SCIENCE, HUMANISM, JUDGEMENT, ETHICS: PERSON-CENTERED MEDICINE AS AN EMERGENT MODEL OF MODERN CLINICAL PRACTICE

Andrew Miles
Editor-in-Chief, International Journal of Person Centered Medicine and Journal of Evaluation in Clinical Practice; Director: International Conference and Publication Series on Person Centered Healthcare & Visiting Professor University of Milan Italy, Francisco de Vitoria University Madrid Spain, Medical University of Plovdiv and University of Sofia; Academician, National Academy of Sciences and Arts of Bulgaria/New York Academy of Medicine, USA

ABSTRACT
The Medical University of Plovdiv (MUP) has as its motto ‘Committed to humanity’. But what does humanity in modern medicine mean? Is it possible to practise a form of medicine that is without humanity? In the current article, it is argued that modern medicine is increasingly being practised in a de-personalised fashion, where the patient is understood not as a unique human individual, a person, but rather as a subject or an object and more in the manner of a complex biological machine. Medicine has, it is contended, become distracted from its duty to care, comfort and console as well as to ameliorate, attenuate and cure and that the rapid development of medicine’s scientific knowledge is, paradoxically, principally causative. Signal occurrences in the ‘patient as a person’ movement are reviewed, together with the emergence of the evidence-based medicine (EBM) and patient-centered care (PCC) movements. The characteristics of a model of medicine evolving in response to medicine’s current deficiencies - person-centered healthcare (PCH) - are noted and described. In seeking to apply science with humanism, via clinical judgement, within an ethical framework, it is contended that PCH will prove to be far more responsive to the needs of the individual patient and his/her personal circumstances than current models of practice, so that neither a reductive anatomico-pathological, disease-centric model of illness (EBM), nor an aggressive patient-directed, consumerist form of care (PCC) is allowed continued dominance within modern healthcare systems. In conclusion, it is argued that PCH will enable affordable advances in biomedicine and technology to be delivered to patients within a humanistic framework of clinical practice that recognises the patient as a person and which takes full account of his/her stories, values, preferences, goals, aspirations, fears, worries, hopes, cultural context and which responds to his/her psychological, emotional, spiritual and social necessities in addition to his/her physical needs. MUP, in assimilating such arguments and introducing person-centered medicine teaching into the University, is engaged in a notable and laudable initiative which will function as a salutary example to other medical schools within Europe and elsewhere.

Key words: art of medicine, care, compassion, costs, empathy, ethics, evidence-based medicine, humanity, humanism, knowledge, patient-centered care, person-centered medicine, reductionism, science of medicine, scientific medicine, scientistic medicine, warrants for decision-making

INTRODUCTION
The Medical University of Plovdiv has as its motto ‘Committed to humanity’. But what does humanity in modern medicine mean? Is the practice of medicine by its nature inevitably humanistic? Or is it possible to practise a form of medicine that is without humanity? I answer in the affirmative to this last question and will argue in this Essay that modern medicine is increasingly being practised in a depersonalised fashion and one in which the patient is understood
not as a unique human individual, a person, but rather as a subject or an object and more in the manner of a complex biological machine. Here, a recognition that the patient’s illness may well be far more complex than one that can be understood in terms of the dysfunction of a particular biochemical pathway or organ system alone, is becoming increasingly lost, so that medicine is moving from a holistic understanding of the patient to a more disease-centric, anatomico-pathological conception in its everyday practice. Since such observations are increasingly documented within the clinical and health services research literature and are now commonplace, they call for an urgent explanation. How, then, can we begin to explain this phenomenon of depersonalisation in medicine? How do we understand such a process which by its nature threatens to denude medicine of its grace and nobility and where physicians more and more resemble technicians in applied bioscience - delivering care in accordance with the mandates of practice guidelines derived from population-based aggregate data – rather than attempting to understand the ‘totality of what is wrong’ in the individual clinical case? Has there been some manner of fundamental distraction that has led medicine to forget or ignore its irreversible imperative to care, comfort and console as well as to ameliorate, attenuate and cure? And, if so, what can be done to arrest such an ongoing process and then to reverse it?

In seeking to answer all such questions, I will argue that medicine has indeed become distracted from its irreversible duty to care, comfort and console as well as to ameliorate, attenuate and cure and that it is the rapid development of medicine’s scientific knowledge that is causative in this context. I will go on to describe how the speed of, and extent to which, the caring and curing functions of medicine have become disassociated from one another are functions of time - the time over which medicine has seen exponential increases in the scale of its biomedical knowledge and technical skill. I will note how, as medicine has become more powerfully scientific, it has also become more and more dependent on science to the exclusion of a range of other types of knowledge vital to clinical decision-making – so that an over-reliance on science may now be demonstrated where scientific medicine is being replaced by scientistic medicine, resulting in an incremental collapse of humanistic values in the care of patients. This trajectory of increase and decline, an increase in the science of medicine and a decline in its humanity, is precipitating a decoupling of these two components of clinical practice and the genesis of a crisis in medicine – a crisis of knowledge, care, compassion and costs. As a consequence, we risk the creation of an ethical and moral chaos within medicine and the generation of highly negative outcomes for patients and clinicians alike.2,3

In considering these matters, I will argue that medicine is not a science, but rather primarily a human endeavour which employs science – and only in part, and that the recovery of an authentic understanding and practice of medicine is essential in ensuring the availability of a model of clinical practice that is ‘fit for purpose’ for the future – a future that will be dominated by chronic, rather than acute, illness. Before doing so I will first review signal, historical occurrences in the development of the so-called ‘patient as a person’ movement and then proceed to describe the emergence and progress of the evidence-based medicine (EBM) and patient-centered care (PCC) movements, noting how these initiatives have developed in parallel, but how rarely they have entered into scholarly exchange and functional dialogue. I will contend that both movements have greatly enriched the understanding of the profession of medicine, but that each model remains of itself essentially incomplete as a coherent account of the unique undertaking that is clinical medicine and I will argue that a rational form of integration or ‘coalescence’ between them has become urgently necessary. I will conclude by advancing the characteristics of a model of medicine that is evolving in response to medicine’s current deficiencies and which model has been termed person-centered clinical practice.4

HISTORICAL PERSPECTIVES ON THE RISE OF SCIENTIFIC MEDICINE AND THE ADVENT OF DEPERSONALISATION IN CLINICAL PRACTICE

THE EXAMPLE OF DR. FRANCIS PEABODY

Concerns for the maintenance of medicine’s integrity as a humanistic, altruistic and compassionate activity date from Hippocrates. In our more recent times, one of the earliest examples of a clinician who first articulated significant concerns over how the integrity of medicine had become potentially imperilled through a narrow scientific vision and an impersonal care, is provided by Dr. Francis Peabody. In his article, The Care of the Patient, published in 19275, Peabody writes that: “the most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little
about the practice of medicine – or, to put it more bluntly, they are too ‘scientific’ and do not know how to take care of patients”.

