diagram. A full 12% or more (in this illustration) is 'unknown'. We really do NOT know what is in this area. Herein lies our horrors and our dreams, as well as our failures and our potentials. Herein lies our future creativity; any potential syntheses; the Mystery; and the unimagined. For these reasons, it is also very scary. We don't like the 'unknown'. We want the quick fix; the pill to take away the ill. We don't like the responsibility of having to heal, nor do we want it: we want the 'quick fix'. We prefer the 'expert' – or the person who seems to be one. It is safer than having to face the mysterious part of ourselves. The fear and 'known' pain of

demeanour and disempowerment is less than the fear of the unknown. But it is also in this unknown area that we also usually grow, mature, find wisdom, serenity, or enlightenment even. We usually have NOT found these in the 'known' spaces. So, what is left?

Deep change can only happen in these areas. And the only way to achieve this is to be able to look at our 'known' areas clearly and honestly and take from these the strengths that we need and the skills we have developed to explore the 'unknown'. The best thing that the ancient Greeks could think of to write above the entrance to the cave of the oracle at Delphi – the place where they went to hear the Voice of God, the God Apollo, through the words of the priestess – more than 2500 years ago, and for many hundreds of years – was to inscribe the simple words "Know Thyself". This truth has been largely forgotten by the onset of science and medicine in the last 150 years, yet this sort of basic and fundamental truth doesn't change. It was Aristotle who said that the unexamined life is not worth living.

Even if our 'illness' is potentially life-threatening, like cancer or AIDS, there are many true stories of how people find themselves and discover a purpose for their life in their final days. We are all going to die sometime, and some of the fear that we have about death is also the fear that we have of the unknown. The more that we know about ourselves, and the people round us, the less we have to fear about our inevitable end. Perhaps this is just the ultimate rationalisation: however since the one thing that we do know is that we are all going to die, maybe it is not such a bad thing to do after all: to look at ourselves.

I would like to return for a moment to the role of the doctor, therapist or practitioner in this process. Please, please never, ever, assume that you know what is wrong with your patient. You might be making a reasonable, educated guess about one part of their process. Listen to the messages, spoken and unspoken, very carefully (as much as 80% of communication is often non-verbal). The person may use the excuse of a cold, or a new ache or pain, (or something) in order to come and see you, but it may be that their marriage is in difficulty, or that they have just been made redundant, and they are trying to see how sympathetic you are.

We often really do not know the whole story: maybe the person in front of us is not telling us everything: you maybe therefore be trying to help them with very incomplete information. So ... you might do better if you try to find out what is right with them. What they do well? Where are their strengths; their pleasures? What are their goals and their dreams? Then ask, perhaps, what is preventing them from getting there. What is frustrating them, or stopping them? What is going 'seemingly' going wrong? Not just with them, perhaps, but also around them. At least then you have got a slightly bigger picture than just focussing on their pathology or 'problem'. They

may also be able to see their “illness” or symptom in a better, more all-encompassing (holistic), light and less as something that demeans them.

Eva Reich, a qualified US paediatrician and a daughter of Wilhelm Reich, was a very strong advocate of the ‘home birth’ movement in America. There are very few home births actually ‘allowed’ now in the USA: doctors, midwives and parents can and have been prosecuted. However, even being a proactive supporter, she would never actually attend one herself. She used to say that she had totally the wrong outlook for being present at a home birth, as she had been trained in pathology and would just sit there thinking about all the things that could possibly go wrong. That (for her) was the wrong energy to have at a joyous, natural occasion like the birth of a new baby. Modern medicine has a pathological perspective: it can see only illness. That is the wrong perspective with which to consider health care for the 21<sup>st</sup> century. I am sure that we can do things better in this next century. But we have to admit to our limitations first.

As professionals, we can only offer the person our opinions, our perceptions, our knowledge and experience. I repeat the word “offer”. The person must feel free to use these ‘offerings’ or gifts in whatever way they seem appropriate. Otherwise we are imposing our views on them and that is a form of assault. And this also defeats our aims. We are trying to work towards a more empowered person – a more whole and well person. The ends therefore do not justify the means, and we will not get there by bashing them up; confusing them with technical jargon; impressing them with our knowledge; assaulting them with techniques and procedures which we have not explained, and so forth.

