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The good treatment: a biopsychosocioethical proposition

Jens Gaab PhD^a, Marco Annoni PhD^b, Charlotte Blease PhD^c, Heike Gerger PhD^d and Cosima Locher PhD^e

a Full Professor & Head of Department, Division of Clinical Psychology and Psychotherapy, Faculty of Psychology, University of Basel, Basel, Switzerland

b Researcher, Institute of Biomedical Technologies (ITB), National Research Council of Italy (CNR) & Fondazione Umberto Veronesi, Milan, Italy

c Researcher, Program in Placebo Studies and the Therapeutic Encounter, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA, USA & School of Psychology, University College Dublin, Dublin, Ireland

d Senior Research Assistant, Division of Clinical Psychology and Psychotherapy, Faculty of Psychology, University of Basel, Basel, Switzerland

e Post Doctoral Researcher, Division of Clinical Psychology and Psychotherapy, Faculty of Psychology, University of Basel, Basel, Switzerland

Abstract

While there is undisputedly a great need to establish, maintain, evaluate, provide and disseminate good treatments, the consensus as to what constitutes a good treatment is far less established. Here, we deconstruct the phrase into its components, seeking to describe definitory elements of both what is to be considered a treatment and how this could be good. Thereby, we identify deliberateness in the context of an adequately empathic and humane relationship as being at the core of a good treatment. Thus, care becomes treatment when provided deliberately and treatment becomes good, when provided deliberately with care. Since this understanding encompasses biological, psychological and social treatment constituents in the context of ethical considerations, we propose a 'biopsychosocioethical' model for treatment as a conceptual frame, which is centred on a shared understanding of what should be achieved by the treatment and how this is achieved.

Keywords

Biopsychosocioethical model, care, deliberateness, empathy, ethics, patients as agents, person-centered healthcare, suffering, treatment

Correspondence address

Professor Jens Gaab. E-mail: jens.gaab@unibas.ch

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Introduction

While there is undisputedly a great need to establish, maintain, evaluate, provide and disseminate good treatments, the consensus as to what constitutes a good treatment is far less established. Here, we deconstruct the phrase into its components, seeking to describe definitory elements of both what is to be considered a treatment and how this could be good. Thereby, we identify deliberateness in the context of an adequately empathic and humane relationship as being at the core of a good treatment. Thus, care becomes treatment when provided deliberately and treatment becomes good, when provided deliberately with care. Since this understanding encompasses biological, psychological and social treatment constituents in the context of ethical considerations, we propose a 'biopsychosocioethical' model for treatment as a conceptual frame, which is

centred on a shared understanding of what should be achieved by the treatment and how this is achieved.

Starting from scratch

Survival is crucial and thus several securing and allowing mechanisms have been established during the course of evolution. These range from basic behavioural reactions, diverse and interacting regulatory feedback systems to secure homeostasis, to rather sophisticated and specific biological responses to both internal and external threats. The complexity of these systems is not only a function of the complexity of the respective organism and its organization with and within fellow organisms. Furthermore, these complexities are mutually interacting as a more complex and effective equipment of a given organism not only leads to more complex and effective responses to threats, but this also leads to the further

development of the 'equipment' at hand and in consequence further elaboration of this organisms' measures to secure survival.

While these considerations do not specifically focus on treatments since the aforementioned mechanisms lack a distinct characteristic (i.e., the attempted use of remedies whose constituents are defined by a therapeutic theory), treatments can be still seen as their consequence. Fabrizio Benedetti aptly depicted this in the titles of the respective subchapters of his seminal *The Patient's Brain* [1] which can be summarized as "from cellular to social responses" and as a sequence "from scratch to grooming to scratching someone else to altruistic behaviour to taking care of the sick". Furthermore, and importantly, these mechanisms could serve as a basis to dwell on the components and preconditions of what could be considered a treatment or more precisely - a good treatment.

What is a good treatment?

