Paradigm Shift:

Godly Change in the Language of the Workplace

A train traveler on a busy city line looked on with consternation as a man with three small children entered his already crowded carriage. His consternation increased as the father let his children run riot, climbing on seats, fighting and smearing sticky fingers on all within range.

Annoyance mounted and eventually unable to contain himself any longer the traveller spoke to the father demanding that he control his children. "I am sorry" the father said coming seemingly out of a daze. "We have come from the hospital. My mother has just died and to be honest I am not coping too well."

As the father spoke the traveller underwent a dramatic change in the way he viewed the situation. He came to see that the same information data set could be interpreted in a completely different way. He shifted paradigm. His change parallels the change in worldview we undergo as we switch from Greek dualism to a Biblical view of healthcare.

Paradigm shift, ***reductionist theory*** and ***systems theory*** are phrases out there in the language of the workplace that could be used to progress the discussion of "Biblical Healthcare".

In the days of Babel, mankind had a common language. Unfortunately the people used this gift to raise themselves up against the purposes of God. They sought to build themselves a city, with a tower that reached to the heavens, so that they could make a name for themselves. The Lord therefore "scattered them over all the earth" and "confused the language of the whole world". The fact that a common language would allow a city to powerfully develop was not in question. At the present time, as we consider Biblical change to the city of Healthcare there is a clear need for a common language. We need to be able to communicate clearly with people from diverse backgrounds. If we use the language for Godly purpose, and not to create an idol of the city, as our forebears did at Babel, then "Biblical" transformation of the city of Healthcare is possible.

Often our ‘Christianised’ language excludes rather than includes, and discourages rather than encourages, workplace discussion of the spiritual. So what does a common language sound like? How do we as Christians in the workplace develop it's sound. How do we facilitate discussion over lunch in the staff room of issues like worldview and Biblical healthcare? My thinking is that we need to take words from both the workplace and the theological spheres. We as workers in the system need to weave the tapestry of a new language from the two strands.

Much of what the Lord has been challenging us about in Health Care in Christ is already under discussion in the language of the workplace. There is now, more than ever, an opportunity for us as Christians to enter into and contribute to the development of the debate.

Thomas Kuhn in his book "The Structure of Scientific Revolutions" (1967) defines ***paradigm*** as a “set of perceived beliefs that are not questioned" or a "set of shared assumptions". ***Research*** is seen as a "strenuous and devoted attempt to force nature into the conceptual boxes supplied by professional education". ***Anomalies*** are situations that do not fit into the conceptual boxes. The process of change begins when science encounters anomalies.

Kuhn's theory can be applied to healthcare and there is, at this time in history, a stirring of revolution in the air. The old ***paradigm*** is also known as the ***biomedical model***. It stems from Greek thought and a dualistic worldview. The model is a ***reductionist theory*** where one strips away the confounding psychological, social and spiritual issues to arrive at the pure biological assessment. In essence the model is based on illness and cure (Fig. 1). The patient is the one with the disease or illness. The disease is independent of the person who suffers it and their social context. Physical and psychological diseases are separate except for the psychosomatic category where psychological factors are causative of physical symptoms. Each disease has a specific causal agent. The task of a doctor is to make a diagnosis and provide a cure. In interaction with the patient, the doctor remains a detached observer and the patient a passive (and hopefully grateful) recipient of treatment. Any personal relationship between doctor and patient is not relevant to the interaction and can be frowned upon by peers.

However, ***anomalies*** and problems with the biomedical model abound and particularly so in chronic illness. Take for example, headache or persistent abdominal pain in a general practice setting. Often there are not specific diagnostic labels that can be readily applied. Treatment and cure are not always possible. Patients, I believe, often perceive the injustice of the application of a purely biomedical or dualistic model to their situation. If we are inherently interwoven mind/body /spirit then to separate us into unrelated mind and body categories constitutes an infringement of human rights. The biomedical model disempowers patients because they are reliant on the doctors and medical system rather than their own resources.

So a new paradigm is under consideration (although more strongly in some areas of healthcare than others). A ***systems theory*** rather than a ***reductionist*** approach can be taken. In this, one approaches a problem by considering all significant relationships rather than reducing to simple linear relationship. This is known in the language of the workplace as the ***biopsychosocial model.*** The concept is useful although the name neglects the spiritual aspects. In a ***systems approach*** it is recognised that the system cannot be fully understood by studying individual parts. One needs to

know how parts interact to define overall purpose. A change in any part produces a change in the system as a whole. Figure 2 illustrates a systems theory model of health. Multiple inter-related compartments can all contribute in different ways to a person's health problem. The spiritual component sits above and yet permeates through: "one God and Father of all, who is over all and through all and in all". This approach renders the biomedical model not wrong but simply incomplete. In a medical approach we may be able to address tissue or organ system level of function but we would do well not to forget the other compartments where the spirit of God and the contribution of the person, their family and culture permeate through to contribute to health.

In a systems theory approach conventional disease categories can still be used but within a context. All illnesses have physical, psychological and spiritual components to a greater or lesser degree. All illnesses have multiple causes. The relationship between the healthcare team members and the patient has a profound effect on the illness and it's course. The culture and beliefs of the treating person/team and patient are relevant and the "healing dialogue" between the two is fundamental (Fig 3). The task of the health care team does involve understanding the physical nature of the illness but also includes understanding the patient and the meaning of the illness to him/her. The focus is on a healing journey rather than specific cure. In this model to neglect to consider the culture and beliefs of the patient and oneself constitutes sub-optimal care.

The application of a ***bio-psycho-socio-spiritual model*** to health can influence our interaction with patients in very practical ways. In ***assessment*** of patients we need to allow them space to tell their story. This will help us to identify key beliefs and the meaning of their illness to them. ***Diagnosis*** needs to be multi-compartmental and to be described in terms that are meaningful to the patient. This allows for a shared understanding of the problem and discussion of the contributions of both patient and healthcare team to the healing journey. ***Treatment*** also must be broad-based flowing from the multi-faceted diagnosis. The medical component of treatment needs to be seen as a component part of a program requiring the patient's active participation. Medical intervention needs to lead the patient to a sense of growing mastery over the illness rather than a sense of disempowerment. The treatment plan needs to build their sense of responsibility for their own life rather than a handing over of responsibility to the medical system.

These theoretical concepts and practical strategies are, I believe, well worth further discussion. In developing the concepts further from a Christian perspective we will inevitably empower patients and precipitate interesting lunchtime discussion and we will potentially contribute to our Lord's transformation of the City of Healthcare.

Chris Hayes

Background References

Kuhn TS. The Structure of Scientific Revolutions. University of Chicago Press. Chicago 1967.

McWhinney IR. Chapter 5: Philosophical and Scientific Foundations of Family Medicine p43-71. In McWhinney IR. A Textbook of Family Medicine. Oxford University Press. New York 1989.

Minas H. Cultural Diversity: Ethics and Practice. Presented at Dean's Lecture Series, University of Melbourne 25 July 1997.