Change and coping with change

Based on 15th Brompton Lecture, given at the Royal College of Physicians of London on 16 December 1994

At the end of the 20th century, a century characterised by both wondrous progress and mass destruction of human life, powerful forces are converging to reshape and change our lives at personal, professional, national and global levels. These forces challenge us as never before to find ways of living together in an increasingly interdependent world. Mutual respect for differences, willingness to change and be changed through non-oppressive dialogue, humility and concern for the suffering human condition, are the prerequisites for progress. Events taking place in South Africa illustrate these assertions.

Change in South Africa can be considered to be symptomatic of the social and scientific developments that have transformed the world with increasing speed over at least three centuries and are likely to reshape it even more radically in the next 50 years. The choice we all face as individuals, or as a profession or a nation, is between the relatively comfortable option of trying to maintain the security of short-term stability or the tougher option of understanding the discomforting, yet often appropriate, powerful winds of change sweeping through the world.

Domains of change

Change affects us as professionals at the individual, national and global levels. My intention is to illustrate how we adapt to and are transformed by gradual change within a given mode of thought, yet how we try to resist and oppose the powerful and subtle forces that will shape the future but which we might be able to influence to good purpose if only we could escape the confines of our own limited perspectives.

Individual level

Reflecting on our own personal pathways through medicine reminds us of the profound and ongoing transformation from medical student to professional status in which we were moulded into particular and responsible roles. In this process we learnt about the human body’s structure, function and malfunctions. Our moral experience was shaped by exposure to logical reasoning and technical skills within a scientific framework and the social context of our own particu-

lar health care and value systems. Objectivity and detachment were important attributes that had to be acquired while fostering an interest in our patients as people, as well as the qualities of compassion, empathy and kindness.

We passed through another phase of guided transformation when we entered the field of research, whether in the wards or in the laboratory. Here our appreciation of the importance of objectivity was further enhanced and we became conditioned into the specialised and reductionist way of thinking which is necessary for the advancement of scientific knowledge and for the provision of modern medical care based on understanding pathophysiology and the application of the best available empirical evidence. The post-Flexner era in medicine was to a large extent dependent on this approach for its many successes. The question whether such training is sufficient for the humanistic and ethical practice of medicine concerned Abraham Flexner himself in 1925 when he saw what was happening to medical education as a result of some misinterpretations following his 1910 report [1]:

‘but scientific medicine in America—young, vigorous and positivist—is today sadly deficient in cultural and philosophic background . . . Now science while increasing our vision and solving our problems, brings with it dangers peculiar to its own. We can become so infatuated with progress in knowledge and control—both of which I unstintingly emphasized—that we lose our perspective, lose our historic sense, lose a philosophic outlook and lose sight of relevant cultural values . . . In a modern university, therefore, the more vigorously science is prosecuted, the more acute the need that society be held accountable for purposes to which larger knowledge and experience are turned. Philosophers and critics therefore gain in importance as science makes life more complex, more rational in some ways, more irrational in others.’

We should also recall that William Osler essentially rejected the Flexner report, not because he was opposed to scientific objectivity but because he resisted the notion of a scientific ethos imposing itself between physician and patient [2]. Although we have embraced science in medicine we have thought, until recently, that the traditional Oslerian model of medical ethics was adequate and we have vigorously defended this position.

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The complexity of modern medicine, the plurality of individual values and the increasing weight given to autonomy, the erosion of trust in the medical profession while more is expected of us, together with the need for common standards to foster social justice and protect the public against abuses in medical practice and research, have revived interest in ethics and the philosophy of medicine [3]. Such interest was rekindled first by theologians in the 1950s and subsequently by philosophers with sceptical and critical attitudes who challenged traditional, professionally oriented ethical debate. An initially turbulent era has been followed by increasing acceptance of the enriching intellectual contributions being made to medical education and practice by philosophers and theologians and subsequently by anthropologists, sociologists, lawyers and others. The value of ethics and the humanities in medical education is now widely accepted. The ongoing challenges relate to appropriate methods of education and include questions about who should teach, how ethics should be taught, what to include in the curriculum and how to find effective ways of ensuring that what students learn in theory can become incorporated into medical practice [4].

Another recent and somewhat forced transition has been towards taking on, more formally than in the past, administrative and political functions: documenting, evaluating, choosing, planning and directing health services for the public good, functions for which we have not necessarily been adequately trained. Given our academic quest for the truth, our clinical mind set and our intense orientation towards individual patients, we often find ourselves in conflict with bureaucrats and administrators who are increasingly concerned with population health, with cost containment policies based on economic principles, and with legal considerations. But we are beginning to take on this challenge as well in the hope that the complex organisation of modern medicine will be improved by mutually enriching deliberations.