Taking care of the sick is both a characteristic and an indicator of civilisation and measures to secure and enhance the quality of care are a constant in societal and global development. As much as this has become a matter of course (e.g., in the Constitution of the World Health Organization), the definition of what is to be considered a good treatment seems to be subject to the respective point of view. These perspectives encompass - admittedly, this list is not complete - efficacy, specificity and side-effects, availability, cost-effectiveness, expediency, feasibility and acceptability, including the way treatment decisions are obtained. For the sake of clarity and simplicity, the good treatment will be fragmented in its components, that is, "treatment" and "good", considered individually and then discussed in consolidate fashion. This not only helps to understand both components, but also to identify their mutual interaction. Thus, only when we understand what constitutes a treatment, are we able to administer this treatment and only when considered good, is its administration justified.

What is a treatment?

It needs to be noted that although some species show extraordinarily sophisticated and effective social behaviours to deal with health threats (such as social networking of ants to decrease disease transmission, [2]) or extraordinary levels of empathetic care (such as otherwise unaffected elephants showing consolation toward conspecifics in distress [3]), the provision of a treatment, at least in the current understanding, appears to exceed these social responses. Although it is tempting to consider the conceptualization and provision of treatments to be an exclusive human ability, this would only hold true if these treatments employed different mechanisms and/or clearly surmounted the effects of the aforementioned responsive social qualities. But perhaps this distinction - between a social response and a treatment - is itself not only not feasible, but also unproductive as this would exclude the

very origins of treatments, i.e. the taking care of others. The current definitions of treatment are not selective and also vary between sources. Although they commonly denote the provision of "something" to the sick in a curative manner, this "something" remains elusive and encompasses "drugs, exercises, etc." (Cambridge dictionary), "substance or technique" (Merriam-Webster dictionary), "medicines, surgery, psychotherapy" (dictionary.com), "medical care" (Oxford dictionary) or "medical attention" (Collins dictionary). Also, the word "treatment" itself is not distinct from adjacent constructs, but rather seen in a semantic field next with "care", "therapy" and "intervention" (Wikipedia "Therapy"). According to Wikipedia, the connotative level differs between these constructs, with "care" being more holistic and "intervention" being more specific, and with "therapy" and "treatment" being either, depending on the respective context. Thus, while these definitions do not really provide an exact understanding of what constitutes a treatment, they nevertheless convey a sense of the breadth of this term as well as stake out the frame in which treatments are to be located.

Deliberateness

Coming back to the - probably neither warranted nor helpful - comparative distinction of treatments being exclusively human by design, one might argue that deliberateness might be yet another aspect which could well serve as a divide between supportive, amenable, beneficial social behaviour (such as social support, relationships, trust and empathy in general and the clinical context) [4-7] and what is considered a genuine treatment. Notably, it is not the quality of the respective social behaviour or aspect itself, but rather its deliberate use to serve a clinical purpose, that is, to use it as a treatment, that could serve as a possible delineation between what is to be considered a treatment and what is not. Bruce Wampold - a prominent psychotherapy scholar - reasoned with respect to psychotherapy that the "(...) interpersonal relationship between therapist and patient (...) are robust predictors of outcome and are likely causally involved in producing the benefits of psychotherapy" [8]. Thus, these interpersonal aspects might turn from "mere" social response qualities into a full-grown treatment by "just" using them in a deliberate fashion. Interestingly, although these social response qualities are not exclusively human, Wampold aptly combined both the availability of these qualities with the possible uniquely human ability of using these very qualities deliberately for the treatment of the sick in the title of the respective publication: "Psychotherapy: The Humanistic (and Effective) Treatment" [8]. In summary: we can observe a move from intuitive, non-conscious, and instinctive support for the sick or injured among kin, towards a realm of healthcare that is increasingly reliant on conscious, explicit, deliberative endeavours to aid the ill. Or to use the language of cognitive scientist Daniel Kahneman, the scope of healthcare has culturally evolved from an evolutionary older 'System 1' intuitive response, to a 'System 2' approach - one that is reflective, explicit, and deliberative in its goals [9].