Here are some statistics: In the UK, we spend about 8% of our Gross Domestic Product (GDP) – our annual productive wealth – on healthcare, paid for by us, the taxpayer, and delivered to everyone, 100%, freely, through the NHS. In America (USA), healthcare is paid for by medical insurance (if you can afford it), costs in total about 16% of the GDP, and there are about 45 million people (out of about 305 million) – about 15% of the population – who cannot access that healthcare. Of around 2,500 commonly used medical treatments that have been independently evaluated: 13% have been shown to be beneficial, 23% were shown likely to be beneficial, with 8% considered a trade-off between benefit and harm; 6% unlikely to be beneficial; 4% are likely to be harmful, and that leaves 46% with unknown (or unable to be established) effectiveness.<sup>4</sup> Compare this with the (orthodox medical or scientific) critique of complementary and alternative medicine that these lack adequate evidence of efficacy: and yet, pharmaceutical companies control about 65% of all health-related research.<sup>5</sup> Much of the research, especially about efficacy, is based on some shall-we-say ‘interesting’ paradigms: the cost-benefit analysis of negative reactions to drugs compares the cost of the drug with the incidence of the negative reaction – the financial cost

of a person's life (their death). Very little analysis is done with respect to the 'quality of life', the cost of 'side-effects', or the financial 'value' of the benefits.

In 2003, Dr Allen Roses, Vice President of Genetics at GlaxoSmithKline, famously said, "The vast majority of drugs (more than 90%) only work in 30-50% of the people. ... I wouldn't say that most drugs don't work. I would say that most drugs work in 30-50% of people." We spend about £8.2 billion on these drugs in the NHS annually.<sup>6</sup> The number of deaths from adverse drug reactions to correctly prescribed drugs in hospital patients can be as high as 6-7%, and deaths from medical injuries and post-operative infections in hospital patients can be as high as 5-6%: this can put such mortalities as the third leading cause of death following heart disease and cancer.<sup>7</sup>

I am really not trying to 'knock' the medical profession, nor the NHS, nor America even, but I am trying to show that – perhaps – orthodox medicine, paramount as it is at the moment, is not the all-knowing, all powerful, absolute authority that it is sometimes made out to be – or that it sometimes makes itself out to be. As we move into the 21<sup>st</sup> century, we will have to redefine our systems, especially if they are not working very well – in the same way that we are having to redefine our perception of human activity on the planet in the light of global warming.

We have now the concept of 'patient charters' in the NHS.<sup>8</sup> These impose a patient's perspective on the system; define waiting list times and complaints procedures: if these are to be meaningful, then those who work in the system (as I do myself) have to "walk our talk", every single moment of the day. Do we really put the person ('patient') at the centre of the health care system? Or are (for example) pregnant women still getting artificially induced early before Christmas, so that the obstetricians can have a more relaxed holiday – as is supposed to have happened on several occasions. Patients sometimes also want an early birth process for the same reason: it is called 'social induction'. But it is different if the patient wants it, than if it is imposed on the patient by the system.

Going back to the model (outlined in Diagrams 1 & 2), when these perceptions, these thoughts, these gifts, these insights, are all taken in and processed by the person in the centre, if we – as professionals, friends, partners, etc. - listen very carefully, we will learn whether our perceptions or assumptions about the person are right, or accurate, or appropriate – or not! If we are arrogant enough to assume that we 'know', then we will never learn. We will not hear the "Yes, but ..." and we will not look for the silent, passive refusal. This sort of freedom, for the person at the centre to interpret what is said to them, to use the ideas or suggestions that that we offer, and to determine what is appropriate for them, is a great gift. It leaves the onus, the work, clearly with the person involved. It frees us, on the periphery, from many a burdensome

responsibility: we don't have to be "right" so much or so often. It is now the patient who decides. This sort of switch can also take us clearly into the heart of certain very complex ethical issues, about refusal of treatment, assisted dying, etc. If you take the power away from the 'patient', then the 'professional' is obliged to justify any contentious decision on very strict ethical grounds.