The sweeping changes in medicine in London, the intensity of the medical profession’s reaction and the interaction between doctors and administrators exemplify this. In his recent summary of changes since the King’s Fund Commission in London, the Tomlinson Report and the government’s published response, Robert Maxwell [5] has written: . . .

‘there are (at the extremes) two obvious policy options. One is to break away from change in London, on the grounds that it is all too difficult and unpopular. The other is to continue doggedly with current policies, regardless of opposition and criticism. Both these options must be rejected. The first, because the need for change to the balance of London services remains overwhelming to anyone who will look at the evidence open-mindedly. The second, because what has happened (and some of what has not happened) over the past two years underlines the difficulty of making changes on the scale proposed. In London there is widespread concern that the changes under way are putting patients at risk and that some of London’s most famous hospitals have been pushed into a downward spiral of decline. At a minimum there is a need to re-establish confidence, revise time scales and review the management of transition.’

Similar dilemmas face us in South Africa where they are compounded by the wider gap between polar possibilities and by the political pace demanded within the context of a negotiated revolution [6]. Such transitions are difficult but we are, to some extent, assisted in coping with them by the professional and social support structures around us, especially in stable societies.

However, many other powerful currents of change tend to disrupt the interface between society and the accepted stable model of modern medical thought; forces that we may feel impelled to resist because they threaten a relatively comfortable stability. While we may be correct in opposing those that could be damaging, others have sufficient validity to ensure that they remain unscathed by such resistance. Veheemt opposition to change is often inappropriate and is only credible if we have open-mindedly examined the nature, force and justification of the changing tide. The value we place on thorough evaluation requires nothing less. But can we do this? Have we the will, the skill and the courage to step into an unpredictable and rapidly changing future; a future that calls for creative broadening of our visions?

**National level**

Change in South Africa has been taking place at a considerable pace over at least the past 10–15 years [6]. We have finally reached a stage our oppressed citizens have long desired, as have democratically minded people within our country and beyond its borders.

Given the legacies of apartheid and the demands for social justice, the challenges for the new government and all the people of South Africa are enormous [7,8]. Achieving the greater common good will require cooperation on an unprecedented scale, innovative approaches to redistribution of resources and reshaping educational and health care services in ways that could responsibly empower our citizens to escape from dependency. Closed minds, unwillingness to change and dominance of ethnic and other power struggles for privilege could undermine the future we all desire. How can we cope with and bridge the gap that seems so wide?

Despite the injustices in our society over so many decades there has emerged, almost miraculously, a spirit of negotiation and cooperation that few believed possible [9]. The transition process has been remarkably free of violence, given the great potential that has existed for civil war. How was this achieved? There is
no simplistic answer and as with other major changes in world history, many complex forces have been interacting over decades and centuries to provide the creative tension that gave rise to these changes.

The example of President Mandela’s life illustrates the power with which an individual can bring about major changes. It is important to realise that many other people have also lived constructive lives that in their various ways combined to produce the catalysing forces that made a peaceful transition possible. This should enhance faith in every individual’s ability to contribute towards change, even major change, no matter how insignificant such actions may appear on their own. This applies to many aspects of life in our country, including our health care system.

Transition in the crucible at the southern tip of Africa is an experiment with implications for the world at large. Global forces, in different guises, are challenging even the most privileged nations. The move towards a European Union, the end of the Cold War and subsequent events in Eastern Europe, the unification of Germany, the spread of democracy in Latin America, the debate about partition in Canada, the negotiations and treaties for peace in Ireland and the Middle East, the ‘awakening’ of China, the growing economic power and influence of Japan, events on the whole African continent, and many other social revolutions are all symptomatic of these powerful forces of change. Each nation and its citizens will need to deal with its own problems in its own context.

Global change

The global problems include exponential population growth, with widening economic disparities, detrimental ecological effects, ethnic conflict, new forms of power and control (eg complex information, modern communication systems, market manipulation), and tensions over resource allocation and social justice [10]. These, together with problems such as drug addiction, violence, AIDS, multidrug resistant tuberculosis and other diseases that do not respect boundaries, nuclear threats from unstable countries and escalating refugeeism, pose challenges of a new and greater order of magnitude than any we have successfully dealt with during this century.

Solutions to these problems will not come from science alone although scientific progress will certainly contribute. For example, immunotherapy that could shorten the duration of effective treatment for tuberculosis could have a dramatic impact on this resurgent disease. However, additional social solutions will also be required [11].

