Risk Factors, Subjectivity, and Truth in Healthcare

In a small, intimate room in a tired old mansion serving as a Connecticut prep school in 1966, a gentle giant of learning listened intently to a youth in his class extol Ayn Rand’s theory of Objectivism. It was English class, and Joseph T. Sunega, known time out of mind to the student body as Sunny Joe for his bright eyes drooping at half mast in a perpetual Celtic half dream, dropped a quiet bombshell on the boy and the class. Usually warm and encouraging of students’ ideas, he demonstrated rare form in his dismissal of the author’s philosophical premise: “Truth is not objective,” he stated, “it is subjective.”

The young devotee of Ayn Rand, flush with the enthusiasm that attends discovering “The Anthem” and “The Fountainhead,” stood stunned at this unvarnished didactic move. How did he know with such quiet assurance that truth was subjective at its core? Here was a radical proposition indeed. The thought was left on its own, no elaboration offered, to reverberate in the heads of all present. And like all great teachers, he knew that explanation had to come from the subsequent life experiences of those he was teaching that day.

Years later, in a small, intimate board room in the New York Academy of Science, a professor of another intellectual discipline repeated the lesson, albeit in different terms and involving different applications. It was John Laragh, co-discoverer of the renin-angiotensin-aldosterone system. He, Michael Weber, and Joel Neutel had called a press conference to criticize the JNC VI guidelines on hypertension. Preceding the critique was an exposition by Dr. Neutel on cardiovascular risk factors. Then came the punch line from Dr. Laragh: “Risk factors are a measure of our ignorance, not our knowledge.”

He explained that if we actually knew what was causing the patient’s disease, we would treat that single cause and not multiple risk factors, essentially hedging our bets in the best interests of the patient. But we do rely on risk factors, because we need to. They are often all we know about that patient, and to protect him we must cover all potential bases.

The upshot of this is where it gets really interesting. Because we lack a true knowledge of the disease process in each individual patient, he proposed, we must not take the parochial approach of restricting physician practice to just the official guidelines. Other clinical strategies hold promise, he stated, and the simultaneous pursuit of multiple strategies, even those not fully supported by a robust evidentiary base, is good for medicine. On the other hand, slapping physicians on the wrist for straying from official guidelines will ensure clinical atrophy and an end to scientific discovery. Guidelines, in short, should remain guidelines, not demands for conformity.

Enter managed care, value-based benefit designs, evidence-based medicine, comparative effectiveness research, step therapy, copay incentives, pay-for-performance, and a legion of cost-management techniques “assisting” physicians—or is that just payors and purchasers?—in their unending quest for best practices. Enter too population-based research and its arch rival—or is that its perfect complement?—personalized medicine. What’s a payor, or a physician, to do? How do the multiple stakeholders to the process of care dance around the inherently subjective aspect of patient care—where the individual clinician must take into account the massive body of population-based (objective) research data and then subject it to personalized (subjective) application for each individual patient?

There are genuine pressures aplenty impelling the healthcare community to adopt inflexible, absolute compliance with guidelines. But de facto patient care answers remain elusive and subjective, requiring, inconveniently, the art of the physician as healer—and let no one pretend that committees ever heal anyone. It is the individual provider who performs this service, no matter how sophisticated the evidence-based medicine techniques are devised.

Individual discretion therefore fights with the real need for oversight and compliance with evidentiary standards. It is a good fight and defies oversimplification. The excellent paradox is that objective, scientific knowledge must continue to inform the subjective application of same in the best practice of medicine.

So, may the healthcare debate continue in good faith between the exponents of objective evidence-based medicine and the healer practicing personalized medicine. Hopefully objectivity is the servant of the healer, not its master. The answers will ever evade total...
codification, and this is perhaps the greatest challenge to healthcare as it undergoes its transformation to a value-based system. To remain true to its mission, healthcare must guide facts with subjective insight, giving essential latitude to practitioners even while educating them on the massive objective body of data that informs them on risk factors—often all we will ever know about a disease and its propensity to strike down the vulnerable human host, whom all stakeholders are desperately trying to save.

It is, in the final analysis, unique individuals we love whom we seek to cure, and their inestimable worth makes the struggle to reconcile the objective and the subjective quite worth the effort.

To both of these professors, and to my beloved brother who recently fell before the onslaught of his own risk factors, I dedicate this small footnote to the passionate pursuit of the truth of medical excellence.

Robert Emmett Henry  
Editor-in-Chief

For editorial queries and submissions, please contact rhenry@AHDBonline.com.

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