

**The Medical Model –
its Limitations and Alternatives**
How humanism may synergise biomechanism

David Zigmond

What is the Medical Model?

Although most doctors' working time is spent using the Medical Model, we might find the term difficult to define. This itself reflects particular restrictions of thinking: those conditioned by years of training and modelling ourselves on other doctors. We then find it difficult to stand outside our methodological framework and see other realities.

Here is a preliminary definition: the Medical Model assumes a simple mechanical view of illness and the body it occurs in. Any illness is thus seen simply as a fault in the machine. Although lip-service may be paid to interfering concepts of the mind, the family and the environment, these are uncomfortable bedfellows of the Medical Model and the machine-body continues to be regarded as something that functions autonomously: a hermetic system. Diagnoses therefore tend to be formulated in terms of structural or functional failures of the machine alone. It follows that because treatment methods derive from diagnostic concepts, then medical treatment is likely to be equally mechanistic and exclusive of non-material or psychological factors. The Medical Model sometimes does well with these restrictions: for example, in orthopaedic trauma surgery where the problems are most clearly circumscribed and structural.

The Reasons We Use the Medical Model

The Medical Model has enticing clarity: it is generally succinct, tangible and understandable: it has easy confluence with a scientific method which relies primarily on objective and measurable observation. This has the advantage of offering terminology, formulations and explanations which can (seemingly) be unambiguously understood and then handled in an identical fashion by all similarly trained people. We therefore have the potential of knowing precisely what others are talking about and what they are doing in defined situations. This makes possible the kinds of standardisation of terminology and concepts that are essential for scientific communication and research. These activities can then give us useful information about general patterns of illness and the effectiveness of therapies.

Less defensible reasons for our inflexible and often inept use of the Medical Model lie in habit and conditioning. Most of us were never encouraged or taught to use anything else. Therefore we have developed skills only within a narrow framework: this we continue to use alone, even when a problem requires alternative or additional methods.

Some Snares We Fall into Unconsciously

At its best the Medical Model functions extremely well, providing guidelines for processing circumscribed problems and predicting what the outcome will be, with or without intervention. Such important considerations are invoked by in the concept of diagnosis. Diagnosis provides powerful navigational aid when we have substantial knowledge about what we are labelling: *Substantial diagnosis*. If, on the other hand, a diagnosis does not offer us accurate information about prognosis and intervention, then we can call this a *Nominal diagnosis* because it gives only an arcane name to something we know very little about. Let us take an example of each.

1. Acute follicular beta-haemolytic streptococcal tonsillitis is a Substantial diagnosis. It tells us with relative certainty what the symptoms and signs are, what treatment is going to be effective and what the hazards are of leaving the complaint untreated. The Medical Model works well here. Our concepts and tools are effective. We know what to do and are rarely surprised by subsequent events if we do the right thing. The patient senses this, and he and the doctor will probably get along well in this situation.

2. Non-articular or seronegative rheumatoid arthritis* is a Nominal diagnosis. It really does not tell us much at all. It does not tell us how the patient's health will be affected in the future. In five years' time he may be perfectly well despite not having any treatment. On the other hand he may be crippled with arthritis, blind with iritis and have an ileostomy because of fulminating ulcerative colitis. Furthermore, he may have developed all this despite the best treatment available. The Medical Model is now working extremely badly. The doctor feels unsure and ineffective and is likely to be on the defensive. The patient senses this and reciprocally lacks confidence. The relationship between patient and doctor is now likely to be more strained. The patient may

become 'difficult and demanding'. The doctor attempts to maintain a confident persona by whatever new kinds of investigation and therapy he can think of, because he does not know what else to offer.

Substantial and Nominal Diagnosis

The two diagnoses here are really quite different in their implication. The 'Substantial diagnosis' offers us extremely helpful information as to what we might do and what we should expect, while the 'Nominal diagnosis' does neither satisfactorily. At best it is a descriptive tag which we attach to some apparently similar phenomena which we do not understand. However, such is the power of words that we equate them with understanding. Just as a religious incantation is intended to dispel evil spirits or attract good ones, so the medical incantation of naming the diagnosis is meant to dispel uncertainty and indecision. However, as we can see from the above example it often fails to do this – nevertheless we continue to repeat the ritual and hope the rest will follow.

Many ailments fall somewhere between the Substantial and Nominal end of the diagnostic spectrum. Often a particular illness will shift its position at different times. For example, a man who has the dyspepsia appropriate to a barium-meal proven duodenal ulcer* may well present the doctor with a Nominal diagnosis, as the course of his illness and the efficacy of therapy remain largely unknown. If this same man perforates his ulcer then the situation is one where a Substantial diagnosis becomes very important; treatment is incontrovertible and clear-cut and the prognosis with and without this intervention equally so.

