

DISCUSSION PAPER

WHAT NEXT?

**Reality-testing systemic resistance towards treating
the *whole* person, the *unique* patient.**

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Recently, I was in an informal online meeting with a number of clinicians and academic colleagues from Norway and the United Kingdom, all of whom are active in the CauseHealthⁱ collaboration, and committed to a dispositionalist, multi-causal approach to the unique patient, which has much in common with our whole person-centred treatment approach here in New Zealand. Most of us contributed chapters to the recent CauseHealth book, and had also participated in the more recent podcasted interviewsⁱⁱ based on each chapter.

Naturally enough, the question ‘*What next?*’ emerged. This quickly morphed into ‘*What is the ‘right’ language needed to attract and persuade other clinicians and academics towards our approaches?*’ I remained silent. There was so much to say. In the shadow of such questions lurk many complex issues, and more questions, notably ‘*Is the problem of resistance really about language?*’

In this discussion paper, I break out of that silence and explore these questions from the vantage point of our New Zealand experience with the unitive, non-dualistic, whole person-centred clinical approach. I am confident that our experience will resonate with many other clinicians beyond New Zealand. I hope discussion might help configure answers to the ‘What next?’ question.

The problem

Most Western clinicians who pursue a person-centred approach to physical illness experience significant resistance from colleagues and health institutions. It appears in many

forms and intensities, but mainly in lack of interest or bafflement. At first glance this may seem strange. Wouldn't everybody want to be person-centred and oriented to the unique patient? Isn't it obvious that the appearance and development of disease is commonly multi-causal and multidimensional? There is so much evidence and cogent theoretical reasoning to support our approach, let alone the head-nodding acquiescence of ordinary lived experience. Surely anyone can see that disease is a manifestation or representation within, and of, the 'whole', whether that 'whole' is the presenting individual, or a bigger 'whole' such as family or culture. But life is not so simple.

To understand the complexity, we need to start with the people who are the focus of our professional care—the patients. A specific and representative patient story will help ground the discussion that follows:

A 45 year old woman with several years of crippling rheumatoid arthritis, presents unresponsive to all orthodox medical treatments. That is the medical story.

The *other* story, which had diverse roots, including being adopted at birth, was her sense of stuckness in relationships. It came to a peak with her partner. She felt stifled and hindered. She had repeatedly tried to escape from this feeling.

She said: "I can't get moving", "it's keeping me in a bind like it was with my parents". She felt: "closed to new directions," and "I want to loosen up".

On feeling tied to her partner she said: "I am responsible for his happiness", "it's hard to take freedom", "he still wants me," "I feel tethered, enslaved".

Commenting on who she was, she said: "I don't belong anywhere", "I don't know who I am or what I want," "I lose me in relationship," "I was quite strong in asserting me as a child, but I've stopped asserting me".

Commenting on her geography: "I hate being in that town, it cripples me".

She worked determinedly on her feelings. She left her partner, but they remained good friends. She shifted towns. Her arthritis subsided. Checking in with her 6 years later, she remained extremely well.

She reported: "I swim and bike regularly", "I feel good", "I hardly get sick", "I have a new health and happiness", "I think of the way you wouldn't accept my bullshit, the image of myself that I had chosen to construct", "it was very difficult to leave him", "I love living on my own", "I was really glad I talked to my mum about being adopted, about six years ago, as a result of seeing you".

The connections between her serious disease and medical diagnosis, her severe physical disability, her conflicted relational story, her bravery in facing and working through the insights, and her remarkable recovery are obvious, at least to a whole person-oriented clinician, and certainly to her.

What patients want

Contrary to what many clinicians claim, of all the parties involved in the care of physical illness, patients have the *least* resistance to whole person approaches. They want to be treated as persons and ‘wholes.’ They know they are wholes because they are alive as wholes. They frequently despair when their clinicians won’t listen. But when warmly listened to, responded to, and educated (simply and briefly), many will open up and work on the multiple factors at play in *predisposing* them to, and *precipitating* and *perpetuating*, their physical (sic) illnesses.

