

The medical model is dead – long live the medical model

PREMAL SHAH and DEBORAH MOUNTAIN

Summary Many people criticise, and psychiatrists apologise, for the use of the ‘medical model’. We examine what is currently meant by this term and suggest a refinement of definition to reflect the ideals and contemporary practice of medicine. We propose that psychiatrists should use the medical model to improve and validate bio-psychosocial psychiatric medicine.

Declaration of interest None.

The term ‘medical model’ is frequently used in psychiatry with denigration, suggesting that its methods are paternalistic, inhumane and reductionist. This view has influenced mental health organisations, which in certain areas advocate a departure from the medical model, and contributes to the difficulties in leadership being played out between politicians, professionals and patients. The view has some support from within psychiatry (with some psychiatrists being apologists), from the 1960s’ anti-psychiatry movement, as well as from some in the recovery movement (Ralph *et al*, 2002). Although diversity is healthy, it may fuel unproductive rivalry to be recognised as *the* therapeutic agent between divergent therapies and agencies.

WHAT IS CURRENTLY MEANT BY THE MEDICAL MODEL?

There are various definitions. Clare (1980) suggested that it is a scientific process involving observation, description and differentiation, which moves from recognising and treating symptoms to identifying disease aetiologies and developing specific treatments. Wikipedia, the internet encyclopedia, currently defines it as ‘the predominant Western approach to illness, the body being a complex mechanism, with illness understood in terms of causation and remediation,

in contrast to holistic, and social models’. The Disabled People’s Movement (<http://www.bfi.org.uk/education/teaching/disability/thinking/medical.html>) believes that it is based on a false notion of ‘normality’, with people being judged on what they cannot do. They believe that it sees people with disabilities as the problem, focusing on impairment, provoking fear and patronising attitudes, the powerful doctor shutting the ‘disabled’ away. These definitions potentially combine to form the caricature of a reductionist, mechanistic, disability-enhancing approach, taken by powerful doctors towards patients.

Matters are aggravated in psychiatry because of the Cartesian divide between biological and psychosocial psychiatry. Biological psychiatry is assumed to be mechanistic and reductionist, exclusively concerned with neuroimaging, genetics and medication. Psychosocial psychiatry, championed as being empowering, humane and holistic, is regarded as the antithesis and aligns itself to models such as Engel’s (1977).

IS BIOLOGICAL REALLY REDUCTIONISTIC?

The idea that the ‘biological’ is reductionist and undesirable leads to curious contradictions. The negative view of psychiatric drugs contrasts with views of drugs in other specialties or alternatives such as homoeopathy. The parallel assumption that psychosocial treatments are without risk, are holistic and the treatments of choice ignores evidence that some psychological treatments can cause damage (Rose *et al*, 2002). Furthermore, psychological treatments may work synergistically with drugs (Keller *et al*, 2000). In the extreme, advocating exclusive psychological approaches amounts to ‘psychological reductionism’ and could harm patients by denying them other effective treatments.

Biological explanations and treatments for diseases have helped to reduce fear, superstition and stigma, and to increase understanding, hope and humane methods of treatment (Tallis, 2004). For example, epilepsy is now better understood as a medical condition, which has reduced the perception of it being a fearful phenomenon of demonic possession. Logically a biological perspective in psychiatry should do the same.

Neuroscience demonstrates that biological, social and psychological experiences translate into changes in brain structure and function. Childhood sexual abuse (Teicher, 2000), personality trait differences (Breier *et al*, 1998), and psychological and pharmacological treatments (Seminowicz *et al*, 2004) have all been associated with differences in discrete brain systems, making it difficult to maintain the mind-body split, and offering a potential explanation for how bio-psychosocial treatments actually work.

We suggest that the difficulty lies in accepting that the human mind is also biological. This challenges cherished assumptions about our self-attributed uniqueness and the specialness of ‘the mind’. As Tallis (2004) comments, regarding one’s body as part of oneself but also objectively is difficult. How much more difficult is it to accept that what we experience as ourselves can be understood in terms of brain function? Banishing biology to reductionism merely defends our need to preserve the sanctity of ‘the mind’.

A CONTEMPORARY DEFINITION OF THE MEDICAL MODEL

We believe that we need a simple definition of the medical model, which incorporates medicine’s fundamental ideals, to facilitate clarity and precision, without denying its shortcomings. We propose that the ‘medical model’ is a process whereby, informed by the best available evidence, doctors advise on, coordinate or deliver interventions for health improvement. It can be summarily stated as ‘does it work?’

