Being a doctor, being human

Renaissance humanism as a movement promotes returning to Greek-Roman culture as a means to restore human values, but this definition is not what comes to our minds when speaking of the human values that physicians should hold.

What is being asked of physicians when asked to be more human? Let us take a look at the definition provided by the Random House Learner's Dictionary of American English: "Human. adj. Of, relating to, characteristic of, or having the nature of people. || Sympathetic; kind. || A man, woman, or child."

As with many other things in life, it may also be defined by antagonism or the opposite. The antonym of human is cruel.

So we decided to conduct a survey among physicians to establish what "being human" meant to us. We also asked this question to 5th and 6th year students of the School of Medicine of Universidad Nacional de Córdoba. We wanted to find out what adjective was associated with the **Human** concept.

Ethical was the term most commonly suggested by students. Physicians, unlike students, found more relevance in the term **Caring**, which means "showing concern for others". This is probably because, throughout the course of medical practice, they have experienced this as a useful and tangible value, applicable to everyday activities.

Other outcome measures were also studied in both groups:

- Whether they had participated in any education activity (module, workshop, master class, etc.) on humanism.
- Those who answered YES were asked if they had considered it useful for their present or future professional development.
- Those who answered NO were asked if they believed that it would have helped them or if they considered that ethical and human principles learned from their families were enough.

Only half of students and physicians had participated in an education activity related to the humanities. This evidences that, from the perspective of curricular content and teaching approaches, this subject is considered insignificant. One hundred percent of students had taken Pharmacology, Microbiology or Anatomic Pathology, courses considered to be "serious", having ample resources and work load assigned to develop the proposed objectives. The humanities is sometimes only considered an activity, a break between "actually useful" courses.

However, when asked if the study of humanities would have been useful, all physicians answered affirmatively. This suggests that, in everyday practice with real people, physicians had required a stronger training in the humanities, and that the tools learned from their families were not enough, not because they were scarce but because they were now playing a different and difficult role with as many nuances as patients they had to see.

Communication skills, for example, are essential for developing empathy and a bond with patients so as to achieve a full and comprehensive understanding of their health/disease situation and context.

But this would be a partial view if we only considered the "doctor" component of the doctor-third-party (patient) dyad. So, in a different section of the same survey, we decided to ask patients what attributes they considered their physicians should have.

They were asked to rank the following attributes in order of importance:

A. Having good listening skills.
B. Being affectionate.
C. Having scientific knowledge.
D. Devoting more time to office visits.

Good listening skills came in first. These are critical for communication and the exchange of ideas. Technical and scientific capacity was pushed into second place. It seems that patients want **humans**, people to share their health/disease experience with and who also have medical knowledge. They look for a smart and skillful heart.

Medicine poses two poles of the same world: science or "scientism" (cold, abstract, logical) and humanism (strong, passionate, affectionate). From the balance between these two human medicine will be able to emerge. But these situations are larger than ourselves, they concern every professional activity. Lawyers and architects also fluctuate between these two stances. For this reason, it is essential for every man, whatever their profession or trade, to have a more human attitude.

To this end, it is necessary to cultivate human sciences, such as:

- Words (language), as a communication experiment between two whole beings (body and soul).
- History, to provide a context to the reality and experiences of that "other being".
- Art, as a means to exalting the soul and values of men.

As stated by Mexican Professor Ruy Pérez Tamayo: "an educated physician is a better physician, not just because he/she is a physician but because he/she is a better human being".

In spite of standards, rules and works on "medical ethics", these usually refer to medicine and medical science rather than physicians as individuals. Professionals should be guided by "medical ethics", which should be the same as ordinary men's ethics. There are no dehumanized physicians; there are dehumanized people.

It is worth noting that the core of medicine is the doctor-patient relationship, a human relationship like many others, such as friendship or a father-child relationship, although its purpose is sometimes seeking health, and always bringing peace. As a human relationship, it requires an essential component: affection. We should add love to our medical practice; feelings bring people closer, overcome barriers, brighten things up, iron differences among people and their history.

