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The 'rest of medicine' and psychiatry: why paradigms would differ

In their paper, Bracken *et al*[1] have cogently put forth the limitations of psychiatry comparing its differences with the 'rest of medicine'. They turn our attention to some moral and ethical notions viz relationships, meanings and values, which not only have therapeutic scope but also humanistic importance. Applying evidence-based logic, they show the inadequacy of technological interventions (psychopharmacotherapeutics or therapy-specific aspects of psychotherapies), and at the same time cite evidence of effectiveness of 'non-technical' aspects of care. Considering some of these aspects and the online response it generated, it is important that we refocus our attention to a central and some associated issues.

First, unlike what Bracken *et al* propose, medicine's assumptions on causal mechanisms are still a hotly debated issue. Medicine's apparent authority over human health was convincingly questioned in a historical analysis by Thomas McKeown and his arguments much advanced by Simon Szreter. In short, rather than technical innovations in medicine (such as the advent of antibiotics or immunisation), social and political interventions had a decisive role in advancing human health.[2]

Second, as the field of epidemiology progressively advances and uses newer analytic techniques, monocausal explanations (as the germ theory of disease propounded) gave way to multicausal (as in the case of chronic disease epidemiology) and finally to complex eco-epidemiological causal explanations.[3] In fact, an active engagement with the notion of embodiment that explains how biological processes are influenced profoundly by environmental determinants (e.g. social, cultural, economic, political) lies at the heart of social epidemiology.[4] And biological outcomes are not often mediated by our psyche, although the latter may be similarly affected.

Third, an attempt to compare the effect sizes of pharmacological interventions in both general medical disorders and psychiatric disorders show, barring a few exceptions, that effect sizes of psychiatric drugs are in the same range (i.e. small to medium) as most other pharmacotherapeutics.[5]

Moreover, the oft referred crisis in psychiatry also bothers the 'rest of medicine' and healthcare. Some features of this crisis are the increasing difficulty of grappling with the explosive boom in health-related technologies (consequently increasing the cost of healthcare), the challenge produced by the epidemiological shift in disease prevalence and the marked social inequalities in health. In addition, the notions of 'medicalisation of everyday life'/overmedicalisation, healthism, biomedicalisation and the dominance of the technological paradigm in medicine have also drawn wide criticism. In not considering these as entirely good or bad, the problem is the undue attention to individualised solutions and personalised/customised technologies,[6] transforming health to individual moral responsibility.[7]

On the other hand, under the foregoing transformations in healthcare, medical training instils qualities such as objectivity and emotional distancing to maintain clinical neutrality, concepts partly counterposed to values, narratives and meanings. Similarly, clinicians have come to associate professional status and power with increasing technological involvement in clinical practice, rather than with being sensitive to the patient's distress and life story. Although clinical knowledge is based on biological understanding and scientific methods, it is also interpretive and narrative.[8]

Thus to paraphrase Bracken *et al*, it is not just mental health problems but all health problems in general that undoubtedly have a biological dimension, and that by their very nature can reach beyond the body to involve social, cultural and psychological dimensions.

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5 Leucht S, Hierl S, Kissling W, Dold M, Davis JM. Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. *Br J Psychiatry* 2012; **200**: 97–106.

6 Crawford R. Healthism and the medicalization of everyday life. *Int J Health Serv* 1980; **10**: 365–88.

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Authors' reply: We are broadly in agreement with the thrust of Dr Das's analysis. In our original article, we cited Arthur Kleinman's call for 'medicine in general' to go beyond a technicalised understanding of 'caregiving' and we also noted the resonance between our position and that of Iona Heath in relation to general practice.

We agree entirely that 'an active engagement with the notion of embodiment' would represent a very positive agenda for all of medicine. Our experiences as human beings are shaped by our physiology and the particular way it has evolved over centuries. However, they are also shaped by the particular cultural and historical context in which, and through which, we come to know ourselves and the world around us. In the lived reality of human beings, mind, body and social context are inseparable.