Not that such a sentiment should be interpreted as evidence of some form of ‘anti-science’ standpoint on Peabody’s part at a time when the pace of scientific advance and therapeutic innovation had begun to accelerate to an astonishing extent. On the contrary, Peabody’s writings exemplify a considerable excitement with the progress being made in the development of the science base of medicine during the length of his (relatively short) career. They speak of his amazement at “the progress of science in its relation to medicine” and the “enormous mass of scientific material which must be made available to the modern physician”. Nevertheless, he remained clear that it was increasingly being forgotten that the application of the principles of science to the diagnosis and treatment of disease continued to represent only one aspect of medical practice among many others.6

I find simple, though thoroughly eloquent, Peabody’s insistence that “the art of medicine and the science of medicine are not antagonistic, but rather supplementary to each other” and that there is “no more contradiction between the science of medicine and the art of medicine than between the science of aeronauts and the art of flying”. With reference to the then rapidly growing laboratory research and in vitro testing techniques being employed within experimental medicine and therapeutics, he was careful to remind his students that “disease in man is never the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life”, so that “the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment”.7

An analysis of Peabody’s writings demonstrate his commitment to a vision of medicine that is informed – but not dictated to – by scientific advance. He was clear that a fundamental aspect of medicine is the clinical relationship between doctor and patient and that while the treatment of a disease may be entirely impersonal, the care of a patient must be completely personal. This, for Peabody, was a central facet of medicine that could not be over-emphasised, “for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients”.

Without the ‘anchor’ of the clinical relationship and in the absence of the ‘sure foundation’ that it represented, Peabody felt certain that both doctors and the institutions in which they worked “are apt to deteriorate into dehumanised machines”.5 The humanity of medicine was, for him, then, indispensable if medicine was to retain its fundamental authenticity. Here, an understanding of the patient as a person was for him inescapable. The ‘clinical picture’ of the patient, he stressed, should never be understood simply as “just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears”. It was essential, therefore, that a clinician should strive to build an intimate knowledge of his patient’s circumstances as well as afflictions, without which a vital perspective of care – that of context – was lost. For Peabody, contextual insight and understanding was achievable only through use of “time and sympathy” which must therefore be lavishly dispensed. Peabody taught that in adopting such an approach, although intensive in its nature, the clinician could achieve the formation of that “personal bond which forms the greatest satisfaction of the practice of medicine”, guaranteeing that essential quality of medicine: humanity. It is perhaps no surprise, then, that one of the most memorable and frequently recounted truisms of Peabody’s teaching was that “the secret of the care of the patient is in caring for the patient”. Although Peabody died during the midpoint of his career, he could surely have hoped for no greater accolades or eulogies than those which were awarded to him following his death: a doctor who had demonstrated “pristine humanism” and who had embodied “the noblest aspirations of the medical profession”, combining the roles of “physician, clinical scientist, teacher, healer, counsellor, confidant and friend”.7

The example of Dr. Paul Tournier

It was some decades after Peabody’s death than another prominent voice became heard within international medicine. This was the voice of a Swiss family physician, Dr. Paul Tournier, who, like Peabody before him, articulated major concern at the manner in which medicine was becoming increasingly depersonalised. For Tournier, an effective model of clinical practice required an integrated approach in medicine where clinical intervention occurred within a context of psychological understanding and pastoral counselling. Here, sustained attention was to be afforded not simply to the biological characteristics...
and responses to treatment of disease of the patient, but also to the psychological, emotional, spiritual and social dimensions of the patient, including a proper consideration of the patient’s relationship with his family and with Society more generally.8

Tournier, as Peabody before him, had become greatly worried by what he saw as a growing “mechanical, reductionist medical practice, devoid of ethics and without sustaining compassion”. He went so far as to describe such developments as “dangerous”, lacking an essential understanding of the functional inter-relationship of body, mind and spirit that was in his view so very necessary to restore and maintain health and wholeness. Tournier, very much in the manner of Francis Peabody, did not at any time deny the need to synthesise a scientific knowledge of man, but he was similarly clear that, however successful scientific medicine would eventually become, it would by its nature reveal only one dimension of man’s component nature - that of his biological mechanisms. If this was accepted, then there would always remain a need to augment such knowledge in clinical practice with what Tournier described as “a personal knowledge, which is of a different order, the order of the person, not that of things”.8

THE EXAMPLE OF DR. GEORGE ENGEL

Despite Peabody’s expression of concern at medicine’s early depersonalisation and Tournier’s subsequent registration of alarm at its increase, it was some 50 years following the publication of Peabody’s The Care of the Patient5 and 33 years following the publication of Tournier’s Medecine de la Personne8, before any real form of reaction to the thesis of depersonalisation was effectively registered by the medical and healthcare professions. It was at this point that George Engel published his seminal and landmark paper The Need for a New Medical Model: A Challenge for Biomedicine in the journal Science.9 Engel had been a pupil of Dr. Soma Weiss who herself had studied directly under Peabody and it was Weiss who inculcated in Engel the necessity to place the patient’s narrative at the very centre of the clinical consultation. Engel argued vigorously that medicine should take full and formal account of the psychological, behavioural and social context of the patient. His thesis formally rejected models of medicine based on biostatistical data in favour of a psychosocial model that provided “a blueprint for research, a framework for teaching and a design for action in the real world of health care” and which advocated a recognition of the patient as a person. In publishing his first conceptual paper, and another subsequently on the same core theme more concerned with method10, Engel risked – and precipitated – controversy throughout a medical world that had become seduced by the power of science and preoccupied with the molecular and cellular basis of disease processes.

