COMMENTARY

Losing touch with the healing art: Dermatology and the decline of pastoral doctoring

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Technological advance in society and medicine has brought tremendous improvements and convenience but also a degree of depersonalization. The personal and pastoral aspects of medical practice, which are probably more important in helping patients toward health than we realize, are becoming increasingly stifled by health care systems which are increasingly "scientific," technological, and "efficient." Clinical practice in dermatology requires pastoral as well as technical skills, art as well as science, and yet the balance of current medical culture increasingly favors and encourages "science" over "art." In dermatology, this bias is evident in a reductionist focus of research, the move towards evidence-based medicine and the emergence of teledermatology. Although all these developments are extremely important and valuable, their effect on the doctor-patient relationship needs to be considered carefully. Increasingly rapid scientific advance is paradoxically providing diminishing returns for patients and the healing art is still very much in demand. (J Am Acad Dermatol 2000;43:875-8.)

Ars longa, vita brevis.
The life so short, the craft so long to learn.

——Hippocrates[1]

Medicine has remained an art, but one that has become increasingly difficult to practice as knowledge of the scientific ignorance that underlies it has increased.

——David Weatherall[2]

MODERNITY, ANONYMITY, AND MEDICINE

Although there is no doubt that technological advance brings great benefits, it often does so at a cost. The emergence of anonymity in modern human societies first described at the end of the nineteenth century is now readily discernible, particularly in the Western world, at the beginning of the twenty-first. A visitor from the end of the nineteenth century or even from the remoter corners of the so-called developing world could not help noticing the curious way in which we are now living. Ties of kinship and community are often flimsy and fragmented by transient relationships, the need for mobility, and the tendency for people to live in small family units. Shopping takes place in large impersonal superstores on the edge of towns and cities and may soon be superseded by electronic commerce. Locomotion, even for short distances, is increasingly by car, often, oddly, carrying only one person and affording no opportunity for meeting or greeting along the way. The skills of story-telling, conversation, and letter writing are becoming atrophied by disuse and, although we are said to be living in the age of communication, it only needs a little thought to realize that this must refer to quantity rather than quality.

The practice of medicine is a normal part of most human societies; therefore it is not surprising that doctors and others who work in the field of human health have found the nature of their work changing as a result of the broader social changes outlined above. Ironically, it may well be those aspects of medical practice most threatened by modernity and technology, the more intangible, human, social, and pastoral qualities of doctoring, that are needed all the more by patients who live in this increasingly anonymous world. In striving to provide an ever more scientific and efficient service for our patients, are we also in danger of distancing ourselves from them as fellow human beings?[3] Moreover, could it be that these more intangible aspects of medical care actually play a much greater part in helping our patients toward health than we would care to admit?[4]

PASTORAL DOCTORING AND DERMATOLOGY

The importance of pastoral doctoring has been excellently summed up by W. Mitchell Sams Jr:

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> Although the physician is a scientist and a clinician, he or she is and must be something more. A doctor is a caretaker of the patient's person—a professional advisor, guiding the patient through some of life's most difficult journeys. Only the clergy share this responsibility with us.[5]

Are these the words of a family doctor describing the role of a general practitioner? They could be, but in fact this paragraph is written by a dermatologist in an article arguing that the emergence of managed care in the United States is undermining the ethical standards and moral duty of the doctor as laid down in the Hippocratic oath.

Pastoral doctoring, the healing art, advising and counseling, or whatever else you care to call it is, of course, important in all medical practice, but it is perhaps particularly pertinent in dermatology for several reasons:

1. Although dermatologists do save lives—literally, when, for instance, they diagnose malignant melanoma and metaphorically, when they clear up life-wrecking psoriasis or acne—generally speaking, they tend to be more in the business of treating diseases that are not ordinarily deadly. The stigma of skin disease is as powerful as it is subtle, and much of their work therefore consists not of heroics but of gently dealing with a particular type of morbidity, which is highly personal and private. The dermatologist is unafraid to touch diseased skin and is familiar with the impact it has on the patient's life. This understanding is of immense importance and an integral part of dermatological care; so often what patients seek is not so much a cure (important as this is) but someone who understands and will listen. This, too, is life-saving.
2. Most diseases in dermatology are eminently treatable, but few of them are curable. Therefore much of the dermatologist's work involves being honest about the limitations of available treatments and helping patients toward an acceptance of their disease.
3. Many dermatology patients have chronic diseases that do not affect longevity, thereby making continuity of care another important aspect of the discipline.