To begin with, we need to develop a deeper understanding of the adverse as well as the beneficial effects of Western civilisation over the past 300 years [12-15]. We now live in a divided world, a world in which the humanity of some has been sustained at the expense of others, a world in which domination, exploitation and militarisation have led to a small and shrinking rich core, and a large and growing poor periphery. Courage is required to acknowledge deep-seated deficiencies in international relations that lie behind world events and to propel movement towards a concept of global citizenship and inter-cultural cooperation that must surely be as inevitable as the eradication of apartheid.

Herein lies the excitement of recent developments in South Africa where the world’s problems come into sharp focus. A great fund of human goodwill amazingly exists in a country with such an oppressive history. There is also widespread realisation that the rewards for a successful transition towards democracy, economic growth and greater equity are so enormous and the price for failure so high that a consensus approach to the future is of prime importance. However, the turbulence of transition in other countries and the ever present risk of retrogression (even if only temporary) despite the best intentions of transformative regimes, cautious against over-idealistic expectations.

The obvious changes we see in South Africa and elsewhere reflect the less obvious global undercurrents that we either fail to detect or ignore. For example, the elimination of apartheid takes place not only in the wake of increasing concern for human rights everywhere (since the International Declaration of Human Rights) and recent anti-apartheid pressure and action, but also in the context of less obvious, but nevertheless real discrimination and oppression that regrettably continue to pervade the world in many guises. Economic, military, political, technologic, cultural and gender imperialism remain extraordinarily powerful forces with an adverse impact on the self-esteem, dignity and lives of millions of people both in the developing and the developed world.

In the developed world these manifest in the ‘post modernist’ movement that includes Afrocentricism, feminism, multiculturalism and deconstructivist academic and populist movements that have arisen in response to oppressive forces and which we can ignore only to our disadvantage [12].

While we may legitimately dismiss the extreme cases made by the most radical advocates of various postmodern positions, the real challenge is to recognise the valid claims for respecting different identities and for empowerment that underlie these strident claims. We cannot and should not avoid confronting academic and other critiques within the western world that have sufficient force to undermine confidence in most of the West’s great intellectual projects: critiques that pose challenges to disciplines as diverse as philosophy, history, art, literature, medicine, science and of culture itself. Previous confidence in spiritual force, in our capacity for knowledge and our ability to conquer nature are being replaced by loss of faith, uncertainty in knowledge, a mutually destructive relationship with nature and intense insecurity about man’s future [12].

This complex, ‘postmodern’ condition, shifted by a
diversity of intellectual and cultural currents with deep historical roots can either be seen as a threat to our strongly held belief system or as a dialectical force with justifiable origins, but flawed construction. Rather than being intensified through rejection, its radical elements should be confronted in a scholarly manner, and if appropriate rejected on justifiable grounds. Other aspects, established as valid in open debate, could be shaped through dialogue into a more richly informed intellectual vision and moral conception of life in an interdependent ecosystem in which the quest for knowledge must be endlessly self-revising [12].

The developments towards social democracies in Europe, and the growth of communitarianism as a new political ethic in the USA in response to a liberal culture that has allowed community values to decline [16, 17] and the response of liberal individualism to its own deficiencies [18] have profound conceptual and practical implications and are healthy signs of this self-revising process.

We need to consider not only these divisions within our Western world view; we also need to understand better the implications of our attitudes to the cultural differences between peoples of different nations that have arisen from ‘deep trajectories of thought and social movement which have become institutionalized in subsequent intellectual and social life so that they form a stratum of human presupposition and habit of which people are not always fully conscious’ [19].

As Sir Isaiah Berlin has pointed out, this does not have to be rejected as disastrous cultural or moral relativism but rather can be accepted as a challenging opportunity for improving communication between cultures [20]. We cannot avoid the need to try to understand value systems other than our own. This is not to say that we should blindly accept them but rather that we should be willing to enter into a dialogue that could enable us to find a middle ground on which peaceable progress could be built. Progress lies not in propagating false dichotomies but rather in deeper understanding of differences and a willingness to create solidarity through greater identification with common attributes and aspirations.

The great divide between the scientific and literary cultures within our own world was clearly described by C P Snow in his 1959 influential lecture, ‘The two cultures’ [21]. It was clear to Snow that there was a link between this cultural gap and the widening gap between rich and poor nations. He believed these gaps could be narrowed. But in many respects they have become wider. Further divisions, both within science and the humanities and between them, emphasise the need for intra- and interdisciplinary communication [22]. We have come to accept the need to bridge the gap between science and the humanities in medicine; the need to transcend other boundaries is illustrated by sensitive and deeply insightful writings by African authors [23,24], Western philosophers [16,17,25,26], anthropologists [27], political scientists [16,17], African-Americans [28], and many others [29,30]. They have contributed humbling and uplifting insights into how we will have to change our attitudes if we are to live together in greater international justice and peace.