If Engel’s overall contribution to the study of depersonalisation in medicine is to be summarised, then it may be said that his thesis rejected a monistic or reductionist approach to clinical practice, where a given phenomenon is mechanistically reduced to its constituent parts (typically the biological level) in favour of a preferential emphasis on the complexity of the illness and social situation of the patient. Engel’s sentinel contribution was, then, not intended to cause some form of paradigmatic change in medicine, but rather to broaden the scope of the clinician’s ‘gaze’, arguing for an understanding of the patient as a person and a way of ‘thinking’ and ‘doing’ in clinical practice that formally rejected the development of a cold, impersonal, technical, biomedically-dominated style of clinical practice which either ignored - or rejected - the human dimension of suffering.3,4,9,10

THE NATURE OF MEDICINE

How successful has Peabody’s, Tournier’s and Engel’s vision been – among others - in promoting a model of practice which allows advances in biomedical and technological progress to be translated into medicine, but without a depersonalisation of clinical practice occurring as part of that process? Certainly, modern medicine continues to place great emphasis on the study of organ systems and the use in practice of objectively measurable biological indices of dysfunction and disease and it would be ludicrous to argue against the fundamental importance of such an approach. Nevertheless, it seems clear that a point has been reached where an emphasis within medicine on patient biology has become so disproportionate that clinical practice risks reaching a stage where the patient is seen as part of the disease, rather than the disease being seen as part of the patient.11 This is a dangerous position to have arrived at, given that a knowledge of illness in purely biological terms fails to understand the essence of the human person and the totality of ‘what is wrong’. By concentrating preferentially on the biological body in isolation, clinicians are actively failing to meet, learn and know about the ‘someone’ inside it. This ‘someone’ is the person of the patient, who attends with worries, fears,
anxieties, hopes, aspirations, stories, goals, values, preferences and psychology, emotionality and spirituality and who presents at the consultation from a cultural context and a social situation.\textsuperscript{11} Sadly, this contextual reality is routinely ignored by perhaps even a majority of today’s doctors and when patients themselves disclose these so called person-related factors to their doctors, they typically experience a visibly startled or plainly uninterested clinician.

Why is it that clinicians appear to have ceased to be concerned with their patients as \textit{persons}, as unique individuals with unique needs? Modern attempts at explication have concurred with previous ones in observing that as medicine has become more powerfully scientific, it has also become increasingly depersonalised, so that in some areas of clinical practice an over-reliance on science in the care of patients has led to the substitution of \textit{scientific} medicine with \textit{scientistic} medicine and an accompanying collapse of humanistic values in the profession of medicine.\textsuperscript{2,12} Strikingly, it appears that as a direct consequence of phenomenal scientific and technical advance, clinicians have decided that now that they can ameliorate, attenuate and cure, they have no further need to care, comfort and console. Indeed, they appear preferentially inclined to distance themselves from an ethical intimacy with the patient in favour of an entirely science-based algorithmic treatment of the presenting symptoms, based on the effect sizes from RCTs and meta-analyses, rather than being, in addition, concomitantly concerned with wider, person-related issues.\textsuperscript{2}

Not all clinicians will find themselves in agreement with Weatherall, former Regius Professor of Medicine at Oxford University, when he says that “the ability of doctors to care for their patients as individuals has been lost in a morass of expensive high technology investigation and treatment…” and that, in consequence, \textit{“modern scientific medicine is a failure”} (italicisation mine).\textsuperscript{14,15} Indeed, as I have argued elsewhere\textsuperscript{11}, modern scientific and technological advance in medicine can, in fact, accurately be described as a triumph - but a triumph of scientific and technological advance, not a triumph represented by an increased excellence in clinical practice per se, if excellence (versus competence) is to be defined as the successful translation of such advances to patients within an overtly humanistic framework of care – the process which represents and causes contextualisation. While Weatherall’s use of the word “failure” might seem exaggerated and perhaps even nihilistic, it has certainly been observed that in terms of clinical practice, medicine has entered a time of crisis, a crisis of knowledge, care, compassion and costs, “urgently needing to re-learn what it has forgotten in over a Century of empiricism”.\textsuperscript{2} It is contended here that what has been forgotten is precisely this: that medicine is primarily a human endeavour, a moral enterprise which employs science, but which does not equate to it.\textsuperscript{12} The equation of medicine as science, rather than to understand medicine properly as a science-using practice has, it is asserted, directly precipitated the depersonalisation of clinical practice into the reductive model that is visible today.\textsuperscript{1,4,11-13} In my view, the representation of medicine as science is in reality a frank misrepresentation of medicine, but one in which the majority of doctors now collude.

\textbf{The Misrepresentation of Medicine}

Why, then, do clinicians misrepresent medicine as science? To begin to understand such a question and to proceed to try to answer it, I turn now to Montgomery.\textsuperscript{16} Montgomery has pointed out that the status of medicine in Society depends in considerable measure on the scientific nature of much of its information, a status that the majority of doctors would be loathed to relinquish. But the increase in the scientific nature of medicine that has underpinned this status does not make medicine a science. Secondly, when one examines the abilities of medicine to ameliorate, attenuate and cure conditions and diseases in 1913, for example, and if we compare its abilities in this context to the present year of 2013 – or even halfway to the 1970s – then it is easy to understand the awe, excitement, joy and optimism of the modern clinician when he looks at his own potential and compares it directly to that of his predecessors. He will be right to recognize that it has been the rapidly expanding science base of medicine that has represented the prime mover of such staggering progress. Certainly, a huge accumulation of biological knowledge of relevance to the care of patients has resulted in a quite extraordinary expansion of the drug-based therapeutic armamentarium and where this increase in pharmacotherapeutics and biological therapies has been matched by an equally extraordinary increase in the library of technical procedures of medicine and surgery. These developments have revolutionized, to be sure, the scope and power of medicine and the nature of its effects and have caused huge shifts in individual and population health. But this increase in the science base of medicine, while it has made
medicine more scientific, does not make medicine a science. Thirdly, in times of illness and distress, patients want, indeed perhaps need, to consider their physicians as learned, assured and quintessentially infallible figures. The allure of science as a means of attaining such ‘perfection’ in practice is clearly very attractive to clinicians and patients and so, for their own respective reasons, neither patients nor doctors are motivated to challenge this ‘folie a deux’.\textsuperscript{16} But submitting to this allurement does not make medicine a science.