Patients do have their own resistances to discovering the psychological and social factors at play in their illnesses. But implacable defensiveness is not inevitable, and once ‘on board’ many patients show remarkable improvement in their chronic illnesses.^{iii iv v} Repeatedly we see patients’ whose defenses against such knowledge is worsened, and their healing impaired, by the refusal of clinicians to entertain psychological and social factors as natural potential elements in an individual’s disposition towards illness and disease.

Barhava-Monteith^{vi} has recently shown that patients with physical illnesses, who *experience* being listened to and responded to from a *whole person perspective*, frequently report remarkable experiences, both in satisfaction levels and positive illness treatment responses.

The dualistic, non-whole perspective imposed on patients by biomedical culture and clinicians, whilst offering many wonderful benefits, constitutes a scandalous limit on healing and good healthcare.

What are the alternatives?

The unique patient and the *other* story: In the New Zealand alternative we focus on the unique patient, and listen for the shape of their unique *story*. Our use of *story* should not be confused with the *narrative* of Narrative Medicine. The latter is a construct around *sense made of illness once it has occurred and diagnosed*. It does not entertain the possibility that the story either predisposed the patient to an illness or triggered it.

In our work we mean the story of the *whole*. We see story as a host construct for everything, physical and non-physical, that is involved in illness. But for us it typically presents in its physical aspect. We avoid the binary reductions of ‘just physical’ or ‘just psychosocial’. The story is simultaneously familial, relational, cultural, psychological, spiritual, archetypal, physical, medical, environmental, and genetic. We *hold* this sense of the whole whilst we address aspects of the whole. When a patient consults us, they are coming, implicitly, with all of this, expressing or representing it, limiting or hiding it,

consciously or unconsciously, within the clinical relationship. Of course, without facilitation, much of the story, and of significance to the therapeutic task, will be left unheard.

Patients, people, humans resonate strongly with the notion of *story*. It is the way things are put together, or how we create coherence in the complexity, the 'miracle' of the universe and our lives. With stories we map our experience and the world. They entail our meanings, emotions, connections, and, very importantly, our bodied existence and presence. In these stories we hang our 'lived' being in all the dimensions.

The story is, in a sense, a revelation, but only if it is heard.

Stories and sub-stories: What we present to, and share, with one another, in ordinary day-to-day and professional life, are sub-stories or ante-room stories or 'tip-of-the-iceberg' stories. Nevertheless, our *presented* sub-stories do in some manner *introduce* and even *represent* the whole. Sub-stories are frequently present as physical symptoms and disease (see the above example), which may constitute a convenient hiding *and* revealing of deeper, essential aspects of the whole. Physical symptoms and disease may also constitute severe reductions of the whole, an inability to express intensity in a more appropriate mode, such as language within a relationship.

There are sub-stories everywhere. In healthcare we have patient stories, scientific stories, philosophical stories. They are all important, as long as we remember they are always partial and should not displace or reduce the whole, at least in any ultimate sense.

Where do we start? Inevitably, we always start with ourselves, our roles, specialties, diagnostic frameworks, organized views of the world, and our assumptions regarding the nature of reality. In short, we arrive in the consultation as *persons with stories garnished, by training*, with all kinds of professional insight, truth and established evidence. Not denying all that, our primary job is to shift attention to the 'other', to start with the patient and their story, to see if we can meet them usefully, always working in a fundamental attitude of openness to multiple factors and multiple dimensions.

I do not use 'story' in the sense that it is a fiction, nor that, in some way, it displaces accepted (sic) truth or fact, or the extremely helpful scientific and philosophical stories. These latter are essential elements of our greater story. But what usually stands as 'established' fact or truth, via science and measurement, is only part of the story.

The other parts include meanings, the skeins of human emotions both individual and communal, the rich and deep physical and cultural complexities of our relationships to one another and the world, the nature of our being, and the inchoate ontological and epistemological premises we bring to our storied utterances.

Making one's way with the person, into this unique, multifactorial, multidimensional story of the whole, rests on certain assumptions:

- that the patient always presents, *in some way*, a doorway into their 'story'
- that we can trust that doorway and, given permission, we can enter. This implies certain clinical skills
- that on entering, we can assume any direction is *potentially* open to us because the patient is a unitary whole.