In formulating diagnoses we need to be aware of their position on this spectrum. Are we really making meaningful statements, or are we merely tagging labels onto phenomena we are ignorant about? If it is the latter, who is benefited by the Nominal diagnosis – the doctor, the patient or the institution? Complex terminology is often used as a defence against substantial ignorance. If the doctor is lost, bemused and largely ineffective, then at least he can fall back on some technical words and 'scientific' concepts which he hopes will maintain his position in his own and the patient's eyes as

the potent and unassailable authority. Such unconscious defences and collusions are not always a bad thing, but they can often block the doctor's opportunities to explore more fruitful avenues of rapport and investigation.

What the Medical Model Misses Out

Because it has its roots in the scientific method, the Medical Model functions best when incorporating phenomena that are measurable and quantifiable. That is, it copes well with the physical or organic components of illness, but has much less assurance with other factors, the most important of which are personal and psychological. Most of us are instinctively aware of the importance of external stresses and inner emotional conflicts in the precipitation, course and eventual outcome of many illnesses. Yet the problem of being unable to directly measure stress or emotional conflict is always problematic.

There have certainly been attempts to rate and scale such reactions as fear (anxiety) and dispiritedness (depression), but on scrutiny these endeavours only measure phenomena which are assumed to have a direct relationship with the inner experience, which itself remains elusive and unmeasurable to our tools of scientific enquiry. True, we can measure and classify certain of the simpler aspects of behaviour – that is, reported speech and habits, alcohol consumption, compulsive rituals etc – but never the inner life that motivates them. Rating scores of described experiences are beset with ambiguities and potential distortions. If the usual Medical Model is incapable of dealing imaginatively with these aspects of illness then we have two alternatives. We can ignore the non-organic, non-measurable aspects of medicine and remain always within the respectable territory of scientific convention, or we can use alternative modes and models – we can add to the more traditional medical diagnoses.

Such a whole-person or even whole-family approach to illness has received increasing attention in recent years. Perhaps the most influential work in this area pertinent to the general practitioner was investigated by Michael Balint. Much of his work indicates that the traditional medical diagnosis used alone is often severely limited in the amount of help it gives to the doctor in

understanding the patient's illness, what he can do about it, and what he might expect in the future. Balint found that these limitations can be countered by the doctor entering into new, speculative territory where skills of empathetic imagination might attempt to formulate the position of illness within its matrix of family relationships and internal emotional tensions. Such formulations – cannot give us the same sort of uniform agreement of the more traditional diagnoses, but this venture offers much else in terms of understanding and influence. The following case illustrates a typical medical formulation, then expanded by humanistic speculation.

A Case from General Practice

Mr CT is 65 years of age. One month before his date of retirement he developed ankle oedema and ascites. His general practitioner first saw him late one night when he developed acute and severe dyspnoea. Examination indicated mild hypertension, biventricular cardiac failure and slight cardiac enlargement. Routine investigations yielded only the one additional useful finding that his cardiac failure was probably caused by ischaemic heart disease (ECG evidence). Unfortunately, fairly large doses of Digoxin and diuretics had no effect on his ascites and oedema, although his blood pressure was well controlled with Methyldopa. He had no further attacks of pulmonary oedema.

One month later, therefore, he was hospitalised with a view to controlling his right-sided heart failure. Even with complete bed rest and massive doses of Frusemide and Spironolactone this problem was extremely difficult to manage. At this time he became increasingly anxious, irritable and demanding. It became difficult to keep him in bed or to get him to take his medication, which he seemed to view with suspicion. Eventually this ended in a mixed manic-paranoid reaction. He claimed to be in perfect health and said that he was in hospital to help his wife's illness (she was in good health).

While embarking on numerous impractical projects simultaneously, he would make grandiose and untrue proclamations about how wealthy and important he was. His distractibility made it difficult for him to sleep or eat, and his motor restlessness made him a difficult nursing problem. At times he showed fluctuating paranoid delusions about the nursing staff, saying that they had poisoned him and stolen his money. On

the other hand he became unprecedentedly sexually suggestive and familiar with the same nurses. Although showing undoubted manic signs when interviewed, the depression was just below the surface. He became extremely distressed and tearful when certain important and personal and life topics were discussed. Although Chlorpromazine was needed to contain the immediate situation, the bulk of his improvement came from helping him come to terms with his underlying emotional problems.

Before we move into this alternative and personal diagnostic area, we might formulate the medical diagnoses thus: mild controlled hypertension with ischaemic heart disease causing decompensated right ventricular failure. Superadded mixed manic-paranoid psychosis.

Method or Madness?

Let us now look into the story of this man's life and see how his illness fits in. The hallmarks of Mr CT's life were caution, safety, orderliness and continence. He only took the minimum and essential risks in life, and then only with the maximum preparation. He had married 40 years ago and had lived in the same house ever since. Throughout these four decades, he had worked in the same clerical job, though with minor promotions. In his work he was diligent to the point of obsession and found any criticism or disorder highly disturbing. His marriage was contained in a similar framework of orderliness and safety. His wife never worked outside the home because he found the idea threatening. Their life together was safely but drably concordant, and structured by well-worn routine. Their sexual life sounded courteously suppressed and obscured: latterly he had been rendered impotent, probably because of his Methyldopa.