The misrepresentation of medicine as science constitutes, then, a serious intellectual dishonesty among doctors in terms of medicine’s technical abilities and limits and raises unrealistic expectations in patients, the outcome of which can be seen in the huge rise in malpractice claims and negligence suits and in the necessity to institute increasing numbers of health care quality assurance and risk management programmes within international health services. Is the existence of such developments commensurate with the idea of medicine as a replicable, quasi-infallible, probabilistically predictable science? I think not. On the basis of these observations, Montgomery\textsuperscript{16} is surely right to argue that we therefore make a great, even dangerous, mistake about medicine when we assume it to be a science in the realist Newtonian sense, or even as Lewis Thomas once described it, as the ‘youngest science’. Indeed, such an assumption leads directly to the expectation that medical knowledge is invariant, objective and always replicable – \textit{which it most certainly is not}.

So if medicine is not a science, then is it an art? I believe the answer to this question to be unexpectedly simple, even if the process is not. Medicine is neither a science nor an art, but rather a rational practice based on a scientific education and sound clinical experience. Montgomery sees the art and science of medicine in terms of a binary economy, where art and science need to be yoked together yet held apart in order to accure the strengths of their polar positions – soft versus hard, intuitive versus analytical, inductive versus deductive, visual versus logical. For her, then, an inadequate understanding of this interrelationship has the potential to render medicine facilely described and poorly understood, given that medicine is far more than just a body of scientific knowledge and a collection of well-practised skills, but rather the conjunction of the two: ‘the rational, clinically experienced and scientifically informed care of sick people’.\textsuperscript{16}

We have, in modern medicine, then, a seemingly contradictory proposition, where it can be claimed or even demonstrated that science has diminished clinical medicine as well as advanced it. Surely, the articulation of such a claim may on first reading appear utterly extraordinary, even ridiculous. Yet Leder\textsuperscript{17}, for example, has argued, that clinical medicine can best be understood not as a pure science, but rather as a hermeneutical enterprise, an activity involving the ‘interpretation of texts’ where the physician seeks to arrive at a coherent reading of the ‘text of the ill person’. This hermeneutic of medicine is rendered uniquely complex by its wide variety of textual forms, including the experiential text of illness as lived out by the patient; the narrative text constituted during history-taking; the physical text of the patient’s body as objectively examined and the instrumental text constructed by diagnostic technologies. Leder\textsuperscript{17} is clear that many of the most prominent flaws in modern medicine arise from its rejection of a hermeneutic self-understanding. Indeed, in seeking to escape all interpretive subjectivity, medicine has threatened to expunge its primary subject - the living and experiencing person of the patient. It is this very activity that has so powerfully assisted medicine’s depersonalisation, a position from which we need urgently to recover.\textsuperscript{1,11}

\textbf{REACTIONS TO MEDICINE’S DEPERSONALISATION AND SCIENTIFIC ADVANCEMENT}

The growing depersonalisation of clinical practice on the one hand and the exponential rise in biomedical and technological advance on the other have led to the appearance of two conceptually distinct approaches to clinical care: the patient-centered care movement and the evidence-based medicine movement, respectively. Before proceeding further, to an examination of what might constitute a ‘way forward’ for modern medicine, let us consider the core elements of these two movements and what they teach us, perhaps, of the elements that we might hold fast to in an ideal conception and practice of medicine and the elements which, in pursuit of the same, we might seek to reject.

\textbf{PATIENT-CENTERED CARE (PCC)}

The earliest contributions to the literature which present patient-centeredness as a conceptually distinct entity pre-date the two landmark papers by Engel already cited\textsuperscript{9,10}, although there seems little doubt that the development of patient-centered care has been highly influenced by Engel’s argumentation. A
sizeable increase in research activity and literature citation in the PCC field is documentable from the mid-1950s and the contemporary use of the term ‘patient-centered care’ is directly traceable to Levenstein and his co-workers, whose 1986 paper in *Family Practice* ‘The patient-centered clinical method – a model for the doctor-patient interaction in family medicine’, was greatly influential in generating an increased awareness of the need to move medicine back towards a clear focus on the individual patient. An attention to and maintenance of patient satisfaction with the process and outcome of healthcare intervention has remained at the heart of the movement from its inception and throughout its history to the present day. Deriving from efforts to place the patient and his needs and circumstances at the very centre of clinical consultations, patient-centered care was characterised initially not so much by a definition of what it was, but rather by explanations of what it was not: not technology-centered, not doctor-centered, not hospital-centered, not disease-centered.

The evolution of the movement has generated varying and sometimes inconsistent definitions of person-centeredness and has yielded differing results from independently conducted studies. This is perhaps unsurprising, given the lack of availability of standardized tools for general use and also the wide range of disciplines conducting patient-centered care research. Here, differing disciplines, bringing with them differing perspectives and methodologies, have almost certainly generated the inconsistencies clearly visible within the literature, even though there is much obvious convergence of their overall philosophies. For example, patient-centered care has been described by one school of thought as conceptually based on the effects of illness on the patient, his family and healthcare providers and how these effects of illness are dealt with. A related school of thought insists that patient-centered care, while clearly focussed on the patient and his family, is based on ensuring a recognition of the patient’s values, preferences, abilities and self-expressed needs. Yet another describes patient-centered care as maintaining the traditional doctor-patient model of care, but which ensures that the patient is at least informed as part of decision-making, if not necessarily actively participative, on the premise that shared decision-making may not be appropriate in all cases.

Other approaches to conceptualisation have elected in favour of a far more encompassing and broader approach to study. Of particular relevance here is the landmark investigation by Gertels and colleagues, cited earlier, which addressed four principal questions to patients, their families and healthcare providers in an attempt to determine the basis of what should constitute person-centered healthcare: (1) What do patients want? (2) What do patients value? (3) What helps or hinders their abilities to manage their health problems and (4) What aspects of care are most important to patients and their families? On the basis of the results obtained from their study of more than 8000 subjects, Gertels and associates were able to identify 8 individual dimensions of patient-centered care:

1. Respect for patients’ preferences, their values and self-expressed needs;
2. Physical comfort;
3. Emotional needs;
4. Communication, information, education and explanation;
5. Access to healthcare services;
6. Continuity of care and follow-up;
7. Involvement of the patients’ family and friends in the care process and decision-making; and
8. Coordination and integration of healthcare services.

