Médecine de la Personne
International Group

Autumn letter 2016 – reflections on our annual meeting in England

Dear friends of Médecine de la Personne,

This year, our annual meeting took place from the 25–30th July in the South of England, in Sussex. The theme was 'Decisions on treatment: who makes them?'

The majority of the 53 participants including two children had already met for the leisure days at Pilgrim Hall, a conference centre near Brighton. We were blessed with good weather and visited grand houses and gardens of which dreams are made, learned astonishing facts about English nobility and immersed ourselves in the times and life of George IV. Thanks to the impeccable organization of Kathy Webb-Peploe, we were able to prepare ourselves very pleasantly for the study days.

The highlight of the opening evening was provided by Gareth Williams, Kathy's husband, and three friends of his who entertained us with barbershop songs delivered with great skill and spirit.

I would like to summarise here some of the ideas from the lectures and the bible studies and invite you to explore them in more depth by reading the texts on our web site; www.medecinedelapersonne.org/en.

Lectures

Luc Perino had us reflecting on the meaning of 'care' when we are dealing with illnesses that are real, virtual or potential. The real illness is defined by a clinical episode experienced by the patient and recognised by the doctor who deduces from the symptoms a biochemical diagnosis. Treatment follows current scientific evidence in order to reduce the signs of illness. In contrast, virtual illnesses don't have a clinical episode underlying them but they have a biological reality in terms of laboratory results or clinical reports without any subjective symptoms. The patient has a statistical risk of developing an illness and dying from it. The suffering only becomes a reality at the point where the patient is confronted by the possibility of being ill. Medicine thus becomes the creator of illness and, depending on the psychological state of the patient, of real suffering as well. A third form of illness which is going to influence the work of doctors in the future is the group of potential illnesses. In these cases, there are genetic predispositions and other statistical factors which can or will be able to more or less predict from what illness a person will suffer or die, without there being any other symptoms or signs. What is the attitude of the doctor in these cases, what sort of 'care' should he give or avoid?

The function of occupational health was explained in a very practical way by ***Francois Scherding*** who has been working in this field for many years. Besides clinic visits in his consulting room, work-site visits, visits to farms, forests, stables and elsewhere allow him to form an idea of the

personal situation of the person who needs to return to work, or the person whose position is no longer suitable for them. Going on a mower or threshing machine or in a lorry which collects the milk by night in winter in snowy conditions gives a very different impression to that conveyed by a written account. Problems of going back to work, disability or retirement on grounds of ill health demands a particular dexterity on the part of the doctor who has to advise all the relevant authorities. It is surprising how much medicine of the person can influence the decision-making process in the practice of occupational health.

Gordon Caldwell plunged us into the world of acute hospital medicine. Chest pain in a 53 year old man, a smoker, with signs of an acute myocardial infarction, has angioplasty and stenting but his lung cancer passes unnoticed even though it is visible on his chest x-ray. On a sub-sequent attendance at hospital the mistake is noticed but the lung cancer is now inoperable. The emergency care focussed solely on the cardiac presentation and on reassuring the patient have led to wrong treatment.
A 60 year old woman, a former tourism guide, who has had several operations for a cerebral tumour, expressed the desire to spend a last Christmas with her family. She was so well accompanied during her last weeks that she not only celebrated Christmas at the heart of her family but was also able to talk of her prognosis and of her death. In this case, the important end of life decisions were able to be taken with the patient. Caldwell makes the case for a medicine which allows the patient a maximum participation in decisions about them. He organizes his ward round to allow the patient a real chance to take a view with regard to their illness and their treatment. He would like doctors to stop taking important decisions without discussing them first with patients.

Klaus Ammann has examined the records of several Swiss hospitals according the following criteria: respect for autonomy, non-harm, doing good and equity (T. L. Beauchamp, F. Childress, 1977). The respect for autonomy is upheld by only one of the clinics, a psychiatric clinic. Ammann quotes: ‘psychiatric care is a difficult exercise in balance – between the personal ideals of the therapist, those of the patient and the values of the social milieu’. But it isn’t just about respecting the autonomy of the patient, it is also about respecting that of the care-giver. Each criterion is more or less considered in the hospital charters. The participation of the patient in decision-making is however not the only factor in doing good and not harm. Economics and quality are much more important in the hospital charters.

Roland Stettler describes current medical practice, with the doctor as provider of services and the patient as consumer, with their internal state of mind having no importance as far as their interaction goes. But in a real-life doctor-patient relationship, the values of the patient and those of the doctor play an important role, more or less consciously realised by those involved. He mentions three models for this relationship: the informative model allows almost complete absence of attention to each person’s values. The doctor transmits information and leaves the patient to take their decisions. In the classical paternalist model, the doctor decides according to his own opinion, for the good of the patient. The deliberative model requires an exchange of

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International Group

ideas and a communal elaboration of decisions which are, above all, marked by the ideas and values of the two people taking part. The capacity for discernment (competence), understanding, the freedom of the patients and the authenticity of appreciation by the two partners are the conditions for this model so that the decision is made in a mutual understanding, allowing a continuation along a common path. The doctor plays a double role, as expert on the one hand and human companion on the other. 'Relationship therefore does not replace technology but it is a necessary condition for success.'

Three bible studies helped us to reflect on the use of our talents (Rutger Meijer), the freedom of the patient to also believe in miracles (Johanna Goldbach) and the rigidity and harshness of laws and protocols in relation to a decision taken about a special and unique person (Pierre Marès).
In the small groups, there was lively discussion about all these thoughts and how they related to our personal experience.

Again, thank-you to all those who contributed to making this meeting so successful.

We are looking forward to our next meeting which will take place in Switzerland from the 13th to the 19th August 2017. We will be talking about situations where medicine and treatment makes life hard rather than making it better.

I wish you all plenty of fine experiences and the best of health until then.

Frédéric von Orelli

Arlesheim, 23th September 2016