In everyday medical and clinical practice, we may need better speaking and listening skills. Many times we will need to work from the heart, not just using our brains. We should awaken cosmic interests so that our light shines at everything. We should exercise medical and other type of knowledge through interdisciplinary and transdisciplinary activities in conjunction, each doing their part. We should learn to see life, people, and their reality, which are as varied as they are single and important, from a holistic perspective. Finally, we should also treasure a bit of a clown in our soul, so that tears and smiles live together in harmony, and keep hope and joy on edge, even in the most painful places of our soul. ■

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An attempt to include happiness within the psychiatric disorders

PREFACE

The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V)[1] extends the range of new diagnostic criteria for adult and pediatric conditions. Since these criteria are so wide, there is a risk for a large portion of the general population to be included in one of the diseases described in the manual. On this basis, and in order to be consistent with the DSM-V, I thought it was appropriate to make a comment on an excellent article by Richard Bentall, from Liverpool University.[2] His article is longer than this comment, and includes a more extensive bibliography, but here I describe the complexity of definitions and the classification of "disease" as a nosologic category established as necessarily true.

Doctor Bentall's considerations are quoted in italics.

ARTICLE DESCRIPTION

Bentall introduces his article by stating *"Happiness is a phenomenon that has received very little attention from psychopathologists; for this reason, research on the topic of happiness has been rather limited. Nonetheless, the guidelines described*

in the DSM-V provide sufficient case for classifying happiness as a psychiatric disorder. Although this proposal is likely to be resisted by the psychiatric community, the diagnostic criteria for happiness might be even more secure than those used to diagnose schizophrenia and other conditions".

Bentall based his work on Argyle M.'s research,[3] which recognizes three components to happiness: affective, cognitive, and behavioral. *"There are happy people across all cultures, which suggests that happiness may be biological in origin. Uncontrolled observations, such as those found in plays and novels, suggest that happy people are often carefree, have a high frequency of recreational interpersonal contacts, and display prosocial actions towards others identified as less happy. In the absence of physiological markers of happiness, it seems likely that the subjective mood state will continue to be the best diagnostic criterion* (as occurs with pain). *Argyle has remarked that 'if people say they are happy then* ***they are happy****'".*

"The epidemiology of happiness is little-known, its incidence and prevalence depend on the diagnostic criteria used, as is the case of the diagnostic limitations posed by schizophrenia. Thus, although a survey conducted in the United Kingdom found that 25% of the sample said that they were 'very pleased with things yesterday',[4] Andrews and Withey found that only 5.5% of adults felt 'satisfied with life'.[5] In addition, if television soap operas in any way reflect real life, happiness is a very rare phenomenon indeed in places as far apart as Manchester, London and Australia. The prevalence of happiness also depends on the social classes: individuals in the higher socio-economic groupings generally appear to feel they 'enjoy life more' than lower socio-economic classes".

"The etiology of happiness is unknown but some theories have implicated it is the result of positive life-events, while the advocates of genetic factors state that some people are generally happier than others, therefore reinforcing biological reasons related to self-esteem and social skills.[3,5] With respect to the environment, there seems little doubt that discrete episodes of happiness typically follow positive life-events. Moreover, several brain centers and biochemical systems have been observed to be related to this disorder; stimulation of various brain regions has been found to elicit the affective and behavioral components of happiness in animals, as has the administration of drugs such as amphetamine and alcohol".

"The question of whether or not happiness is a disease is yet to have a clear answer, but a sensible approach makes it worth referring to other psychiatric disorders, e.g. schizophrenia, bipolar syndrome, etc.[6] As these conditions, happiness may be best thought of as a dimension of affect. However, the relationship between the dimension of happiness and other affective dimensions remains unclear. Thus, in a factor-analytic investigation it was observed that reports of happiness and reports of negatively valued affective states loaded on separate factors, suggesting that they are independent of each other".