His leisure time similarly drifted: passive and unexplorative. He watched television indiscriminately and fell asleep after supper while reading the *Daily Express*. Occasionally he would potter in the garden, but took little else in the way of physical activity. His lack of pursued hobbies or interests and led to boredom and irritability at weekends: time and freedom became enemies. Anger was never overt; he would similarly avoid or appease any conflict, which he evidently found threatening. In his social relationships he had

cordial but ritualised contacts, hence no committed or intimate friends. Because of his passivity and temerity, he felt exploited at work: a cruel consequence of his diligence and compliance. He was resentful that after 40 years of service to his employers, he left with little promotion, perfunctory compliments and a gold watch. Secretly he had hoped for grand applause and a big send-off.

Last, but not least, this man had never been seriously ill.

Understanding and Management

How does this backcloth help us in our understanding and engagement with this frightened and frustrated man? One of the most striking features about him is his inability to assert himself as an individual, or act in any way that would lead to dissonance with others. His early background can help us understand. He experienced his father as authoritarian, overpowering, distant yet violent when drunk or frustrated. His mother and siblings learned that the only way to be safe was to be silent, obedient and unnoticed. He had carried this legacy of submissive, stoic resentment throughout the rest of his life.

Until the onset of his illness.

In his fantasy life he had vaguely hoped that retirement would bring some of the fulfilment and satisfaction that had always eluded him. The reality turned out to be very different. Even without his illness, his fixation to many years' routine, his inflexibility and lack of creative interests made retirement an extremely demanding testing-ground for this overadapted and underdeveloped man. It is even possible that he recognised this unconsciously, and that his heart-failure represented a lost battleground: the disconsolate 'loss of heart' – that this was all there was to his life.

What is evidently true is that his serious illness then brought to consciousness the possible imminence of his death. This insinuated the futility of his life: all the things he wished he had achieved, yet had avoided. Such a demeaned view of his life was intolerable: a defence was essential. Hence his manic reaction; thence his grandiosity, his multiple and unrealistic plans, his display

of hypersexuality and the demanding urges he had kept so well contained for so many years. Equally difficult for him was the way in which physical illness had underlined his shamed self-perception of passivity and weakness; hence the denial that he himself was ill, and that any illness within him was displaced from his wife, or the result of others poisoning him.

Other destabilising facets emerged: the established structure of his marriage had been radically changed. Although a sedentary man, he had claimed the conventionally undisputed dominant marital role: his submissive wife offered him some sense of domestic power. His illness, however, had reversed their roles. Now he was the partner who had to stay at home and be provided for – her role until he fell ill.

He struggled painfully and tearfully with coming to terms with these realities. With a growing sorrowful calm he perceived how his mania and paranoia were defences against his deep-rooted frustrations and sense of loss. It was bravado in the face of grief. He was both grieving and raging for the life he had feared to live, and whose possibilities were now passing.

The human core of this formulation lies outside conventional scientific and medical methods. It can neither be proved nor disproved, because his feelings and his entire inner world cannot be objectively observed or measured. With unprovable plausibility they can be logically inferred; with imagination, intuitively felt. Yet without this meeting in the regions of uncertainty he must endure his grief, fear and primitive anger alone. Enabling him to share these brought compassionate palliation and relief. His manic and paranoid defences became no longer necessary.

Understanding his rage enabled him to metabolise it. He has then been freer to cope with his diminished and disabled life. Although sorrowful he is not now 'ill' in the strict psychiatric sense. Interestingly his heart failure became much better controlled. Has his cardiac function improved because his heart is no longer subject to the autonomic-nervous and hormonal storms that beset it in his previous state of emotional turbulence? Happily he no longer needs major tranquillisers to assure his sanity and stability: his inner healing

has now anchored this.

Conclusion

This case illustrates how the Medical Model can be integrated within a wider framework of alternatives. From a strict scientific view these other concepts do not avail themselves so readily to more direct kinds of empirical testing. Yet the price of ignoring these alternatives is high. Mr CT would probably have continued his mania, paranoia and depression and had a much more turbulent end of life. It is likely, too, that his cardiac failure would have remained intractable: his improvement was definite and otherwise unaccountable.

Such pursuits are subtle: they require more flexibility in approach than we are generally trained for. In return our understanding of, and rapport with, the whole patient becomes richer. The benefits extend beyond prevention or curtailment of significant illness in others – we ourselves derive greater human interest and satisfaction from our work.

D. Zigmond, MB, CH.B, DPM, is Registrar in the Department of Psychological Medicine at University College Hospital, London WC1.

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**Post-scripted note December 2014. In the thirty-eight years since this was written, scientific knowledge has advanced, so that these conditions are now more contained with Substantial (rather than Nominal) diagnoses. Thus the knowledge has grown – the examples are now somewhat obsolete – but the guiding principles remain.*

Rather than rewrite the examples, they are retained for historical interest. It is hoped that the underlying argument is unobscured. It remains seminal to this book.

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