SOUNDING BOARD

THE PSYCHOLOGY OF RESPONSIBILITY

Some Second Thoughts on Holistic Medicine

HUMANISM and holism have hit the medical profession with the searing force of righteous anger, and the health-care system will never be the same. As a powerful counterforce to the increasing technology and dehumanization of post-Flexnerian medicine,[1,2] which posits an omnipotent technician-physician and a passive, helpless patient, humanism and holism emphasize consideration of the person rather than the disease,[3] the interpersonal relations between physician and patient[4] and the individual patient's responsibility as an initiating participant in his or her own health care.[5] Responsibility is a key word in the humanistic rhetoric. People are encouraged to take responsibility for maintenance of positive health. Patients are extolled to become active warriors in the fight against their diseases.

Such rhetoric arouses in us a variety of emotions. On the one hand, we acknowledge that this trend is all to the good. For too long, people have been shut out from the care and maintenance of their own minds and bodies. For too long, they have been passive observers, the playthings of overeager biomedical scientists, pharmaceutical firms or Madison Avenue admen. On the other hand — and the other hand is what this article is about — there seem to be several caveats that we need to consider in relation to this newly discovered insistence on individual responsibility in health care.

At the simplest level, all these encomiums for personal responsibility strike us as somewhat irresponsible. Our culture trains us, through its legal, community and family value systems, to seek a leisurely life-style of inadequate physical movement, a diet rich in fats and carbohydrates and lacking in essential nutrients, and a reduction of tension through the use of tobacco, alcohol and other drugs. How can you bring up a whole generation on eggs and bacon, only to adjure them to pay attention to their cholesterol levels? How can you bombard the adolescent mind with infinite inducements to pick up a cigarette and then expect the adult mind to protect his or her heart and lungs? A great deal of energy, brain power and, above all, money has gone into marketing bad health in this country. It is naive and indeed irresponsible to hope that a few single-spaced articles in *Consumers Reports* will turn the situation around. The most likely outcome of this strategy will not be self-responsibility but only self-incrimination. Having been given none of the skills of taking responsibility, having had all too few experiences in their prepackaged lives for actually assuming responsibility, most people will cling to their candy bars and their cigarettes.

In this vein, what is needed at this point is not more platitudes about responsibility but a stress on the practical aspects of learning how to engage in responsible behavior. The skills of responsibility are complex and need detailed examination. In brief, they may include a familiarity with decision-making paradigms, an ability to analyze one's environment for positive and negative influences and a competency in assessing contingencies so as to modify one's own strengths and weaknesses.[6] If we are to talk about responsibility, let us begin by teaching people how to be responsible, and let us harness the powerful forces of Madison Avenue advertising to help us in this educational process.

However, this problem of skill deficits in responsibility is far from the only flaw in the be-responsible approach to health care. The approach produces guilt feelings about failure of will power, and also guilt feelings about what becomes, by definition, a basically self-destructive impulse. Consider a 23-year-old woman who, a few days after hysterectomy, cries, "Somehow I did this to myself. I could have prevented this awful development in my life, but I didn't. I brought this on myself. It is my fault." These kinds of feelings certainly do not contribute to good patient care. We are concerned that there is callousness in any philosophy that provokes this sense of abandonment and self-condemnation. Patients are isolated, left to their own resources. Furthermore, a convenient by-product of this line of reasoning is that it lets society off the hook. If the individual alone is responsible for his or her own well-being, society can continue to encourage us to abuse our bodies and, even worse, can continue to profit from these abuses.

No one would (or should, at any rate) deny that a person's psyche can have a tremendous, overwhelming effect on his or her well-being. In this sense, responsibility is the welcome return of what has always been rightfully ours — ourselves. But lingering just below the surface is a disturbing element in all this emphasis on self-responsibility. The term has a vaguely Thoreauian ring about it — self-responsibility, self-reliance, the hardy individual standing firm against all that comes. According to the be-responsible gospel, we are told to battle our cancer cells, fight invading viruses. The rhetoric posits a basically antagonistic relation between the individual and the disease.

However, such an attitude is uniquely Western, as any cross-cultural survey will attest. Other cultures, such as the Buddhist, endorse a quite different attitude toward disease. Death and disease are accepted as part of life, not viewed as forces to be repelled and struggled against. Eastern philosophy, for example, accepts human beings as small in the vastness of nature, even when an aberration of nature (such as disease) is concerned.[7] Westerners, by contrast, have always charged ahead, determined to conquer nature in all its forms. In the be-responsible language, conquering remains the prevailing idiom. There seems to be little place for acceptance or yielding in this model. Not that the fighting spirit is always misplaced — far from it. Our quarrel is simply with a widespread in-

sensitivity toward the limits of people's power over themselves.

