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Rethinking medicine

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There's something going on out there

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Modern medicine is one of humanity's great achievements. It improves, prolongs, and saves lives by applying the biomedical and clinical sciences to the diagnosis and treatment of disease. Its strength lies in its clarity and focus, making it an easy model to explain, understand, and put into practice. People have found it powerful, beguiling, seductive even. It is not surprising that the medical model is proving so popular: it serves society well.

But there's something going on out there. Increasing numbers of doctors and patients are questioning whether medicine has overstretched itself,[1] whether it is always as effective as proponents claim, and whether there are instances when the side effects and unintended consequences outweigh the benefits. This critique is not new,[2 3] but it has recently found a common voice in initiatives that transcend health systems and national borders, such as minimally disruptive medicine,[4] high integrity care,[5] and rethink health.[6]

In the United Kingdom unease with the medical model may be contributing to doctors' low morale and to problems with the recruitment and retention of the medical workforce. But the unease is also being expressed in how doctors are thinking about and practising medicine. Some doctors are expressing concern about overdiagnosis and overtreatment and the attendant potential for harm and waste,[7] particularly among people with multiple conditions and those who are frail or at the end of their lives. Others are concerned about the limited effectiveness of what they have to offer in the face of the wider social determinants of health such as poor education, unemployment, and the unequal distribution of wealth.[8] They are increasingly prescribing social interventions[9] and are mobilising the established collective strengths that exist within many local communities to improve health and wellbeing.[10]

Shifting focus

Some doctors are trying to change their relationships with patients, to listen more carefully to their narratives and work alongside them, sharing information about diagnoses and options for treatment and offering more personalised care and support.[11] Others are focusing on helping schoolchildren to understand and manage their health and wellbeing and to understand where doctors do and do not add value.[12] Still others are attempting to improve the context within which clinical medicine is provided, drawing on organisational and systems perspectives and on approaches to quality improvement originating from the manufacturing sector.[13]

These evolving activities in which doctors are choosing to focus their energies are connected. Underlying them is an awareness that some things doctors do are effective for some clinical problems but that different approaches are required to respond to an increasing number of the challenges that doctors face. Rather than becoming entrenched in traditional ways of working, doctors are searching for different ways to make clinical practice more effective and more doable.

Some initiatives are being developed at a national level to support this process. "Prudent healthcare" in Wales[14] and "realistic medicine" in Scotland[1] represent concerted efforts to create a new set of principles and activities to guide clinical practice, and a narrative which builds on the ground-up energy for change. Early evidence suggests that this work is engaging clinicians who want to have greater impact, patients who want to be listened to, and policy makers who want to optimise value from the healthcare spend. Similar work is starting in England, led by the Academy of Medical Royal Colleges.[15]

We believe that the process of rethinking medicine is a necessary challenge. We need to define more clearly where the application of a disease focused medical model adds value and where it

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doesn't, to help doctors actively develop more productive relationships with patients, and to help them incorporate social interventions into the more traditional armoury of biological and psychological interventions. This will require radical changes to undergraduate and postgraduate training curriculums and the content of continuing professional education. It will require a strong focus on personalised care, community and population health, and the skills required to develop new ways of working with people in local government, the voluntary sector, and local communities.

In 1974, Richard Smith, then an idealistic medical student who was later to become an editor of *The BMJ*, attended a lecture by Illych entitled, "Limits to medicine." The lecture gave voice to Smith's deep but poorly formed concerns about medicine, and he immediately decided to drop out of medical school. Three days later, uncertain what else to do, he dropped back in.[16] Forty years on, a growing number of doctors with similar concerns are experimenting with alternatives to ceasing clinical practice. Medicine is being rethought, and doctors have an opportunity to contribute to the wider initiatives taking place in the UK and elsewhere or to incorporate the different elements of these initiatives into their clinical practice. Doing so is likely to revitalise what it means to be a doctor and transform our relationships with patients.

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