Tidsskriftet Tidsskrift for Den norske legeforening

Filosofisk poliklinikk – diagnosing medicine

PERSPECTIVES

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The author has completed the ICMJE form and declares no conflicts of interest.

Filosofisk poliklinikk [Philosophical clinic], an independent think tank affiliated with the University of Bergen's Faculty of Medicine, is celebrating its 25th anniversary. The aim of the think tank is to prevent over-simplification and wishful thinking in medicine and the health service. The method employed is philosophising – exploring how to think better.

Doctors are good at thinking and as a result, we are able to help sick people and prevent disease to an extent that surpasses everything in our history. But medical thinking can be too self-centred and constricted. Doctors and medical students need new impetus for professional reflection (1). The think tank is led by doctors who are passionate about medicine and believe that the quality of education and patient care can be improved (2). In this feature article, I will explain what a philosophical approach can contribute to the medical profession at a time when technology, demographics and secularisation are changing the world.

Education with no human depth

As a 26-year-old intern in Namsos and Kautokeino, I felt uneasy in the doctor's role. The concept of moral stress did not exist at the time, but in retrospect, I have understood that my growing cynicism towards patients and their families,

and thoughts of finding a different path, stemmed from a sense of meaningless and powerlessness in relation to my profession. I remember the feeling of indifference that came over me as I flicked through the procedure manual to find the treatment algorithm for a young patient with an acute, severe illness. 'Why am I doing this, anyone can look up a user manual.' The patient died, no doctor spoke to the family and no colleague spoke to me about what had happened.

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My medical studies had provided me with education without self-formation. Proficiency meant memorising differential diagnoses and assessment procedures so that the patient's problem could be labelled, and treated according to a formula. When that did not work, and the symptoms did not disappear and patients could not be reassured, I felt helpless and frustrated. I frowned on patients who came to my doctor's office with 'the wrong expectations'. Slowly I began to understand that it was my own *competence as a doctor,* approved by medical school, which did not correspond to reality. In frustration, I wrote the article entitled *Medisin og hjernevask. Hvordan legers virkelighetsoppfatning formes slik at den blir til skade for dem selv og folks helse* [Medicine and brainwashing. How doctors' perception of reality is shaped in ways that harm both themselves and people's health] (3). A deluge of positive reactions from colleagues showed that I was not alone.

I gathered a handful of young colleagues for evening chats in order to air our experiences from clinical work. A felt security in the group allowed us to share uncomfortable acknowledgements of inadequacy in the profession. We saw that problems and frustrations that we had interpreted as personal weaknesses – 'There's something wrong with me' – were caused by blind spots in our medical education. We had learned nothing about communication, ethics, psychology, or the theory of science. We did not know that a patient's illness is interwoven with their life history. We did not understand that evidence-based knowledge is founded on statistics, and, as such, carries inherent uncertainty for individuals. We had not reflected on the power of medicine, natural science, and the pharmaceutical industry in our secular society. We had not learned to think of the mind and body as interconnected. And above all, we had not been told that 'doctor' is a cultural symbol of security and hope, and can therefore have an immediate impact on patients' well-being and physiology – if the doctor understands their own role as a healer and sees the whole person, not just the diagnosis (4, 5). The title of doctor covered up the fact that we were moulded into technicians and bureaucrats, not healers.

In 1998, we adopted the name *Filosofisk poliklinikk*, booked the big central auditorium at Haukeland University Hospital and arranged a debate with the title *Fundamentalisme i hvitt. Om makt og autoritetsunderkastelse i medisin og helsefag* [Fundamentalism in white coats: Power and submission to authority in medicine and healthcare] (6). Around a hundred medical students,

a handful of doctors, and dozens of curious members of the public, many with experience as patients, showed up. That was the start of a series of meetings and an institution, the think tank, that has existed for 25 years. It has been easy to find inspiring topics for a series of meetings held over many years, which incidentally can be found on YouTube (2). It has also resulted in several international seminars such as 'Dignity and Dialogue. Exploring Medicine's Relational Foundations' and 'The core of medicine: Identifying goals and methods for professional identity development in medical education'.

Box 1 Filosofisk poliklinikk's umbrella themes 2013–2023 (selection)

Crisis!

Religiousness, spirituality, and modern medical practices

The health business – the new oil?