This brings us to another peculiarly Western characteristic, which involves an overweening desire to be in control — of our jobs, our lives, our diseases, our deaths, our universe. Somewhere in all this push for self-responsibility we see a basic contradiction. No matter how purely we eat and drink, no matter how carefully we guard the air we breathe, no matter how much we become involved with our doctors and they with us, the mortality rate will still be 100 per cent. Not all diseases and decay are self-induced. The process of living wears us down as much as we wear ourselves down. Somehow the rhetoric of the be-responsible movement suggests that we can postpone and even reverse this inevitable process of decay. Ironically, we have come full circle to the notion of omnipotence in health care, only this time around it is not the physician who is omnipotent but the patient. Somehow, if we can only control enough, be disciplined enough and be powerful enough, we can prevent all that is potentially bad in our lives.

Into the righteous rhetoric of the holistic health movement, we would like to inject a reminder of compassion and humility toward ourselves and others. Certainly, we are not suggesting a return to the ignorant, passive patient whom everyone platitudinously protected to no avail. We have a right to know what foods are poisonous; we have a right to know why we are sick; and we have a right to know why we may die. We also need to learn to take responsibility for influencing all these aspects of our lives and deaths. By all means, let us aspire to longer, healthier and more physically and psychically fulfilled lives. By all means, let us engage our doctors in discourse, and let us engage our diseases as well. But let us not abandon our sick and dying, and let us not condemn them. Let us give them skills to be responsible, as well as the knowledge that responsibility for one's life can extend only so far, and beyond that, let us learn a yielding and an acceptance.[8] We must remember the limits of responsibility, remember our mutual responsibility as interrelated human beings and, above all, remember our own finitude.

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CORRESPONDENCE

Letters to the Editor are welcomed and will be published, if found suitable, as space permits. They must be signed, typewritten in double spacing (including references), submitted in duplicate, must not exceed 1½ pages in length and will be subject to editing and possible abridgment. To be considered for publication, letters referring to a recent *Journal* article should be received within six weeks of the article's publication date.

MESANGIAL DEPOSITS (BY ELECTRON MICROSCOPY) IN IDIOPATHIC MEMBRANOUS GLOMERULONEPHRITIS

To the Editor: In Case 14-1979 in the issue of April 5 Dr. McCluskey observed that mesangial deposits found by electron microscopy are very uncommon in idiopathic membranous nephropathy, whereas they are common in the membranous lesions of systemic lupus erythematosus.

In an attempt to determine the prevalence of such mesangial deposits in membranous nephropathy without lupus, we reviewed the electron micrographs of renal-biopsy specimens from 107 patients followed at the University of California in San Francisco.

In nine (8.5 per cent) of these patients, mesangial deposits were observed; they were minimal in five, moderate in three and extensive in one. These patients were followed for two to 16.5 years (mean, 9.8), and in none did clinical or serologic features of lupus appear. This subset of nine patients did not differ from the membranous group as a whole.

Thus, mesangial deposits may be encountered in idiopathic membranous nephropathy and, though uncommon, should not be used to exclude membranous nephropathy due to causes other than lupus.

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The above letter was referred to Dr. McCluskey, who offers the following reply:

To the Editor: One of the problems in evaluating the frequency of mesangial deposits (as seen by electron microscopy) in patients who appear to have idiopathic membranous glomerulonephritis is that some of these patients subsequently have evidence of systemic lupus erythematosus. The findings of Drs. Shearn, Biava and Hopper are therefore of particular interest, since they are based on a group of patients who were followed for sufficiently long periods to make the diagnosis of systemic lupus erythematosus unlikely. The finding of mesangial deposits in 8.5 per cent of cases is higher than that cited by Ehrenreich and Churg,[1] who failed to find mesangial deposits in 50 patients with membranous glomerulonephritis. Obviously, variations in sampling technics may account for the differences. Furthermore, it seems likely that the category of idiopathic membranous glomerulonephritis is itself heterogeneous in terms of causative factors or antigens involved, and there may therefore be a higher incidence of mesangial deposits in some groups of patients than in others.

In any case, even the findings of Shearn et al. indicate that "moderate or extensive" deposits are rare (3.7 per cent) in idiopathic membranous glomerulonephritis and certainly much less common than in membranous lupus nephritis, in which the great majority of patients have mesangial deposits.[2]

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