This is heavy freight!

But every approach is 'freighted'. We should not forget that each time a typical biomedical clinician offers a consultation for diagnosis and treatment, it is, in turn, freighted with assumptions of personhood and disease, which have accumulated over centuries of physicalism and mind/body separateness. We know very well the cumulative freight of scientific erasure of the 'subject', privileged diagnostic systems, single organ foci, fragmented specialization, and the attention to bodies and diseases rather than whole persons. Heavy indeed.

In contrast, what does an initial consultation look like when a 'whole person-centred' clinician meets a unique patient with a physical disorder? Of course, it cannot involve hours of obsessional exploration of every possible dimension. It rests on the reality that the story is 'always already' there. It is signified in the simple, the little, and the complex, in the headache, in the inflammatory flare, in the anxiety, and much more. It needs to be *invited*. For those who want to, it can be seen and heard. This is very hard for clinicians who do not see the unity of the whole and the natural connections within.

Simple language and the whole person-oriented consultation with the unique patient: We are immersed in complexity, but communication of this to patients can be very simple. For instance, I may introduce my orientation with language like: "I am interested in whole persons;" "We are all wholes;" "Body and mind are not separate;" "Everything is in there together;" "Many different factors lead to the development of a disorder;" "It's true for all of us;" "But each one of us is different too;" "Because of this, I want to ask you some questions from several angles, physical and non-physical;" "I do this with everybody;" "Are you OK with that?" Clinicians who try to work in a whole person way but don't express this to patients simply, wisely, and generously often get misunderstood.

Saying these things is not formulaic, because each patient and each consultation is unique. Whatever shape it takes, in each consultation I include appropriate exploration of important orthodox diagnostic elements *and* appropriate consideration of potential emotional and relational contributions to the disorder. Deciding what is appropriate rests on vision and wisdom.

In a sense, none of this is simply 'simple', because the comments and language used are merely the surface representation of important background premises. My language declares my *attitude* toward the *person as a whole*, and that *holding this reality between us* is very important for that person's care. Patient responses to this simple, 'plain English', democratising approach, which states the way things are, *and the way patients know they are*, is nearly always open or positive and sometimes enthusiastic, such as "That sounds really good!" Barhava-Monteith's research showed that in these circumstances patients feel "at last, someone is going to treat me as I am" (*my summation of a variety of responses*).

Put another way, I am actively bringing into the encounter *a mix of whole person, dispositional, unitive, multifactorial and patient-uniqueness "freight"*. Patients feel and accept, via the clinician's simple language, the unstated freight of 'whole person-hood', *with which they intuitively agree*, because that is the way things are.

It's more than language: What we say is embedded in a style of *open relating between two persons*, patient and clinician, both of whom have stories and substories. It is ultimately a relationship-based process.

The crucial contrast. In an illness approach oriented to unitive, whole persons, in which all dimensions of personhood are potentially at play, we bring to consultations an implicit freighted language and an attitude which is *very different* to that which is implicit in a practice based on typical biomedical, and dualistic conceptualization and premises.

In this marked difference lies some of the challenge in drawing clinicians toward a whole person-centred approach.

Why is all this important for understanding clinician resistance? It is very difficult to do whole person-centred work, and get traction with patients, without a radical refurbishment of our conceptual and clinical working framework and skills. Otherwise, clinicians keep defaulting or reverting to the narrow dualism of orthodox practice.

There is a wider framework of resistance. It is one thing to act and practice like this with individual patients who are highly motivated to grasp anything that will relieve their suffering, but it is another thing entirely to educate and persuade healthcare professions to change their ways of working.

We tend to assume that clinicians will or should 'see the light' once they have read the right literature, assessed the available evidence, been jolted by numerous case histories, realized the power of qualitative research, or worked alongside us and seen for themselves what can happen when whole person-centredness is privileged.

We expect they will be suitably affected by, for example, the evidence of longitudinal child health studies showing long term chronic illness outcomes rooted in historical abuse, or the epidemiological studies of human need for social connection, purpose and meaning showing the relations between these and disease outcomes and longevity.