Deliberateness could thus be seen as both a crucial aspect to define treatments as well as a driving force behind the increasing professionalization and elaboration of these treatments. The deliberate clinical use of a treatment - usually employed in matters of greatest importance: health, reproduction and survival - at best implies a deeper and reflective understanding of what is considered to be a treatment in the given case. Historically, the validity of these treatment theories was restricted by the validity of the available knowledge and methods, which interestingly did not prevent the application of otherwise harmful or ineffective treatments. For example, and with regard to the former, ulcers have been treated with (rather involuntary and rather unrefined) surgery as early as 400 BC. ("He went away whole, but the chamber was covered with his blood", Goldstein, 1943, cited in [10], p.5193.) Also, and with regard to the latter, Roberts and colleagues [11] examined the effects of medical treatments, which first were found to be effective (in uncontrolled trials) and which turned out to be ineffective (at least in comparison to independent and/or placebo-controlled trials). These treatments included gastric freezing for the treatment of intractable duodenal ulcer [12]. Patients had a deflated balloon inserted through the mouth into the stomach, which was then inflated with cooled ethyl alcohol for approximately one hour. This procedure was reported to be extraordinarily effective in uncontrolled trials, with two reports showing good to excellent clinical responses in about 45% of treated patients [11]. However, once tested in randomized double-blind (and independent) trials, gastric freezing was not shown to be better than sham procedures and, subsequently, was discontinued as a treatment for duodenal ulcers. Thus, deliberateness might be considered a defining aspect of what is to be considered a treatment, although this does not imply that a deliberately administered treatment is necessarily effective or correct. Rather, treatments were administered long before the tools and methods to verify or test their effects and specificity had been developed and became integral to their acknowledgement in clinical practice. Even though the use of placebo control conditions has been documented ever since the Sixteenth Century (in case of so-called "trick trials" in Christian exorcism rites [13]) and Eighteenth Century (for example in case of Benjamin Franklin's test of Mesmer's animal magnetism [14,15]), the call for the necessity of randomized placebo-controlled trials was only voiced some sixty years ago [16].

Ethical considerations

Interestingly, and aptly, the rise and development of deliberate clinical practice in medicine has ever since been sided by ethical considerations. This is seen in the proverbial Hippocratic oath, but also - and slightly more recently - in John Gregory's *Lectures on the Duties and Qualifications of a Physician* (1769/1770) [17] which considered the provision of treatments as a profession (in contrast to a self-interested entrepreneurship) and which laid the foundation of the contemporary professional responsibility model (e.g., [18]). Accordingly, physicians

need to be committed to "(1) competence in clinical practice; (2) primacy of the health-related interests of the patient and the secondary status of self-interest and the interests of third parties to the physician-patient relationship and (3) evidence-based medicine as a public trust that exists for the common good rather than the protection of the economic, social, and political power of physicians" (cited from [19]). This integration of evidence, clinical expertise and patient values is understood as evidence-based clinical practice and has become clinical standard in medicine [20] as well as in psychology [21].

The importance of deliberate actions and ethical considerations is also the cornerstone of the distinction between placebo and non-placebo (i.e., *verum*) treatments by Grünbaum [22]. Although he originally set out to define what is to be considered a placebo, Grünbaum also provided a theoretical definition of the constituents of the treatment process and their effects. In his understanding, treatments are grounded in a therapeutic theory, which then defines the characteristic and incidental constituents of a given treatment for a given disorder. In this understanding, neither a treatment nor its application is mere incidental or trial and error, but a deliberate and theory-driven action. Interestingly, this becomes an ethical matter as the - intended as well as inadvertent - application of incidental constituents as treatment constitutes an instance of placebo, which again is considered unethical as "in the clinical setting, the use of a placebo without the patient's knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient" [23].

Thus, the deliberate use, which implies the constant elaboration of social response qualities, which would otherwise not be considered as a genuine treatment, appears to be a definitive criterion. Deliberateness does not necessarily imply effectiveness or validity of a deliberately administered treatment. In consequence, ethics has been called upon to turn a treatment into a good treatment.

What is good?

One possible approach to define a good treatment is to derive it from the ultimate goal of the given treatment. If a certain treatment successfully advances and fulfils such a predefined goal, it is to be considered good. In this perspective, what makes a treatment good depends on its goal achievement. Hence, if one could indicate the ultimate end of a given treatment, then one could also define whether this treatment is good or not.

However, perhaps unsurprisingly, specifying the end of a treatment has been a controversial topic of debate, at least since Hippocrates [24,25]. The professional provision of a clinical treatment is a complex practice and it is difficult to agree on its ultimate end. Amidst such difficulties, however, a notable attempt has been made by Pellegrino [26] and, more recently, by Oakley and Cocking [27]. According to Pellegrino [26], one can eventually agree that the primary goal of medicine - as a more general denominator and discipline providing treatments - is "the

cultivation and restoration of health and the containment and cure of disease” (p. 267). Therefore, according to this definition, a good treatment is one that restores and promotes health or cures and contains diseases; and the more a treatment is successful in doing so, the better it is.