Stewart has noted that patients, when offered a patient-centered model of care, elect overwhelmingly in favour of this approach to healthcare practice and delivery, understanding this ‘option’ to be one which (a) explored the main reason for their visit, concerns and need for information; (b) sought an integrated understanding of their individual ‘world’, that is, their whole personality, emotional needs and life issues; (c) attempted to identify ‘common ground’ on what their problem was and to seek a mutual agreement on the method of management; (d) encouraged an enhanced approach to prevention and health promotion and, finally, (e) sought to enhance the continuing relationship between them and their doctors. Epstein, writing in the *Journal of Family Practice* in 2000 had argued that patient-centered care enables an expansion on the disease-orientated model of clinical care through its incorporation of the patient’s experience of disease and its ability to take account of the psychosocial context of illness, enabling also a greater interaction of clinician and patient in the form of shared decision-making. Here, emphasis had been placed on the centrality of trust and responsibility as part of patient-centered care.

In a provocative article, Berwick offered his own understanding of ‘what patient-centered should mean’, advancing a new definition: ‘The experience – to the extent the informed, individual patient desires it – of transparency, individualisation, recognition, respect, dignity and choice in all matters, without exception, related to one person,
circumstances and relationships in health care\textsuperscript{38}, acknowledging that patients would be able to modify the definition to include the experience of family and loved ones. Berwick acknowledges the radicality of his definition, recognizing that as part of his vision, the healthcare system would be ‘uncomfortably different’ from its current form. He advances eight separate determinants of such a new model: (1) hospitals would have no restrictions on visiting – no restrictions of place or time or person, except restrictions chosen by and under the control of each individual patient; (2) patients would determine what food they eat and what clothes they wear in hospitals (to the extent that health status allows); (3) patients and family members would participate in rounds; (4) patients and families would participate in the design of healthcare processes and services; (5) medical records would belong to patients. Clinicians, rather than patients, would need to have permission to gain access to them; (6) shared decision-making technologies would be used universally; (7) operating room schedules would conform to ideal queuing theory designs aimed at minimizing waiting time, rather than to the convenience of clinicians and (8) patients physically capable of self-care would, in all situations, have the option to do it.

Two recently published articles have continued the longstanding debate on patient-centered care. In the first, Epstein and Street argue that lost in the continuing discussions of patient-centered care has been a proper understanding of the ‘revolutionary meaning’ of what it is to be patient-centered. For these authors, patient-centered care is a quality of personal, professional and organisational relationships. Confusion over what patient-centered care actually means, the authors observe, can result in efforts to achieve it that appear superficial and unconvincing. They argue that with social changes in medicine, the operational definition of patient-centered care is changing and that measures to reflect these changes are therefore in need of development, especially given the large scale investments currently being made in the improvement of the patient-centeredness of healthcare interventions in many developed countries, confidently asserting that patient-centered care has “made it to center stage in discussions of quality”.\textsuperscript{39} In the second, Frankel and colleagues, observing the progress of the patient-centered care movement to date, argue that a more recent expansion of the patient-centered care model is represented by the emergence of a renewed emphasis on the concept of relationship-centered care.\textsuperscript{40} The authors contend that inherent in patient and relationship-centered approaches is the idea that establishing and maintaining healing relationships is central to delivering high quality healthcare, requiring the clinician to have achieved a deep personal knowledge of himself. This perspective is noteworthy, emphasising as it does, the requirement for the acquisition of self-awareness skills, essential if the clinician is to respond empathetically to a patient’s expression of suffering or if he is to consider his own sadness in delivering bad news. In this context, Frankel and colleagues proceed to examine three principal educational approaches to self-awareness: mindful practice, formation and communication skills, describing in detail how each approach can actually be taught.\textsuperscript{40}

Evidence-based medicine (EBM)

Evolving in parallel with the patient-centered care movement, but rarely having entered into dialogue with it, has been Evidence-based Medicine (EBM). The term was first employed by Guyatt in 1990, with the nomenclature appearing briefly within the literature in 1991\textsuperscript{41} in advance of the formal promulgation of the method within the Journal of the American Medical Association in 1992 as a ‘new approach to teaching the practice of medicine’\textsuperscript{42}, which asserted that the current paradigm in which international medicine was imbedded had become untenable and was urgently in need of substitution by a new philosophy of medical practice and teaching. EBM, advanced as the ‘new paradigm’ for medical practice, de-emphasized intuition, unsystematic clinical experience and pathophysiology as adequate grounds for clinical decision-making, preferentially recommending the use of scientific evidence from clinical research as the basis for practice. For the first time, an explicit recommendation was made within medicine that argued for medical practice to be based on the principles of clinical epidemiology, astonishingly accompanied by a formal admission from the authors that no definitive evidence existed to demonstrate the superiority of the proposed new paradigm over and above the existing one.\textsuperscript{41,42}

The 1992 promulgation of the EBM thesis excited differing responses from differing sections of the international healthcare community, with learned controversies focussing on what exactly counted as knowledge for action in clinical practice and early rejections of the so-called hierarchy of evidence proposed by EBM and of the notion of a paradigm shift as having taken place. The scale of reaction within the global medical community to
EBM’s claims\textsuperscript{43} and the failure of the 1995 Davidoff Editorial ‘Evidence-based medicine: why all the fuss?’\textsuperscript{44} and other associated works to extinguish the controversy generated, led Sackett to publish a further paper one year later entitled: ‘Evidence-based medicine: what it is and what it isn’t’.\textsuperscript{45} A similarly brief Editorial, it likewise failed to resolve the tensions that had arisen from a demand by the proposed ‘new paradigm of medicine’ that the basis of clinical practice should be biostatistical data derived from quantitative study designs, with the randomised controlled trial described as the gold standard for the generation of evidence for patient care and cumulative meta-analysis of randomised studies, a statistical technique laden with methodological limitations, advanced as a powerful source of evidence for clinical decision-making.\textsuperscript{42}

Such a model of medicine, affording primacy in clinical decision-making to scientific evidence derived from epidemiological study designs conducted in rarefied trial populations (the so-called ‘E’ of EBM), effectively precluded the use within medical practice of the plurality of other sources of clinical knowledge of immediate relevance to the care of patients and for this reason EBM quickly became described as dogmatic, reductionist and scientistic. Indeed, Feinstein and Horwitz, writing in the American Journal of Medicine in 1997, were clear that EBM, by its nature, was effectively unable to assimilate the humanistic dimension of clinical practice which included, as the authors pointed out, psychosocial factors and support, the personal preferences of patients and strategies for giving comfort and reassurance.\textsuperscript{46} The fundamental inability of the EBM model of practice to incorporate such vital inputs to the decision-making process when such inputs are in conflict with the ‘E’ of EBM, has been clearly visible from the inception of EBM in 1992, directly to the time of writing. A recent and highly noteworthy analysis from the EBM Community admitted as much\textsuperscript{47}, describing this fundamental inability of EBM as ‘vexing’, with extensive scholarly commentary confirming the same.\textsuperscript{48-54} Even the latest Apologia from the EBM Community\textsuperscript{55} fails, on detailed analysis\textsuperscript{56}, to resolve this philosophical and clinical conundrum, directly indicating a foundational irreconcilability between the fundamental principles of EBM and those of patient-centered care, a profound difficulty to which I will turn later in suggesting an approach aimed at resolution.