"Interestingly, people who report high-intensities of happiness also report high intensities of other emotions, suggesting that happiness is related to a neurophysiological state of disinhibition; nonetheless, the frequencies with which people report happiness and the negatively valued affective states appear to be negatively correlated".

"Some confusion also exists about the relationship between happiness and mania. Although Argyle[3] has noted that mania, in contrast to happiness, is mainly characterized by excitement, the diagnostic criteria for hypomanic episodes employed by the American Psychiatric Association seem to allow happiness to be regarded as a subtype of hypomania".

"Just as it is possible to elicit schizophrenic symptoms in some individuals by stimulating the parietal lobes, so too it is possible to produce happiness (by stimulation of subcortical centers). It has been suggested that positive (euphoric) and negative (depression) emotional states are regulated by a balance of both subcortical brain centers. Thus, abnormal affective states reflect a disturbance of this balance".

"There is a lack of clear data to state that happiness is statistically abnormal, but should it be associated with a biological disadvantage, it would be enough to consider it a disease. There is empirical evidence of an association between happiness, self-indulgence, obesity and alcoholic beverages. Given the link between both alcohol and obesity and life-threatening illnesses, it seems reasonable to assume that happiness leads to impulsive behavior and poses a moderate risk to life".

"Happiness may be considered a disease also from a philosophic perspective. According to Radden,[7] the difference between a behavior that should not be the subject of psychiatric scrutiny and a psychiatric disorder is the ***irrationality*** *of the latter. Irrationality would be a behavior that is bizarre, leads to no specific utility, fails to realize manifest goals, is contradictory, with no apparent sense and a lack of impartiality. Many of these characteristics are observed in happy states. Happy people overestimate their own achievements and share their unrealistic opinions about themselves when comparing to others. It is clearly evident that people suffering from happiness should be regarded as psychiatrically disordered".*

"One possible objection to this proposal is that

happiness is not normally a cause for treatment, but this may also be argued for other conditions such as anorexia nervosa and sickle-cell anemia, which became recognized as diseases that should be treated well into the 20th century. Also, the fact that a condition is culturally accepted as positive is extremely dangerous; there is a risk of accepting as adequate the tradition of certain Hindu sects of burning widows alive so that they can join their recently deceased husband into the next world".

On this basis, Bentall proposes that happiness be included in the DSM-V under a more formal title and replacing "happiness" by "**major affective disorder, pleasant type**".

COMMENT

Bentall raises several fundamental questions:

First of all, it stands out that he managed to publish his article in a medical ethics journal. He probably believed that this was a transdisciplinary issue that involved medical practice in general, regardless of the discipline.

He sets out the debate on what disease means. Strangely, physicians rarely even consider such classification. As physicians, we believe that diseases are entities that existed before medicine, and that medicine only came to discover them, just like the laws of nature are once first described. But, as it turns out, there are no diseases in nature; the concept of disease is a social construct,[8] and its criteria depend on culture.

To Egyptians, a malformation was a warning of their gods regarding the outstanding nature of the malformed subject that had to be respected; a seizure in the Middle Ages meant a demonic possession. In 1950 in Argentina, homosexuality was mostly considered a disease, and now equal marriage is legal.

As indicated by Bentall, another criterion that may be used to define disease would be statistics but with variations in the prevalence of happy people across countries, as occurs with hyperactivity disorder, which is extremely variable.[6]

The third criterion to define disease is the obvious "need for treatment" but once again, this criterion poses problems in relation to culture and even politics. In the 1950s in the Soviet Union, many political dissidents were considered "mentally ill" and were confined based on their disagreement with the regimen.

There are many examples of the definite influence of culture, history, and even politics on the creation of disease, so it may be easily deducted that these criteria may be influenced by financial factors. In this case, reasoning would be as follows: "If defining something as a disease is profitable, let us recognize it as such".