This perspective is attractive, for it is indisputable that one of the primary objectives of treatments is to restore and promote patients’ health. However, defining a good treatment only as a treatment that is successful – that is, effective – in modulating patients’ health is reductive. Consider the classic and extreme case of an adult and competent patient refusing a life-saving blood transfusion because of his religious beliefs (e.g., Adam in the novel *The Children Act* [40]). While the transfusion may be a good treatment from a purely health-perspective, it can likewise be perceived differently from the patient’s point of view. Or consider the case of a terminal patient facing the difficult choice between a last round of aggressive chemotherapy and a switch to palliative care. Even though the treating oncologist has good reasons to believe that chemotherapy may be effective in extending the patient’s life, the oncologist is also aware that this will severely impact the patient’s quality of life. Thus, it seems reductive to judge whether or not a treatment is good only on the basis of its capacity to restore or promote patient’s health in terms of efficacy measures, without relying on the patient’s personal point of view.

These examples highlight why effectiveness alone cannot lead to a satisfactory definition of the good treatment as good is a capacious term which, in certain circumstances, may admit conflicting and yet equally legitimate specifications. Sometimes a treatment is good because it is effective; other times, instead, a treatment is good because it allows patients to achieve their goals in a way that is consistent with their values, preferences and beliefs – even though such goals may be not directly related to health and even deviate from what a physician would consider most health relevant. Once patients’ autonomy is acknowledged as a fundamental value in medical ethics, it is no longer possible to characterize the goals of clinical practice solely in reference to health and wellbeing – at least, as these terms are traditionally understood in biomedicine – thus excluding patients’ agency. Taking into account patients’ agency, however, entails a twofold change in how doctor-patient relationships are usually framed. First, it requires a re-conceptualization of the patient’s role. Indeed, the etymological definition of “patient” – from the Latin verb “*pati* – to suffer” – suggests that “patients” (i.e., “those who suffer”) should normally play only a passive role in clinical encounters, as the mere recipients of medical treatments. Yet this narrative is structurally inadequate to represent the new role that patients’ agency has acquired in contemporary clinical contexts. Therefore, as Walach and Loughlin [28] have recently argued, the classical “narrative of the patient” must now be complemented by a new “narrative of the agent”, in which the person in need of clinical care is conceptualized as someone capable of action and activity. In turn, this new narrative requires also a shift in how medical decision-making is organized. Acknowledging a patient’s agency, in fact, implies that doctors abandon paternalism as their default model of

clinical decision-making in favour of a more “person-centred” approaches based on “shared-decision making”, in which the articulation of patient’s values and preferences acquire a paramount role [29].

Against this background, and following other scholars, we propose to conceptualize a good treatment as a treatment that is based on, or exemplifies, the virtue of deliberate care [30,31]. In general, a virtue can be defined as a socially admirable trait of character, while a moral virtue is a trait of character that is morally admirable. However, as the etymology of words such as “medical care”, “healthcare” or “caregiver” suggests, care is a particularly prominent virtue in medical contexts. More specifically, the virtue of care “refers to care for, emotional commitment to, and deep willingness to act on behalf of persons with whom one has a significant relationship” [30]. Grounding the concept of a good treatment in the virtue of deliberate care has a few important implications.

First, it makes explicit that a treatment, in order to be “good”, must always be administered with the intention of benefiting patients. Thus, a treatment administered by a ‘quack’ or with the sole intention to benefit the provider of the treatment (either personally or financially) can never be good. Second, it shifts the focus from a treatment (such as its effectiveness) to the actual preferences, values and needs of those receiving and administering (*vide supra*) them. Hence, the same treatment (e.g., aggressive chemotherapy) can be good or bad depending on to whom it gets administered and who is administering it. A care-based perspective, thus, is intrinsically person-centred rather than disease (or health) or treatment centred; for in order to decide what treatment will be good it is first necessary to relate to and understand who will receive it as much as who is administering or providing it. Third and in consequence, it acknowledges that medical treatments are always provided within the context of a relationship connoted by an asymmetry of knowledge and power. Patients seek clinical aid only when they are in need and physicians are usually the only ones that possess the knowledge and the means to satisfy those needs. Yet the physician-patient relationship is fundamentally different from other relationships – such as the one between a provider/salesperson and a client/consumer – for patients are, by definition, in a condition of suffering and thus of vulnerability. Such vulnerability is reflected in the fact that in each relationship based on care, there is always someone who cares and takes care, and someone who, instead, receives care or is cared for. Such a care-based relationship, however, is not purely rational, but it involves an essential reference to one’s emotions and feelings. On this view, clinical professionals can administer good treatments only if they care properly for patients and their vulnerabilities – that is, within the context of an adequately empathic and humane relationship.