We also tend to assume that *just a bit more* of this evidence will make the difference, maybe create a tipping point. We write more papers, books, give presentations, run conferences, and keep revising and refining our concepts and depth of thought. All of which are essential, and very stimulating. We are very fortunate that over the decades there has grown a body of research and academic study in diverse disciplines supporting need for change in the way we approach patients and disease.

Using a mercantile metaphor, I suggest most of this energy for persuasion has been directed at the 'supply' side of healthcare, at convincing professional peers and colleagues. Let's tell them about this change in conceptual framework, and teach them new skills. The hope or fantasy is that if we can change the philosophy and the clinicians, everything might change! Which seems eminently sensible, but it is not very effective.

For example, there been a huge research output over several decades on psychoneuroimmunology, but, as an immunologist, I see no impact on the attention of clinicians or on the clinical care of the myriad of patients with immune-related conditions. And this is in a healthcare environment where evidence is everything.

Still, the general acceptance of the terms 'psychosomatic' and 'somatisation' or 'stress on the body' suggests that most clinicians and patients know or believe people do express emotional aspects of themselves indirectly, in bodily form, as a way of defending against or avoiding such expressions.

Importantly, the deeply embedded dualism of Western culture and medical practice means that this tendency to express one's distress (etc.) in a physical form is only considered in a limited range of disorders, typically characterized as *psychosomatic* or *functional*. All the rest, the 'real' (sic) diseases are to be understood as purely 'physical'. Thus, we have reduced the 'real' diseases to 'body-only', and the many potential mind, relational, social or subjective factors are rendered non-existent.

Clinicians and patients are co-dependent in the enactment of this dualism. Patients have been acculturated to present their physical distress as 'body-only', because that is the way they will be responded to. We know that many patients with chronic illnesses are deeply dissatisfied with this situation. This co-dependence can be reconfigured with clinical language that is simple, educative and normalizing, rather than stigmatizing or reductionist, and when the relational approach of the clinician is warm and person-centred. *Many patients turn out to be not so resistant after all.*

I don't minimize the clinical difficulties that arise because of the acculturation of patients to the biomedical reductive approach. We commonly see patients who are very resistant to confronting certain causal factors in their own health situation. But many patients find

whole person-centred care transformative and healing. This is true for both the so-called 'psychosomatic' or 'functional' conditions and the equally badly named 'organic' (or 'real') physical disorders.

But patient defensiveness and resistance are still not sufficient reason to explain or justify clinician resistance. Clinicians may be consciously or unconsciously wary of whole person approaches because of *their own* stories, illness and suffering, and therefore fears of what might emerge painfully for them in accepting the premises of a whole person approach or multicausality.

I read somewhere recently an assertion that the most powerful force in human society is 'conformity' and 'not passion.' Maybe, or not. But it resonated. In my efforts to communicate the patient stories and principles of whole person-centred clinical care, I have found many clinicians respond very positively to this emphasis and may even agree that a whole person approach might be in the best interest of their patients. Yet they turn away. There is yet another major reason for this. As clinicians we are hugely conformed to the normative principles and practices of our disciplines. Professionalism engenders, maintains and limits insight and creativity. Moreover, a clinician 'belongs' in their profession. It is their 'family.' I don't think we can understand resistance without taking into account our universal need to belong, to be attached safely and securely, much of which has primordial roots in the beginning of life, and in the recognising and evoking nature of relationship with parents. Children go where the 'family' goes, more or less. It is extremely threatening for a child to be marginated, disciplined, excluded, and we work hard to preserve our places in our families. We carry these tropes with us into our adult lives and professions. These adult 'families' have a strong tendency to extrude the eccentric, the marginals, the rebels.

We need therefore to look at the ways the healthcare profession 'families' stifle or resist whole person-centred approaches.