Wiser after COVID-19?

Too many health services: useless, dangerous and confusing

Living in death's light

Feelings, health and medicine

Sex! Skin! Gender and organs!

Migration, medicine and morals

Prioritising means saying No, doesn't it?

The Norwegian sickness role

Self-formation as a doctor. How can students acquire knowledge, virtue, and professionalism?

A main premise for the work has been our belief that medicine as a subject, despite all its success, embraces assumptions and traditions that create problems for patients, health personnel and society, and is in need of reflection and renewal. Let me give a key example:

Diagnosis – a necessary tool and a therapeutic trip-wire

The intellectual focal point in the science of medicine is the diagnosis. 'Diagnosis' is not an objective entity in the biological world, but a philosophical principle, a tool for thoughts that doctors spend many years acquiring, and that makes us useful as helpers. When someone seeks help for a problem, a symptom, a disability, the doctor thinks, 'What is the diagnosis?' Without diagnoses, doctors cannot make decisions, give explanations, or send reimbursement claims. Diagnostics bring order to the seeming chaos that patients present, make medicine effective and trustworthy, trigger patients' rights and financial security, and give doctors their identity, job satisfaction and status.

«A medical education whose ultimate learning objective is diagnostic knowledge fails to give students sufficient tools to function as healers and problem solvers»

So how is this problematic? Firstly, the aim of medicine is not to make diagnoses but to help sick people. A medical education whose ultimate learning objective is diagnostic knowledge fails to give students sufficient tools to function as healers and problem solvers. Diagnoses are in principle simple and repetitive, and can be understood through scientific knowledge, whereas sick people are complex, always different and require psychological, communicative, and emotional skills. International research shows that the methods of teaching and assessment that characterise medical education can result in a naïve, over-confident and unscientific perception of medical knowledge as objective, indisputable and adequate (7), consisting of medical texts and skills linked to diagnoses, along with corresponding screening and treatment protocols.

Doctors who take it for granted that a good knowledge of diagnostics is all that is required to be a doctor will find it difficult to cope with a clinical reality that is always deeply emotional and professionally complex. Moreover, they must compensate for a lack of verifiability and their inevitable ignorance by means of clever improvisation and interaction. 'An exquisite understanding of disease cannot explain why the patient is sick any more than the formula H2O can tell you why water is wet' (8).

It is possible to simplify the patient's problem by reducing it to something that suits the doctor's understanding and tools – 'If all you have is a hammer, everything looks like a nail'. This occurs in both hospitals and general practice, when doctors, for example, adopt a purely technical approach to a cancer diagnosis, and confine their work as a physician to assessing blood samples and the next round of chemotherapy without engaging with the patient's despair and existential anxiety. This is also the case for tens of thousands of people who visit emergency services, their GP and specialist outpatient clinics for medically unexplained physical symptoms (MUPS), i.e. pain, lethargy, fatigue, sleep difficulties, balance problems and so on, accompanied by anxiety and a need for an explanation. They are often met with either comprehensive and expensive assessments or trivialisation of the problem, without receiving effective help to understand, accept and live safely with their bodily symptoms.

Frustrated patients pursue their quest for clarification and treatment from both public and private healthcare service providers. At the systems level, this is one of the drivers of overdiagnosis and overtreatment as well as the explosion in health service costs, while at the individual level it leads to the medicalisation of health.

Filosofisk poliklinikk's therapeutics: reflection and

pedagogics

We members of the think tank believe that having a scientific approach is necessary for becoming a good doctor. But science is not just lab rat models and statistics; it also encompasses a self-critical philosophy, a respectful way of thinking by all those who have wisely realised that erroneous conclusions and self-deception are unavoidable. In 1865, the founder of experimental medicine, Claude Bernard, said that the scientific approach is to seek the best objections to that which one wished were true (9). A critical, reflective mind, practical experience and emotional confidence are the hallmarks of skilled doctors. We need doctors with *real* intelligence at a time when artificial intelligence and other technology can release us from having to function as diagnostic robots.