Conclusion - What is a good treatment?

Based on the previous arguments and considerations, care becomes treatment when provided deliberately, and

treatment becomes good when provided deliberately with care. Notably, this understanding is not only independent from the aetiology of the given disorder or disease, it rather explicitly calls us to offer deliberate care irrespectively of what ailment prevails. Moreover, good treatment does not stop at the borders of a given treatment category or specialisation, but rather calls for a comprehensive approach. Following the seminal call for a biopsychosocial understanding of diseases and disorders [32] this should comprise biological, social as well as psychological treatment constituents administered in an ethical framework. Of course, “the classical formulation of the (biopsychosocial) model as conceived by Engel was never intended to be a clinical decision-making model” ([33, p.197]) and likewise, the call for a biopsychosocioethical model for treatment neither calls for nor offers a definitive and distinct approach to clinical decision and management. Rather, it proposes a conceptual frame, which is centred on a shared understanding of what should be achieved by a treatment and how these aims are realized.

Of course, in exercising such a caring attitude, those delivering the care should also respect precise deontological and professional standards. In exchange for their position of power, they commit themselves to at least two kinds of professional duties. The first series of duties regards their technical competences and specialized knowledge. Any clinical professional, in order to prescribe and/or administer treatments, must possess the necessary competences to appraise and decide upon the available experimental evidence. Hence, even though a treatment can be good without necessarily being the most effective one, this does not exempt the prescribing professional from knowing which other therapeutic options are available, how effective they are according to available evidence, and what implications and risks they might entail.

While most of the former could be considered commonplace lore, clinical care too often is reduced to so-called specific or - in Grünbaum vocabulary - characteristic treatment constituents. This resembles a clinical “iceberg” approach, in which only visible parts of the treatment are deliberately administered and acknowledged as treatment. This can not only be rather unjustified from an empirical perspective, but also unethical. For example, the share of methods and techniques in established psychotherapy schools on outcome is small and astoundingly fits rather well with the amount of ice above the waterline - about 10% - and the rest - about 90% - is related to rather basic care-related treatment constituents, such as shared goals, empathy, respect and the alliance between patient and treatment provider [34]. Likewise, and for example, up to two thirds of the effects of pharmacological treatments for depressive disorders in all ages [35-37] and surgery for pain and obesity [38] is due to non-specific or incidental effects, that is, placebo effects. This does not imply that a good treatment has to intendedly or inadvertently harness the placebo effect and by this way become effective, but certainly be unethical [39]. Rather, this calls for the consideration that while striving for specifics, clinical research too often has degraded care by deliberately demeaning it into a control or placebo condition,

considered either too mundane or unethical to be deliberately used in care. From the perspective of the biopsychosocioethical model, this stance is unjustified. And of course, and in consequence to our argumentation, good treatment deliberately and actively needs to be person-centred.

Acknowledgements and Conflicts of Interest

This paper reproduces Chapter 15 [a] of a forthcoming volume which is being serialised in the *Journal* in advance of the publication of the book itself in late 2020. For details see [b]. [a] Gaab, J., Gerger, H., Blease, C. & Locher, C. (2020). The Good Treatment: a biopsychosocioethical proposition. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 213-220. London: Aesculapius Medical Press. [b] Asbridge, J.E. (2020). Progress in the conceptual understanding of person-centered health and social care. “Person Centered Care: Advanced Philosophical Perspectives”. Loughlin, M. & Miles, A. (Eds.). London. Aesculapius Medical Press. *European Journal for Person Centered Healthcare* 8 (1) 17-19. The authors report no conflicts of interest.

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