Social and cultural impediments to change: Attempts by clinicians to enact whole person-centred and individualized care of the unique (rather than the statistical) patient are typically swamped by many factors, including:

- the erasure of 'persons' in favour of diseases;
- the limitations of statistical evidence arising from group studies of diagnoses rather than persons;
- the privileging of quantitative over qualitative data;
- pan-cultural, out-of-control technological impulses;
- trends towards the medicalization of suffering;
- the industrialization of healthcare;
- the financial and career investments of clinicians and academics;
- the inherent defensiveness of biomedically trained experts and elites who 'know' best, and presume a dominant power position;

- the deference of major funding systems to the dominant biomedical reductionist model; and so on.

These issues have been focused on by numerous other commentators. It is sufficient for the moment to list them and display the extraordinary potential resistance to any substantial change in approach.

There is more. Let's consider the very grounds of our thinking as clinicians.

Since 1987 I have trained, mentored and supervised both individuals and various groups of physicians, general practitioners, allied health professionals, medical psychotherapists, clinicians doing post-graduate studies, and medical students and groups of mixed disciplines. In facing patients as wholes, the majority struggle to allow multiple perspectives to exist in the same clinical time/space. The ability to 'think' of a *person with illness* as *one*, as a unity, or of mind *and* body, object *and* subject *together* in the same time-space is very difficult for them. It may be there for a moment and then it vanishes.

It seems that the clinicians must narrowly and exclusively choose one perspective or the other, or back away from one to get to the other. There is no or little flow of each to each. Or little ability of the clinician to switch from one perspective to another, and back again. It is as if the patient must be carved into parts, or compartments, rather than seen as wholes.

In this respect, Jean Gebser's extraordinary work *The Ever-Present Origin*^{vii} is valuable. He explores the unfolding and flowering of the structures of human consciousness over millennia. I am concerned here with the most recent, what he calls the Mental structure, which has flowered since the 'discovery' or enlarged capacity for perspectivity in human consciousness. This structure is characterized by *perspectivity*, '*directedness*' and '*sectorial partitioning*'. It is revealed, for example, in the focus of our intellectual creativity upon matters of time and space, measurement, the physical world, and technology.

In medicine, this narrowed perspectivity has been accompanied by a diminishing role for, and valuing of, subjectivity, the person, the patient as subject and as a whole. We are dominated by the excluding, quantitative scientific thinking and technological approaches, which significantly disregard the person as a whole.

Consideration of this structure of perspectival consciousness, and its history, reveals its flowering, fruit and decay. It has hypertrophied to a point where its deficiency is clear to see. Deficit and decay are experienced when we reach beyond the limits of any structured mode of consciousness.

A correction is needed, or perhaps an expansion. Gebser calls for an **Integral A-Perspectival** structure of consciousness. This does not mean **non**-perspectival or **anti**-perspectival, but is a way of seeing the person (and the world) as being '*always already*' *a whole, moment by moment, prior to any useful or limited perspective*. This is what I had come to, over many years of integrating medicine and psychotherapy, whilst treating patients with physical illness.

We do need perspectives but we don't need reduction to one perspective. The problem is that most people, including clinicians, have a deeply entrenched habit of consciousness, awareness, and psychic structuring typical of the Perspectivalist position. This can be argued, but my experience is that most clinicians reveal an entrained and entrenched disinclination for seeing illness from several perspectives and treating people as wholes.

Where does dualism fit? Much has been written on dualism and its consequences. I will just say that dualistic thinking is clearly related to, or is an aspect of the perspectivalist structuring of thought and language, of subject and object, of quantitative and qualitative, of mind and body. The privileging of these dualistic binaries constitutes a strict corralling of thought itself.

Is this all too much?

It seems very difficult to get major change at the current stage. Yet, there are many clinicians scattered, both as individuals and in small clusters, around the world, who share person-centred and whole person-centred emphases, and who have less difficulty in taking an a-perspectival position, or at least moving towards that. And many patients don't have much difficulty either, because intuitively they know they are not 'carved-up', except in the minds and behaviours of clinicians.

So, what next? Historically, using a mercantile metaphor, the efforts made by many of us to bring about change have been largely focused upon the 'supply' side of healthcare, our clinical, professional and academic colleagues. I am not disparaging the importance of continuing research and having good evidence and literature available. We must have a coherent and deep understanding of what we are asserting and undertaking, and we must be able to articulate this clearly on many levels, and to diverse audiences.