Such an observation of irreconcilability is, perhaps, unsurprising. The idea that data derived from the results of intrinsically methodologically limited epidemiological study designs such as RCTs and meta-analyses would be routinely applicable to individuals in clinic or at the bedside and that the recommendations from EBM-style systematic reviews of the literature could ever have formed the base of clinical practice as required by evidence-based medicine, was always an intellectual and clinical ‘impossibility’ even an absurdity. Sackett and colleagues had, certainly, talked in terms of the importance of ‘integrating individual clinical expertise with the best available external clinical evidence from systematic research’, discussing also the need to consider “individual patients’ predicaments, rights and preferences in making clinical decisions about their care”.\textsuperscript{57} Unfortunately, however, neither at the inception of EBM\textsuperscript{42}, nor in its subsequent major publications\textsuperscript{57-59}, nor in articles purporting to address such issues\textsuperscript{60}, nor in the current incarnation of EBM\textsuperscript{61} are coherent methods advanced through which to integrate patients’ predicaments, rights and preferences with the E of EBM, that is to say, with quantitative trial data, in the making of clinical decisions.

The debate on the philosophical tenability of the EBM thesis and on its clinical validity has, at the time of writing, spanned 22 years. Now, following these 22 years of intensive philosophical and clinical argumentation\textsuperscript{62-76}, there are indications of a final recognition by the EBM community of the inescapable complexity of clinical practice which mandates a need to embrace and maintain the human dimension of medical care. Certainly, medicine has witnessed no less than four serial reconstitutions of the EBM philosophy and method since the publication of the initial EBM thesis to date. Charles and her colleagues\textsuperscript{61}, for example, writing from the same department and institution which saw the birth of EBM, are clear that the sequential revisions of the initial 1992 EBM model of practice demonstrate a lack of clarity and logic, being inconsistent and incomplete, with an ambiguity and incoherence that results from the lack of an underlying theoretical basis and the absence of empirical evidence to support the validity of the EBM thesis, even in its current incarnation, ‘Version IV’.\textsuperscript{61} In an impressive analysis, these authors conclude that EBM is more belief-based than evidence or theory-based and under-developed in terms of the articulation and definition of its constituent components, being devoid of a justification for the inclusion of varying principles into successive revisions of the EBM model and lacking
a philosophical and methodological approach for the integration of EBM’s ‘values’ into routine clinical practice. It is for these reasons, the others I have discussed above and with reference to the substantive content of the citations made, that I contend that evidence-based medicine, even as ‘Version IV’\textsuperscript{61}, remains highly problematic as a conceptually coherent and practically viable model of modern medical practice and that a further reconstitution of both nature and scale is necessary to cause a modification of EBM’s current status and use within clinical medicine. To begin to understand the reasons for and necessity of such a reconstitution we may turn to Hartzband and Groopman.

Hartzband and Groopman\textsuperscript{77} have noted that the success of modern health will involve medicine taking a fuller account of the complex psychological, sociological and cultural factors with which patients present and that the skills associated with humanism in medicine will become more and more important in helping physicians to understand patients’ values and needs, so that there is an urgent need to ensure a “thoughtful collaboration between evidence-based medicine and humanism”. Groopman is clear that a dual use of both science and humanism in the decision-making process is needed, but where the need for cost-effectiveness and containment is also properly acknowledged. In discussing the parallel emergence of the patient-centered care and evidence-based medicine movements, the authors fear that, ‘now, when it is most important for them to coalesce, they are poised to collide’.\textsuperscript{77} The authors believe that such an ‘outright collision between medical humanism and evidence-based guidelines for standardized care can be avoided as long as clinical guidelines (beyond safety measures) remain recommendations rather than mandates’. Since increasing cost pressures within health services tend for their own purposes to favour standardization as a means of cost-containment and given that evidence-based medicine remains ideologically committed to scientific evidence as the base of clinical practice, this is an important point – indeed warning. Not that EBM and cost-containment are normative bedfellows. On the contrary, and as Miles and Loughlin\textsuperscript{78} have pointed out, EBM is as a model of practice a ‘two-edged sword’ for healthcare policymakers, fully capable of greatly increasing healthcare costs as well as reducing them as a function of its identification, through its own rules, of what ‘works’ (‘evidence’) in clinical practice and what does not.

It is in my view important to join with Hartzband and Groopman\textsuperscript{77} in respecting the fundamental ethical recognition within medicine that it is the patient who must exercise the final choice of treatments and interventions as part of the clinical decision-making process as it is he or she who will either benefit or suffer from that choice. Thus, a healthcare system which mandates the use of ‘evidence-based’ guidelines as part of, for example, a UK NHS-style commissioning system or a US-style ‘pay-for-performance’ model, has the potential to lead directly to a ‘misaligning (of) the goals of doctors and patients’. Clearly, a system which predisposes clinicians, even pressures or forces them, into recommending treatment options to patients that are not necessarily in the interests of the patient and which do not allow their values and preferences to be taken fully into account, is a retrograde action in a forward moving society. For Hartzband and Groopman, it is shared decision-making that represents the most obvious solution, with both patient choice and clinical judgement retaining a central place within the consultation.

**THE COALESCEENCE OF EBM AND PCC**

As described elsewhere\textsuperscript{4}, I agree with Hartzband and Groopman\textsuperscript{77} that the time has come for EBM and patient-centered care to coalesce and for precisely the reasons that these authors discuss. While both the EBM movement and the patient-centered care movement have challenged medicine to move forward in an entirely necessary manner – EBM actively insisting that greater attention should be given to the results of biomedical and technological advance and patient-centered care insisting that greater attention should be given to the needs of the individual patient – both models ultimately lack a vision of medical practice that logically accords with the Hippocratic ideals and historic mission of medicine as a science-using (not ‘based’) practice, centered upon the persons of the patient and the clinician(s) engaged in a mutual and dialogical process of shared decision-making, focussed on the patient’s best interests, within a relationship of equality, responsibility and trust. How, then, may such a coalescence be achieved, for the purposes for which it has become necessary? After all, the greatest body of the patient-centered care literature advances a definition of the activity that is conceptually in complete opposition to that of evidence-based medicine, so that a fundamental irreconcilability may be identified between the two models when they are analysed comparatively.