And to benefit the patient further, we should look, as well, to offering (again, that word) some tools that the person can use to further their process. There are plenty of 'technologies', perceptions, tools, experiential methodologies, insights, and arcane pieces of information, that we have at our fingertips, and that that person might need. We can teach them to fish, rather than just giving them a fish. We can disseminate some of the principles of our craft, instead of hanging onto them and maintaining the mystery for ourselves. We can help educate the person, and the people around them, appropriately; we can interpret, distil, refine, and condense the huge amount of information that we have available as professionals to just what is relevant to that person. Perhaps that is our purpose?

We can even try – as health care professionals – to make ourselves redundant as quickly as possible, so that the person is fully empowered to go on and heal what needs healing, explore what needs exploring, and confront what needs confronting, within themselves – and without us, if needs be. And they will. They will have to. This prospect has the final gracious advantage of freeing us up, to help others, or to help ourselves. In this new century, the needs of the many can all too easily overwhelm the few, unless we take this route of self-help and empowerment, from the start, right the way through any treatment, and on afterwards as well. As health care professionals, we are less likely to burn out this way. Our work can become a pleasure rather than a never-ending chore. But it will take a different perspective on Health Care to achieve this.

Finally, a word on how to pay for this system: as in many countries, health care is largely paid for out of a form of taxation, sometimes on income, sometimes on employment. In the UK, it is part of the National Insurance contribution: a weekly deduction as a percentage of the gross pay, plus a parallel contribution from the employer. Theoretically, this amount should also pay for one's basic pension as well, but with longer lives and a 'baby boom' of post-war population now reaching retirement age, this is inadequate for both. If the National Insurance contributions, the total amount of £78 billion (in 2004), was devoted only to the cost of basic health care, then there would be almost enough money available – and this total amount would be geared towards covering basic health care for everybody – not just the employed, but children, pensioners and the unemployed as well. The UK National Health Service is the largest employer in Europe, with approximately 1.3 million staff, and provides an enormous range of services to over 57 million people. In 2007, the annual budget was around £90 billion. Get rid of some of the

wastage in the superfluity of managers of the system, and there would almost be enough money available. Other savings can also be made. This is for 'basic' primary care. Already most people have to pay something towards the cost of their prescriptions. This principle could be extended a little further: if you want additional treatments (medical or complementary), there should be a nominal charge.

If people then want to purchase further health care: dental treatment; a wider variety of treatments; complementary health care; special or quicker care, etc. – then that should be an option, and they would have to pay extra – either to private medical insurance, or to the state. There is also private health care insurance available, which can and should be used only as a 'top up' for those who want it. This sort of system would mean that basic health care for every citizen was largely free - and the government would have an independently 'ring-fenced' budget (the National (Health) Insurance contributions) with which to provide that amount of health care. That is the basis of a good social contract. There is then an in-built encouragement on both the government and the individual's side to ensure everyone is working who is able to work: malingering (voluntarily avoiding work) therefore carries a social cost. It is also in everybody's interest to educate people properly – about smoking, obesity, alcoholism – as this would help bring the medical costs of treating these ailments down and (maybe) put social pressure on the users of these substances not to waste limited resources on people who do not look after themselves. Health education and (illness) prevention can thus be prioritised – both nationally and individually. Health & Safety legislation can augment this. The often very expensive costs of car accidents, accidents at work, and preventable illnesses are carried – not just by the health care system – but by the individuals and the employers as well. The system should work and could be made to work.

It is not the age of the central hospital, or a totally state-run health care system: these former large central hospitals are too open to abuse as we have seen in the UK with poor hospital cleaning and the growth of hospital 'bugs' like MRSA<sup>9</sup> and *C. difficile*<sup>10</sup>, and government control can perform its own abuses as we saw in Russia, in the 1960s and 1970s, when dissidents were put into asylums. Nor do we need to revert to the Chinese 'barefoot doctor' model, though a readily available and locally provided system of basic health care is absolutely essential to rural communities.