For all these reasons a great deal of clinical work in dermatology needs art as well as science, human qualities as well as technical ones. In many ways the work of the dermatologist is similar to that of the family doctor in which the blend of scientific knowledge and pastoral understanding is so important. It is this blend and balance of art and science in medicine that is so vulnerable in the current social climate and needs to be preserved, nurtured, and developed. Dermatologists have their own unique perspective of this problem and a crucial part to play, therefore, in ensuring that the art of medicine does not get squeezed out by too much science.[6]

REDUCTIONISM IN MEDICAL SCIENCE

In recent decades there has been something of an explosion in the scientific understanding of the mechanisms of disease. Most advances have occurred within the disciplines of immunology and genetics and by and large represent a natural acceleration of the process that has driven scientific medicine since its inception. This process is essentially one of reductionism, the belief that disease is best understood by breaking it down into the smallest possible components and examining them in ever greater detail: small is not only beautiful but also true.

In arguing for a need to get away from the domination of reductionism in dermatology, Hywel Williams uses the illustration of a tree.[7] The tree of Dermatology leans precariously over, weighed down on one side by genetics, immunology, and molecular biology—the areas of research that seem to dominate our efforts to understand diseases of the skin. On the other side of the tree, greatly underrepresented in dermatological research, are public health, health service research, and epidemiology. There is an extraordinary imbalance here and even a cursory glance at any major contemporary dermatology journal will confirm that this lopsided tree is no fabrication. There are a plethora of papers about cytokines, adhesion molecules, T-cell receptors, tumor suppressor genes, and point mutations but precious few on health service research and epidemiology. So much of our research appears to betray a fixation at the molecular level. There is no doubt that increasing our understanding of the immunopathology and genetic basis of skin disease is of immense importance but should we not also keep in mind the possible limitations of the reductionist approach?[8]

The broader picture does not just consist of epidemiology and health service research. It consists of clinical and qualitative research, ethics and sociology, history and philosophy. Focusing so concentratedly on the molecular basis of disease tends to make us think of disease in vitro rather than in vivo, in isolation rather than in its individual human and social context. In the words of William Osler, "It is much more important to know what sort of patient has the disease than what sort of disease the patient has." A reductionist bias can also have the effect of subconsciously reinforcing in our minds, and in the minds of our patients, the erroneous notion that science can somehow answer all questions and solve all problems. If the research base of our discipline con-

tinues toward a narrow reductionism, our practice and the way we deal with our patients cannot help but be affected. By separating the disease from the patient, we distance ourselves further from the possibility of seeing the patient holistically.[9]

"SCIENTISM" IN MEDICAL PRACTICE

In rather the same way that reductionism is dominating medical research, the application of scientific principles to the practice of medicine is now having a profound effect on the way in which doctors practice their craft. The advent of evidence-based medicine has resulted in something of a revolution in which anecdote and opinion are relegated to their rightful place and interventions are judged more rationally on the basis of empirical evidence provided by properly designed trials. This has led to a healthy reappraisal of all kinds of therapies and practices that hitherto were carried out more because of dogma and out of habit than for any other reason. However, evidence-based medicine is not without its limitations and critics, and there is a danger that it can be used as a blunt instrument to achieve economic expediency.[10]

Its implementation can be greatly hampered by lack of good evidence[11] or difficulties that arise when trying to interpret the available evidence,[12] but these problems are potentially soluble. A further concern, however, is how readily and legitimately we can apply the results of systematic reviews and meta-analyses to the management of individual patients. This is not as straightforward a process as it might at first appear. At a technical level, the patient in question may differ in some significant way from the population examined in the systematic review.[13] At a more philosophical level, there is the question of whether evidence-based medicine can really bridge the gulf that lies between research and practice because these two activities have such different goals and are based on different principles.[14]

Clinical research attempts to overcome the effect of individual variation by randomization, and its results are expressed as the overall outcome of the intervention on a population—the bigger the population the more persuasive the results. Clinical practice, on the other hand, is a more personal matter, involving a contract (usually unwritten) between practitioner and patient, in which the particular features that distinguish this patient from others are deliberately explored and defined to make decisions about management. The evidence might be able to tell us what is best for a group of patients most of the time, statistically speaking. It cannot dictate what is best for this individual patient here and now.[15]