In order to initiate a debate on how conceptu
ally such a coalescence could be achieved and how methodologically it could be operationalized for practical use within clinical medicine, I have argued that medicine does not have or need a base, but that by its nature it is of its essence a science-using (not ‘based’) practice which operates well within a dynamic framework centered upon the persons of the patient and the clinician(s) engaged in the mutual and dialogical process of shared decision-making, focussed on the patient’s best interests, within a relationship of equality, responsibility and trust. Thus, it is contended that while it is imperative that medicine must be actively and continuously informed by science, science cannot function as the base of medicine and that the dialogical nature of the consultation precludes a patient-centered approach. Instead, I assert that a model is therefore required which enables science to inform clinical practice alongside a range of other warrants for decision-making and that the consultation must be centered upon both patient and clinician(s) and that this model is represented by a medicine not reductively focussed on the person as a patient, but rather centered on the patient as a person.

In his 2002 article: ‘If not evidence, then what? Or does medicine really need a base?’, Upshur noted that in response to the emergence of EBM, several commentators had argued for the importance of including qualitative dimensions of clinical practice as constitutive of the base of medical practice, identifying narrative-based medicine, context-sensitive medicine, interpretive grammar, clinical ‘jazz’ and tacit knowing, in example. Upshur was clear that a common theme among these varying approaches to a more complete form of clinical practice than had been envisioned by EBM was the need to overcome the dualism between facts and values and to foster a realisation and acknowledgement of the complex interplay of values, perceptions and beliefs that frame how medicine is practised, dimensions which have typically and historically escaped the conceptual thinking and methodological preferences of the EBM thesis. Reviewing the interpretive approach in medicine alongside a consideration of phenomenological approaches to clinical practice, Upshur was clear that the value of anti-foundationalism in medicine is precisely that it pushes medicine away from simplistic conceptions of the relationship of science and medicine and actively prevents incomplete and reductionist models of practice, such as EBM, from prevailing. In summary, Upshur argued that scientific evidence is unable to function as the base of medicine and that (from the anti-foundationalist standpoint), medicine is not in need of a single, solid foundation, but can operate well within a dynamic emergent framework. Not that foundationalism, per se, is automatically excluded from a coherent theory of medicine. On the contrary, and as Upshur, pointed out, real possibilities exist for the integration of categorically different approaches within medicine, so that science and art and fact and value, rather than being held apart as polar opposites, can and should be increasingly yoked together in the service of medicine and humanity.

Within this overall context, perhaps the most striking development in recent medical discourse which reflects an acknowledgement of the ‘impossibility’ of a medical practice based on quantitative trial data alone, is the increasing use by colleagues and institutions that previously would have employed the prefix ‘evidence-based’ (and did so incontinently), of the prefix ‘evidence-informed’ (italicisation mine). The Evidence Centre of the British Medical Association’s journal, for example, now speaks in terms of ‘building evidence into practice’ and ‘developing evidence to inform healthcare decisions’, so that healthcare can be improved by ‘putting the most current research into practice, alongside healthcare professionals’ experienced and expert opinion’ (italicisation mine) and the Cochrane Collaboration has similarly presented its vision that ‘healthcare decision-making throughout the world will be informed by high quality, timely research evidence’ (Italicisation mine). Moreover, Godlee, Editor-in-Chief of the British Medical Journal, writing jointly with Rawlins, Chairman of NICE in the UK (an influential healthcare guidance-making body actively advising a range of non-UK governments), now speaks in terms of the need to promote ‘cost-effective, evidence-informed healthcare policy as a means of improving global health ... (to) ... support rational decision making’ (italicisation ours). Of notable symbolic importance is the Oxford Centre for Evidence-Based Practice, founded by David Sackett, which now appears to promote ‘the integration of relevant evidence with clinical experience ... (as forming) ... the cornerstone of evidence-based practice’ (italicisation ours). In further example, the UK Centre for Reviews and Dissemination (founded on the original principles of EBM) now talks of its mission as one which aims to formulate databases for use in underpinning ‘evidence-informed healthcare decisions in the UK and internationally’ (italicisation mine).
CLINICAL MEDICINE, INFORMED BY BUT NOT BASED ON SCIENTIFIC MEDICINE AND EMPLOYING A RANGE OF OTHER ‘WARRANTS’ FOR DECISION-MAKING

The suggestion that medicine and healthcare practice more generally should be informed by science and not dogmatically based upon it is not new, but the understanding of how an ‘informing’ of medicine and of the patient should take place has taken various forms. Glasziou, for example, employed the term in 200590, although in a manner appearing to have been advanced more for strategic rather than philosophical reasons. Indeed, being predicated on the belief that once patients are informed of the EBM that they were potentially ignoring, they would then (almost certainly) confirm a change in their thinking. As Nevo and Slonim-Nevo’s excellent 2011 paper ‘The myth of evidence-based practice: towards evidence-based clinical decision, risks description as essentially a paternalistic re-assertion of the central tenet of EBM via a rhetorical sleight of hand. A detailed and scholarly discussion of the need for an evidence-informed approach to healthcare practices more generally may be obtained via a reading of Nevo and Slonim-Nevo’s excellent 2011 paper ‘The myth of evidence-based practice: towards evidence-informed practice’.91

A model of clinical care that is fully and actively informed by a complete knowledge of the latest, clinically accepted scientific evidence, rather than ideologically and ‘impossibly’ based upon it, is suggested to be entirely uncontroversial, logically in accordance with the natural evolution of medicine as a science-using practice and fully consonant with the principles of patient-centered care. But quite what would such a model of care look like if it were to be based on no one source of knowledge for action in clinical practice, but where it preferentially drew upon – and was informed by - a plurality of sources? To begin to answer this question, we must turn to Tonelli.