> ***«We need doctors with real intelligence at a time when artificial intelligence and other technology can release us from having to function as diagnostic robots»***

Patient contact as a subject in medical school

First year medical students in Bergen take the subject Patient Contact (PASKON) in which ideas from *Filosofisk poliklinikk* are translated to innovative teaching (10). The experiences of sick people are a core focus, while diagnoses take a back seat. All students meet at least twenty patients, and have a dialogue with one of them over time in the patient's home. The students learn to explore through conversations and theory the impact of illness and loss of function on a person's life, what being dependent on help entails, and how doctors' emotional sensitivity is used therapeutically in the interaction with vulnerable people. Experienced clinicians guide the teaching, older students supervise younger students before the meeting with the patient and subsequently provide feedback on reflection texts. The teaching applies transformative learning theory (11), in which individual life experiences, role models, group activities and reflection are combined to foster engagement, in-depth learning and personal development.

Filosofisk poliklinikk as a method: more rationality

Rationality is a praiseworthy quality. However, a technical-bureaucratic rationality that seeks efficiency and control through systems, can be morally shortsighted. In the clear light of objectivity, the individual's grief, suffering and subjective lifeworld may appear to be irrelevant, leading to unfeeling, and thus ineffective, clinical practice. To avoid a limited rationality that becomes complacent and therefore ceases to function as common sense, the German philosopher Jürgen Habermas argues that three types of rational thinking must be balanced against each other (12). *Instrumental* rationality is concerned with

using effective means to achieve the goal and fix the problem. However, it does not ask, 'How do we decide what is a good goal, and for whom, in a reality that no one has a full overview of?'. For this we need to build *critical* and *communicative* rationality respectively. Critical rationality entails awareness of the danger of self-deception, and looks for power issues and self-interest among well-intended professionals who enjoy the trust of society. Communicative rationality entails listening, inclusiveness and dialogue, and an awareness that this manifests in actions that protect human values, emotions and traditions.

The think tank's role is to create arenas in which medicine's instrumental rationality can engage with facts, stories, and discord from the lifeworld of human beings: critical questions on technology and power, personal narratives about existential vulnerability and strength, as well as artistic reminders of reality. Moreover, we need historical, theological, and philosophical perspectives on the role of the doctor – we live in an age where people's irrational beliefs are more often connected with science than with religion.

Although an evening meeting at *Filosofisk poliklinikk* does not solve all of your problems, it does help you to face the problems that will not disappear.

REFERENCES

1. Schei E, Fuks A, Boudreau JD. Reflection in medical education: intellectual humility, discovery, and know-how. Med Health Care Philos 2019; 22: 167–78. [PubMed][CrossRef]

2. Filosofisk poliklinikk. https://filosofiskpoliklinikk.no/ Accessed 8.9.2023.

3. Schei E. Medisin og hjernevask. Hvordan legers virkelighetsoppfatning formes slik at den blir til skade for dem selv og folks helse. Nord Med 1992; 107: 62–4. [PubMed]

4. Schei E. Hva er medisin. Oslo: Universitetsforlaget, 2007.

5. Schei E. Doctoring as leadership: the power to heal. Perspect Biol Med 2006; 49: 393–406. [PubMed][CrossRef]

6. Schei E. Fundamentalisme i hvitt? Om makt og autoritetsunderkastelse i medisin og helsefag. Omsorg 1998; 16: 63–7.

7. Cooke M, Irby DM, O'Brien BC. Educating physicians: a call for reform of medical school and residency. 1ste utg. San Francisco, CA: Jossey-Bass, 2010.

8. Cassell EJ. The nature of healing. The modern practice of medicine. Oxford: Oxford University Press, 2012.

9. Bernard C. Introduction to Experimental Medicine. New York, NY: Dover Publications, 1865/1957.

10. Schei E, Knoop HS, Gismervik MN et al. Stretching the comfort zone: Using early clinical contact, emotions, and professional identity formation in

medical students. J Med Educ Curric Dev 2019; 6: 2382120519843875. [PubMed][CrossRef]

11. Slavich GM, Zimbardo PG. Transformational Teaching: Theoretical Underpinnings, Basic Principles, and Core Methods. Educ Psychol Rev 2012; 24: 569–608. [PubMed][CrossRef]

12. Eriksen EO, Weigård J. Kommunikativ handling og deliberativt demokrati. Bergen: Fagboklaget, 1999.

Publisert: 17 October 2023. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.23.0538
Received 15.8.2023, first revision submitted 6.9.2023, accepted 8.9.2023.