Evidence based medicine: ideology, hegemony, statistical gaze and beyond (part three)

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Medical gaze and EBM

Michel Foucault was a nineteenth century French philosopher who coined the term "medical gaze". In his book "Birth of the Clinic" he described how doctors modify the patient's story, fitting it into a biomedical paradigm, filtering out rest. Foucault says "facilitated by the medical technologies, the physician abstracts the suffering person from her sociological context and reframes her as a "case" or a "condition"[12]. Foucault referred to this 'medical separation' between a patient's body and his identity and detachment or dehumanization of the body into an object to be isolated, probed, analyzed, examined, and classified as "medical gaze". Then patient becomes a faceless entity and there is minimum or no intimate and personal doctor-patient relationship. Doctors do not identify the names or faces of their patients but, rather, recognize them from their diseased organ or the test results.

Foucault feared that doctors may treat a 'diseased organ' rather than a 'sick patient' with the invent of technologies. One could have a logical apprehension about EBM "minimizing" practicing physicians to mere followers of algorithms. If you enter patient's biological data and symptoms into a computer with their positive/ negative predictive values of a certain diagnosis and relevant tests with their pre and post-test probabilities and sensitivities and specificities the computer not only will give you the diagnosis but may give you the best treatment options using the algorithms and guidelines prepared based on EBM. Basically what we are doing is removing the patient from his "sociological context" making him a "medical entity". The patient becomes a faceless statistic rather than a "sick individual".

EBM resists to include non-quantifiable data from studies assessing patients values and individual perception of "health or cure". In this narrative patient becomes a 'statistic' with 'predictive values' and 'probabilities' rather than a sick person with values and perceptions in sociological context. It is the same as what Foucault described as "medical gaze" or rather we propose to use the term "statistical gaze" in this context.

In 'statistical gaze', sick individual is being identified, isolated and studied as a mere statistic. With funding agencies having a say regarding the outcome of trials and complex statistical application can be used to "read what you want to read" as conclusions of a study. In the final analysis 'statistical gaze' of a patient may not get 'the conscientious, explicit, and judicious use of current best evidence' as expected in the use of EBM paradigm.

This "statistical gaze" is increasingly becoming common among young physician who think there is an answer to all the questions in the domains of EBM.

Biopolitics and EBM

The relationship between power and knowledge has been a central theme in the Foucault's body of work. Power is the ability to influence the behavior of others. Being an essentially a philosophical historian, Foucault explains how power has changed throughout history and how it has influenced our existence. According to Foucault power is based on knowledge and makes use of knowledge; at the same time power reproduces knowledge by shaping it according to its intentions in using it. When knowledge of basic human biological features becomes a power Foucault called it Biopower or biopolitics. This includes of the birth rate, the mortality rate, longevity of the population etc. Biopower or biopolitics, according to Foucault takes charge of our lives, to optimize and modify the life processes. Foucault claims that the dominance of biopower based on scientific knowledge penetrates traditional forms of political power [13]. Biopolitics use the knowledge to achieve control of populations through

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coordinate medical care, normalize behavior, rationalize mechanisms of insurance, and epidemic control, provide psychiatry care, urban planning, birth control etc. How does biopolitics play a role in this discourse of EBM?

In EBM paradigm we arrive at decisions after conscientious, explicit, and judicious use of current best evidence provided by RCTs. After all RCTs evaluate a population of patients and focus on objective data of the whole study population and the resulting 'statistically significant' conclusion may not correspond with individual patient with 'relevant patient factors'. In the background of large RCTs there is a vast network that includes funding bodies, pharmaceutical corporations, insurance industry and public policymakers. The newly acquired knowledge from RCTs are used to formulate new guidelines, to change health policy and in turn exert an influence on health behavior of the population at large. In this sense, EBM is a biopolitical paradigm, a political venture that control, regulate and optimize the lives of populations. As Foucault warns, here, individual lives become 'regularized' through 'a technology in which bodies are replaced by general biological processes'[14].

Where does Hegel come in?

Over time we have identified a change in therapeutic approach of physicians. Opinion based clinical practice is influenced by individual expertise, experiential evidence, heuristics and pathophysiologic rationale. Most of the hypotheses that have been later validated using RCTs were historically stemmed out of this opinion based practice. On the other hand we have EBM paradigm where RCT results based "conscientious, explicit, and judicious" use of current best evidence in making clinical decisions. Then there are factors that are not featured in these two domains but nevertheless important. Art of observation and clinical judgment, individual patient values and preferences, patient's perception of 'good health', and patient-physician relationship to mention a few. These parameters are inherently non quantifiable and require interpretation in different contexts appropriately. Can we incorporate opinion based clinical practice and EBM paradigm with these non-quantifiable nevertheless important factors into one "synthesis"? That's where GWF Hegel comes in.

Hegel's philosophical concepts are difficult to comprehend. He is considered a 'philosopher of philosophers'. His writings are meant for erudite philosophers. If we allow ourselves to scratch the surface of Hegelian philosophy, Hegel claims that progress is never linear. Important parts of ourselves can be found in the history. For an example concept of 'community' was best established in ancient Greek civilization and role of 'honor' in society was expressed best in medieval England. Those ideas can be rescued from the past to compensate the 'blind spots' in the present [15]. Hagel suggests a process called Historical Dialectic to achieve this.

Hegelian dialectic includes a triad of developments. Thesis, anti-thesis and synthesis. First you have stable thesis where practice is not questioned (opinion based clinical practice). Then contradictions or negation start to appear questioning current practice with new determinations (EBM), or anti thesis. Out of contradictions we can produce a new synthesis allowing new understanding and determinations to form. According to Hagel new determinations do not exclude or eliminate all past determinations but include them in new determinations (synthesis). In the process of synthesizing the new determinations, Hagel claims that we go through the process of 'negation of the negation'. The negation of the negation is a process, Hagel describes, where rational beings will synthesize a new determination after discussing and weighing in the value of competing views. It is kind of a negotiation. This is the essence of Hegelian dialectics. This dialectic process should go on until the best determination is emerged [16].

In Hegelian perspective this could be the answer to the impasse we have arrived after analyzing the pros and cons of opinion based clinical practice and the EBM paradigm. We should start a Hegelian dialectic process to arrive at a synthesis which includes best determinants of opinion based medical practice (thesis) and the EBM paradigm (anti-thesis). New synthesis should incorporate new determinants such as patients' values, preferences, clinical judgment and experiential evidence.

Conclusion

Questioning and re-evaluating the EBM paradigm is important to recognize the possibilities beyond EBM. While recognizing the role of clinical epidemiology and EBM in clinical medicine it is important to look into other aspects of medical care that falls outside the domain of evidentiary medicine such as patient's values and preferences.

Use of philosophical concepts to understand what underpins a new paradigm is fascinating to say the least. It is not 'un-scientific' to think outside the domain of EBM when aim of the medical profession is to provide a complete comprehensive and compassionate care for individual patient. In the movie 'Zorba-the Greek' in the final scene, peasant Zorba enlightens the viewer with his wisdom by saying, "everyone needs a little madness, unless no one would dare to cut the ropes and be free" [17]. Likewise you need to venture out of your prescribed academic hubris and be free. Else we will be practicing 'cook book' medicine and will be afraid to go beyond the given 'recipe'.

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