Face validity

Evidence has always been at the core of the ‘medical model’, encapsulated in Hippocrates’ diktat ‘first, do no harm’. This assumes that the doctor has specific knowledge and expertise (evidence) that

an intervention causes greater benefit than harm. Further, it is what most doctors do today, and it is what our patients expect – the days of treating on ‘gut feeling’ have long gone. Although some people question how much daily practice is evidence based (Imrie & Ramey, 2001), there is no call to abandon evidence and rely on faith or instinct alone. Practice is also increasingly determined by guidelines, with legal consequences for not doing so. We suggest that patients are not primarily concerned with a treatment’s ideological background but are more interested in what helps and what harms. Patients want us to provide a balanced view to enable them to decide.

Ideology and assumption free

The history of psychiatry well illustrates the perils of treatment by assumption or ideology. Our definition avoids invoking either ‘psychological’ or ‘biological’ ideologies. Although some people debate whether empiricism is reasonable, we contend that ideologies have fruitlessly divided pharmacology and psychotherapy (as well as psychotherapies themselves). How ‘it works’ is important but is secondary to defining ‘what works’. Not knowing how it works does not invalidate good evidence: vitamins were undiscovered when Lind conducted his scurvy trial (Bartholemew, 2002). Evidence, then, is the first critical step in elucidating what works and helps to validate our bio-psychosocial treatments, defining their dangers and efficacy.

Scrutiny of interventions

The model requires all interventions to be scrutinised using the same methodology. As each intervention is understood on its own merits, protagonists need to justify their treatment with standard evidence and not ideology. It is an unfair assumption that ‘mind’ treatments are beyond scrutiny and that some treatments are somehow innately ‘better’ than others. Such scrutiny is particularly important when public money funds interventions (e.g. in the National Health Service). Indeed, the benefit of the medical model is that it justifies expanding non-pharmacological as well as drug treatments.

THE MEDICAL MODEL AND POWER

We do not believe that the medical model is simply about doctors’ apparent power. The

PREMAL SHAH, MD, MRCPsych, DEBORAH MOUNTAIN, MPhil, MRCPsych, Department of Psychiatry, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, UK

Correspondence: Dr Premal Shah, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF, UK. Email: premal.shah@pct.scot.nhs.uk

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relationship between a patient and their doctor is complex. Patients initially seek a doctor because they believe this may be useful, which could be seen as conferring power to the doctor. However, getting better has always been an active process involving seeking help, evaluating options and making decisions about treatments. Patients do choose not to engage with treatment (e.g. only half of patients collect their prescribed medications), and may sabotage their own care. When vulnerable, people respond in various ways which are probably influenced by their experience of life: some feel powerless whereas others are motivated. Patient behaviours and expectations are not passive – if they were, patients would meekly stop smoking, curb their alcohol intake and have cervical smears! The doctor’s task then is to advise on the most effective intervention, the patient’s task being to decide and act on that advice while making sense of complex and conflicting emotions. ‘Patient empowerment’, therefore, has little to do with rescuing patients from the medical model. In this context, Engel’s psychosocial model does not contradict the ‘medical model’ but rather enhances it.

FUTURE OF THE MEDICAL MODEL IN PSYCHIATRY

We believe that it is important to adhere to the medical model as we have defined it (‘does it work?’). If we do not we may lose our hard-earned gains in defining effective psychiatric treatments. We must continue to gather quality evidence in order to establish which interventions work. This may be particularly challenging when defining which elements of psychosocial treatments are effective. This is critical to improve the credibility of psychiatry as a medical specialty, which has been attacked because psychiatric treatments are multi-dimensional.

We also contend that the well-informed psychiatrist who uses the medical model is ideally positioned to challenge those

who engage on both sides of Cartesian extremism. We need to acknowledge that our medical approach may sit uncomfortably with other doctors and mental health professionals, who may not perceive that psychosocial factors and interventions translate into biology. However, we should use and encourage the developments in neuroscience, which blur the distinction between mind and brain and which may demonstrate how bio-psychosocial interventions actually work. This offers the potential to bring rationality, specificity and validity to our interventions.

Most importantly, we should not apologise for using the medical model. Instead, we should challenge those who use it as a professional attack and question what is being criticised. We should not believe that the medical model is only about doctors’ powers, but remind ourselves that patients are active participants in the interaction. Medicine has always been about helping patients ‘take charge’ of their recovery by whatever means available.

Finally, we should rigorously challenge those who regard the psychiatrist as a uni-dimensional pharmacologist and reductionist. Psychiatrists’ training involves the use of biological, social and psychological treatments, a fact recognised in statute (e.g. the Mental Health (Care and Treatment) (Scotland) Act 2003). Thus, we should highlight what is undoubtedly psychiatry’s best asset (an area that the public may accuse our specialist colleagues of lacking): that of being a medical specialty in which the specialist understands and uses the holistic bio-psychosocial approach.

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