At the end of the 20th century the world is indeed facing awesome challenges, and these are manifest in different ways in different countries. Such challenges call for deep introspection by those nations and groups of people who, like us, have been privileged to benefit most from human progress over the past three centuries. They also call for a re-evaluation of the costs of such progress for the least fortunate in the world who constitute a growing proportion of the total population.

**Medicine**

An analogy can be drawn between these global changes and the transformation of medical professionalism by a growing tendency to base the delivery of medical and health care predominantly on expensive, high technology medicine transacted as a commodity in a market place governed increasingly by economic and legal principles—surely a myopic perspective on medicine and human suffering. The universal humanistic ideals for which medicine strives are being neglected. They must be revived, promoted and cherished if we are to avoid being dominated by our acquisitive instincts and if we are to preserve professional integrity, maintain concern for individuals and improve the health of the population within a spiritual concern for life and its dignity. The need for this in the era of molecular biology will be greater than ever.

Medical education will need many innovative approaches. These will include a new substantive core of biological sciences, greater emphasis on behavioural, social, predictive and information sciences and new interactive techniques for learning [31]. There is, however, less appreciation of the need to reshape medical practice and health care delivery systems to ensure that they provide receptive environments for the evolving changes being introduced into medical education. Paying lip service to change by reshaping medical education and increasing exposure to ethics and the humanities, while allowing medical practice to be driven along a commercialised route, will be self-defeating. The medical profession will have to think deeply about itself, about its role in society and face many challenges to some of its entrenched values if the advances made in improving the health of individuals in the 20th century are not to be confined to a small elite. Advances in scientific and social practices should be designed to extend better health to large populations in the 21st century.

The lead will surely need to be taken by those nations that have sufficient financial and symbolic power to re-embody the spirit of trust, beneficence and community in the daily practice of medicine in
civil societies. Their health care systems, and especially that in the USA, have a major symbolic impact globally. Failure to appreciate how the legitimisation of entrepreneurial dominance in medicine impedes the ability of less affluent nations to build and sustain equitable health services may leave industrialised nations with the historical burden of having undermined the basic morality of medicine.

Coping with change and some conclusions

As we grow older and hopefully wiser we can reflect on the many transformations we have gone through in our lives, how we were influenced and changed by life’s experiences and how we stumbled through to new horizons. If we study the history of our and other civilisations and examine ourselves deeply enough we come to realise the complexity of interacting forces that have shaped our perceptions of ourselves — perceptions that may be narrower and more emotive than we readily concede. Through recognising, acknowledging and studying them we gain greater control over our destiny. The examined life is painful but also richer.

It is through becoming more aware of the human condition and discovering our need to form communities with those different from ourselves that we rediscover spirituality on a wider scale and can search with integrity and optimism for common moral ground. Our experiences in life can thus be described as encounters that require interpretation, often associated with conflict through which we may become transformed [27].

My concern is for a constructive, creative and visionary response to local problems in the context of global awareness. I identify with Isaiah Berlin and the priority he gives to the avoidance of extreme degrees of suffering. His deeply felt concerns for the vast human sacrifices inflicted during the 20th century by ‘armed prophets seeking to save mankind, and some only their own race because of its superior attributes’ [20] requires loud reiteration in a frightening world in which economists have recently described two-thirds of the world’s population as ‘superfluous people . . . In the perspective of world capitalism as we know it these people just don’t count . . . Unless that part of the world develops the capacity for terrorist blackmail, they will be in the charity ward for a long time’ [32].

I conclude by quoting a passage from Isaiah Berlin’s paper: ‘On the pursuit of the ideal’ [20]:

‘How do we choose between possibilities? What and how much must we sacrifice to what? There is, it seems to me, no clear reply. But the collisions, even if they cannot be avoided, can be softened. Claims can be balanced, compromises can be reached: in concrete situations not every claim is of equal force — so much liberty and so much equality; so much for sharp moral condemnation, and so much for understanding a given human situation; so much for the full force of the law, and so much for the prerogative of mercy; for feeding the hungry, clothing the naked, healing the sick, sheltering the homeless. Priorities, never final, must be established. The first public obligation is to avoid extreme suffering.’

Acknowledgement

This lecture was prepared while the author was on sabbatical leave as a Fellow in the Harvard Program in Ethics and the Professions.

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The psychological care of medical patients

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