Do we continue to focus our energies on strengthening the evidence base, writing more papers and books, and encouraging dialogue across the globe between interested parties? Of course. Each generation of professionals needs to be able to read and hear things in the context of their own time. But do we have the balance right? I suspect that if we maintain our focus on the supply side then each generation will experience the same resistances and results.

What would happen if we focused on the demand side of healthcare, the patients, the *suffering public*, and the *funders of healthcare* (including the political class)? What might happen if we turned our considerable historical and present-day resources towards these groups? Thinking about these resources differently, I suggest we already have a huge

amount that could be presented in a way that is digestible and attractive to the host of humans who know that living as wholes, and being treated as wholes when ill, is intuitively right. I believe there is an appetite. Over the years, I have presented my work to many different kinds of public gatherings. Again and again, the lament is 'why isn't this happening in healthcare?'

Hence this paper! There is no one simple answer. We know that generally-speaking clinicians are sticking with the status quo. Given the dominant position of clinicians, we know that politicians will usually follow the advice of the clinicians, unless the public demand something different. Politicians provide the funding. And, risking cynicism, we also know that humans including clinicians tend to follow the money. Thus, the biomedical model retains its dominance. One cannot disregard the power struggles that would be incurred as the vested, perspectivalist interests of scientific culture, corporate healthcare, clinician groups and colleges, resist, protest and challenge any shift from the dominant ways of thinking and acting.

Resistance to change in healthcare is everywhere and reflecting on these things can be intimidating and discouraging.

A turn towards the 'demand' side, or moving out of our supply-side 'echo chamber' has sociopolitical implications that are foreign to many of us. Personally, I have preferred to work with patients and with clinicians who are looking for something different. I greatly enjoy and value these activities, and they have sustained my hope of a gradual wider take-up of whole person approaches. But I don't think this is sufficient.

There is a need for a wider discussion of where to go from here.

Many questions arise. Is there a way to mobilise a 'demand-side' approach along with maintaining an excellent academic, clinical and philosophical exploration of the issues? Could there be a will to do this? What chance is there for establishing a significant multidisciplinary group with energies for activities beyond the habitual and often exhausting clinical and academic work activities? Are there people willing to do the preparation of demand-side digestible materials? Is there a larger cohort amongst CauseHealth people and our New Zealand resources (to mention just two possibilities) that would make it a more effective journey? How do we tackle the essential role of virtual and social media in communicating and multiplying the relevant messages? Do we need a significant patient cohort with modern media skills in a steering role? Where do we find funding for this? It is a 'think big' situation. We only have to glance at climate change pressures and responses, or the Covid19-related mobilisation of resources to imagine what might be involved as the current model of healthcare moves further into crisis.

But I don't think we should get lost in such questions. I have faith that if this is the time for something like this then a direction will emerge.

I think we should be there, visibly and audibly, as it happens.

I would welcome discussion and response on all these issues.

ⁱ **"Rethinking Causality, Complexity and Evidence for the Unique Patient"**

<https://link.springer.com/book/10.1007%2F978-3-030-41239-5> (Anjum et al)

ⁱⁱ The CauseHealth podcast series: <https://www.wordsmatter-education.com/blog?tag=thecausehealthseries>

ⁱⁱⁱ **B C Broom (2007) *Meaning-full disease: How personal experience and meanings initiate and maintain physical illness*. Karnac Books, London**

^{iv} **B C Broom (1997) *Somatic Illness and the patient's other story. A practical integrative approach to disease for doctors and psychotherapists*. Free Association Books, New York/London**

^v **B C Broom (Ed) (2013) *Transforming clinical practice using a mindbody approach. A radical integration*. Karnac Books, London**

^{vi} **["The Difference Between Being Looked at and Being Seen": an In-depth Consideration of Experiencing the Whole Person Therapeutic Approach for Chronic Illness](#) BarHava-Monteith, Galia (Auckland University of Technology, 2018)**

^{vii} **Jean Gebser, *The Ever-present Origin*. (1949,1953, Authorised translation by Noel Barstad, 1985) Ohio University Press, Athens, Ohio**