There is an excellent example of modern thinking to be found in the Nepal Trust's Humla Health Care Project<sup>6</sup>, whereby basic health care centres are being built in each village in one of the most remote areas of the world; local women are trained up to provide a basic level of health care

cover; the land and some labour is provided locally; materials are bought in and volunteer labour is provided; and then Western doctors come out and volunteer for 3-6 months at a time, thus providing expertise and specialised training, mediated through the local health care assistant / nurse, who also acts as a translator and chaperone. This sort of project works with a combination of external finance and expertise serving locally determined, community-based needs.

A project with a similar sort of thinking is also found in the Kitez Community<sup>7</sup> where foster homes are provided for Russian orphans; where ‘family group’ houses are built (initially through Western charity funding, now more from government and European grants); where ‘house parents’ or community foster parents are recruited (similar to the ‘house parent’ concept in Steiner & Waldorf communities for people with learning difficulties); and thus Russian orphans are provided with a ‘family’, in a community setting, where the children can also be educated (more widely than just at school), where all the adults work communally, adult couples needing housing are given a home and meaningful work, provided they act as a ‘house parent’ for orphans who need a ‘family’. It takes vision, cooperation and a degree of ‘screening’ but it does work and both the above projects have been running for about 20 years and have been growing – and winning awards! They are also inspirational. Everybody benefits for a minimal cost.

This sort of 21<sup>st</sup> century thinking – now that it has been tried and tested – needs to be applied more consistently and in a more mainstream fashion to basic healthcare. It will hopefully become the age of the empowered patient, who starts to heal him or herself, with compassionate help and support from those around them.

Courtenay Young  
Edinburgh, Scotland, 2009

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### Endnotes:

- <sup>1</sup> Wilhelm Reich wrote a scathing criticism of society in a book called “Listen, Little Man”(Farrar, Straus & Giroux, 1974)
- <sup>2</sup> BMI: Body Mass Index: a basic height-weight ratio: [www.nhlbisupport.com/bmi](http://www.nhlbisupport.com/bmi)
- <sup>3</sup> Ferruci, P. (2009) *Inevitable Grace: Breakthroughs in the lives of great men and women: Guides to your self-realization*. New York: Tarcher.
- <sup>4</sup> BMJ Clinical Evidence website:  
<http://clinicalevidence.bmj.com/ceweb/about/knowledge.jsp>
- <sup>5</sup> House of Commons Health Committee: *The influence of the pharmaceutical industry*.126pp. London: The Stationary Office.
- <sup>6</sup> BBC News, 17/1/2008: <http://news.bbc.co.uk/2/hi/health/7190267.stm>
- <sup>7</sup> Verkeck, R. (2008) How sustainable is orthodox healthcare? *Positive Health*, May 2008, p. 24

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- <sup>6</sup> Nepal Trust: Humla Project: [www.nepaltrust.org](http://www.nepaltrust.org)
- <sup>7</sup> Kitez Community: [www.kitez.org/en/](http://www.kitez.org/en/)
- <sup>8</sup> The NHS Patient's Charter (for England) was introduced in the 1990s and then abolished in 2000. However, this sort of thinking persists and new legally binding relationships between the NHS, government and the people are continually being called for: viz. Reform Scotland report, 10/4/09, "Patient Power" called for a new NHS constitution to set out the relationship between the health service and patients — and to clarify the role of the Scottish government. "By giving patients legal entitlements, it ensures the system is accountable to them, not government."
- <sup>9</sup> **Methicillin-resistant *Staphylococcus aureus*** (MRSA) is a bacterium responsible for difficult-to-treat infections in humans: <http://en.wikipedia.org/wiki/MRSA>
- <sup>10</sup> ***Clostridium difficile*** is a species of bacteria of the genus *Clostridium* and causes the most serious cause of antibiotic-associated diarrhea (AAD) which can lead to a severe infection of the colon: [http://en.wikipedia.org/wiki/C. difficile](http://en.wikipedia.org/wiki/C._difficile)