In my opinion, it would also be necessary to solve the problem of extreme deviations from normality, e.g., height that is less than the 3rd percentile (by definition, short stature), or children who are either very quiet, very active, or even very rebellious (let us remember there is a condition called "oppositional defiant disorder"[9]), as many other deviations from human behavior which are considered discrete.

These are social constructs of our culture, categorizing them as "disease" may lead "affected" individuals to become a cause for therapeutic concern, resulting in their exclusion from the normal population.

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BRUE: A new term and approach that could improve our practice

Throughout the history of medicine, there are many examples of definitions and terms associated with a specific approach or practice that have changed health care and have possibly improved results. For example, acute scrotum, acute surgical abdomen, and metabolic syndrome.

The term ALTE or apparent life-threatening event was established by expert consensus in 1986 and was intended to solve problems with the term "near-miss sudden infant death syndrome," which was used until then because there was no evidence relating it to sudden infant death syndrome (SIDS).

An ALTE may occur during sleep or a waking state. From an epidemiological perspective, it occurs at an earlier age than SIDS, i.e. one to three weeks earlier.

An ALTE was defined as an unexpected, sudden episode that is frightening and means impending or actual death to the observer. It is characterized by the combination of some of the following signs: respiratory pause, choking or gagging, color change (cyanosis, pallor, or florid complexion), and change in muscle tone.

One of the conclusions of an article published by us in 1995, last reviewed –to our delight– by Carlos Gianantonio, M.D., was that an ALTE did not account for a diagnosis in itself but simply referred to a clinical presentation.[1]

Acronym dissemination and its practical offshoots initially led to an improvement in diagnostic processes by differentiating, on one side, a mild event from a major one depending on the cardiovascular stimulation or resuscitation measures required to modify its course and, on the other side, according to the final diagnosis of idiopathic ALTE or ALTE secondary to various diseases.[1-3]

Over the years, different consensus meetings reinforced the need to take an adequate case history and do a careful physical exam to move forward with a selective testing schedule that is consistent with clinical experience and adequate for severe cases.[3]

However, many times medical practice has favored the performance of a series of diagnostic procedures, including patient hospitalization, although this may lead to an unnecessary risk, which on numerous occasions would probably fail to result in a treatable diagnosis.

The definition of ALTE caused uncertainty among health care providers because it assigned the event an inaccurate meaning by including the observer's subjective perception that it was life-threatening or a feeling of impending death. Such perception resulted in a, many times, excessive health care and diagnostic response, rather based on a defensive attitude than on scientific knowledge, therefore evidencing how inadequate the term was.

The American Academy of Pediatrics (AAP) has recently published a new clinical practice guideline that recommended replacing the term ALTE with a new term: BRUE (brief resolved unexplained event).[4]

The authors define BRUE as an event occurring in infants younger than 1 year of age that is sudden and brief (lasting < 1 minute), and resolves at the time of consult, characterized by at least one of the following signs: cyanosis or pallor, absent, decreased, or irregular breathing, marked change in muscle tone (hyper- or hypotonia), or altered level of responsiveness.

The current proposal also indicates that an event should be considered a BRUE only when there is no explanation after conducting an appropriate history and physical exam.

The AAP Subcommittee on ALTE performed a comprehensive review of the scientific literature from 1970 through 2014 to make the initial recommendations on BRUE management in infants.

Patients younger than 1 year old having a BRUE are classified as low-risk or high-risk patients based on their history and physical exam.

The guideline provides recommendations for BRUE with a low risk of recurrence and without an underlying condition which, in children who comply with the specific criteria, would allow a more conservative management.[4]

Based on this new definition, new guidelines or practice approaches will be agreed upon by scientific societies and in different health care settings for the management of children having these events. Such modification will possibly bring about a better quality, child- and family-centered medicine, together with a reduction in unnecessary and costly interventions.

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