This problem is well illustrated by a particular issue in dermatology. Economic pressures are increasingly limiting the number of dermatology patients who can be treated as inpatients. Dedicated dermatology beds are an endangered species. No doubt evidence could be found to show that day care treatment can achieve similar results to inpatient treatment for conditions such as atopic eczema and psoriasis. Many patients with these conditions are likely to prefer day treatment anyway, but what of the patients whose social circumstances, inextricably bound up with their disease, are such a crucial factor in their management? For these patients, admission for rest, respite, and basic human care often has more influence on the clinical outcome than the specific treatment of the disease itself. Such care cannot be provided by a day treatment unit, and it seems highly unlikely that a busy general medical ward can provide it either. Unfortunately, it is also difficult to conceive how a randomized controlled trial could be designed to adequately demonstrate the benefit of what is known intuitively from experience to be good and compassionate medicine.

TECHNOLOGY IN THE CONSULTATION

Another aspect of modernization in medicine that has great potential both to improve efficiency as well as to depersonalize clinical practice is telemedicine. The advantages of telemedicine are particularly attractive for dermatology (not necessarily for dermatologists) because it is such a visual specialty and because a proportion of consultations involve rapid pattern recognition followed by a straightforward clinical decision. The possibility of substantial savings in time and resources for such consultations is tempting and in theory could provide greater access for patients who really need face-to-face consultations. Whether such theoretical advantages are borne out in practice remains to be seen, and much more exploratory work needs to be done before the place of teledermatology in clinical practice is established.

The technical limitations of teledermatology stem not only from unsatisfactory image quality, and the inability to palpate, alter lighting, perform a total skin examination, and view the skin from different angles but also from missing the more subtle nuances of the history, which do not necessarily depend on verbal communication alone. Such communication, only really possible in a face-to-face consultation, can have an important influence on diagnosis and management.

Most of these questions have been examined to a limited extent in evaluative studies of teledermatology consultations. One such study compared teleconsultations with face-to-face consultations in 126

dermatology patients.[16] Diagnostically the two methods were comparable, although teleconsultation was unable to make a useful diagnosis in 11% of cases and made a "wrong" diagnosis in 4% of cases when compared with face-to-face consultation. The authors reported "high levels of satisfaction with teleconsultations"; however, in their simple questionnaire 23% of the patients implied that they would prefer a face-to-face consultation and only 59% thought that teleconsultation was "just as good as seeing a dermatologist in out patients."

Concerns about how telemedicine might affect the doctor-patient relationship are not new and need to be considered in a consciously unprejudiced atmosphere.[17] Apart from studies like the one mentioned above there has not been a great deal of attention focused on the human quality of technologically enhanced doctoring; indeed, it would be difficult to measure this. For instance, if reassurance is required that a particular lesion is benign when the patient has entertained the possibility of malignancy, how effectively can this reassurance be communicated in a teleconsultation? Again, it is probably time and experience with the technology that will tell us whether patients simply need a straight answer to a simple question or something with a little more of the human touch.

CONCLUSIONS

For several decades there has been concern that medical training is without breadth and balance and that many practitioners lack a holistic perspective and are too scientific and technological.[18] On top of this existing bias, there are now several pressures on the medical profession and other health practitioners to become even more efficient and scientific in their approach to research, management, and clinical practice. Although some of these pressures are well intentioned and to be welcomed, there is a very real danger that the medical community could be losing touch with an extremely important element of its discipline, namely, the healing art.

It is essential to emphasize that scientific and economic principles alone cannot govern medical practice. The human and nonscientific elements of consultation and care are not just pleasant luxuries, but are absolutely vital for effective medicine. Although a move toward the fast, economical, efficient, predictable and reliable delivery of health care is in many ways desirable, the dehumanizing effects of such change and its tendency to stifle creative and imaginative thought must be considered very carefully.[19] Despite extraordinary advances within the past century, orthodox Western medicine still has grave limitations. The science and art of what we do every day remain perfectly and humbly encapsulated in the manifesto "to cure sometimes, relieve often and comfort always." Let us not lose sight of that.

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