Tonelli, a clinician-philosopher in the University of Washington School of Medicine, Seattle, USA, noted the importance of models of healing that contended that the treatment of disease rests upon an understanding of illness in the context of the individual patient.92 Observing that patients seek unconventional therapies not only when conventional therapies have failed, but also when they are perceived to be emotionally or spiritually without benefit93, Tonelli reminds his readers that focussing primarily on quantitative scientific evidence as the basis of clinical decision-making ‘minimises the importance of the intangible physical, emotional and spiritual aspects of illness in the healing process’. Ignoring the importance of these factors would be, then, to ignore the importance of the individual and his circumstances and thus to impoverish the philosophy of medicine as a practice aimed at the treatment of individuals. Thus, Tonelli contended that EBM was ‘unable to promise the best decision in a particular situation’, therefore appearing to compromise the historic mission of medicine which has always required that physicians use medical expertise to respond to the needs of a particular individual.92,93 Noting that clinical medicine is, by its very nature, ‘practical, prudential and personal’, Tonelli concluded that medical practice resembles casuistry far more than it does science94 and that while medicine could benefit a great deal from some of the exhortations of EBM, there was an urgent need to broaden the understanding of what exactly constitutes medical knowledge and reasoning within modern clinical practice. In this context, it was essential for EBM to recognise and embrace the value of all those other forms of knowledge for action in clinical practice that are non-quantitative and clinical trial-based in nature, in order to be able to describe and practise a ‘complete and coherent account of the unique undertaking that is clinical medicine’.92

In 2006, in a landmark paper published within the Journal of Evaluation in Clinical Practice entitled ‘Integrating evidence into clinical practice: an alternative to evidence-based approaches’97, Tonelli presented and discussed a range of what the author described as ‘warrants’ for clinical decision-making, moving the EBM-dominated landscape for clinical practice away from an ideological reliance on science as the basis for decision-making. A further article by Tonelli, published in 200798 following scholarly interchange and discourse99-110 on the 2006 paper97, remains of considerable relevance to the person-centered medicine debate.

In Tonelli’s casuistic model, the potential warrants for clinical decision making fall under five general topics: (1) empirical evidence; (2) experiential evidence; (3) pathophysiological rationale; (4) patient values and preferences and (5) system features. These warrants are presented as exhaustive and necessarily so, in order to ensure that the casuistic model is both explanatory and descriptive. As Tonelli points out, none of the topic areas can stand alone, or hierarchically, as a basis for decision-making, given that some will be insuffi-
cient in certain situations and others irrelevant, as a function of the particular circumstances of the given individual patient. Importantly, the model provides for a fuller account to be taken of the complexity of individuals and of human relationships, greatly more so and much more easily than the EBM model which comprehends these features only when they can be converted into quantifiable patient ‘utilities’. Here, the casuistic model allows the clinician, as part of the doctor-patient interaction, to employ the skills of empathy and compassion, of listening and of being present and to understand and appreciate the need for a personal inquiry into the patient’s own narrative of illness. Finally, the model additionally allows a further perspective to be factored into clinical decision-making and without which it would be essentially incomplete – an adequate consideration of the social context of the patient.99,98,109,110

Tonelli’s casuistic model remains a work in progress in terms of its need to produce case-based studies that demonstrate the application in clinical practice of warrants other than those derived from empirical evidence, but it directly provides some of the theoretical and clinical framework for an actively science-informed, yet humanistic medicine which takes a fuller account of the patient as a person than is observable within international medicine at the time of writing. As such, it is of considerable relevance to the philosophical underpinning and methodological development of efforts to re-personalise presently de-personalised models of clinical care and service provision. It is precisely to this urgent imperative that I now turn, in providing an account for the reader of the current status of the rapidly emerging person-centered model of clinical practice.

PERSON-CENTERED MEDICINE

BASIC PRINCIPLES

In order to participate in the securing of the authentic development of clinical medicine that is person-centered clinical practice, it is difficult to see how EBM can escape the necessity for a fifth reconstitution (beyond its current and fourth metamorphosis), as part of which its vertically ordered hierarchy of evidence is rotated 90 degrees, as it were, to become fully and thus non-hierarchically horizontal.1 When such a horizontally ordered library of clinical knowledge sources to inform clinical decision-making is created, several additions must be made to it and these will be largely qualitative and directly person-related in their nature. None can be given greater weight than another, given that the usefulness of the given knowledge source(s) will depend on the unique circumstances of the individual patient and his/her expected outcomes and goals. It is of course recognised that such a major revision of EBM’s epistemology will necessitate a great sacrifice of its original foundational principles. Unfortunately for EBM, there is no real via media available to it through which it can seek to preserve its ideologies of hierarchy - and overt scientism2,4 - in this context. This, then, is the great opportunity represented by medicine’s crisis – the opportunity to move away from the rigid and hopelessly reductive epistemology of EBM that has dominated – and greatly impoverished - medicine in recent years, towards an epistemology that directly enables person-centered clinical decision-making and treats patients as persons, not complex biological machines. We have, then, the opportunity to move from an evidence-based to an evidence-informed way of ‘thinking’ and ‘doing’.1

NOMENCLATURE

Epstein36,39 noted in the context of patient-centered care that “although different authors have used different nomenclature, the fundamental idea is that the process of healing depends on knowing the patient as a person, in addition to accurately diagnosing their disease” (italicisation mine). I agree. And it is for this reason and the others that I outline below, that I argue for the preferential use of the prefix ‘person-centered’. This terminological use derives not from personal style or aesthetic preference, but rather from a philosophical understanding of personhood. It is unfortunate that the use of the nomenclature ‘person-centered medicine’ risks the accusation that such a term represents a further rhetorical addition to the already rhetorically over-burdened nature of health services. It is certainly true (as was and remains the case for ‘evidence’ in EBM) that the prefix ‘person-centered’ possesses a degree of rhetorical force, having an emotive component as well as a descriptive one. It is, (as ‘evidence-based’ is in EBM), a pleonasm, a superfluous addition to the word ‘medicine’. The PCM movement has, however, elected to employ the prefix ‘person-centered’, not for reasons of sensationalism or hubris (as characterised the inception and promotion of EBM)41-45, 62-64, but rather as a simple mechanism to remind medicine of its epicentre – the person of the patient – at a time when the centrality of the patient within healthcare has become displaced or ignored. As Miles and Loughlin78 point out, when the argu-
ments are won for a medicine informed by rather than one based on the E of EBM and where the person of the patient returns to the very centre of the clinical encounter, all such prefixes may then be detached from ‘medicine’, their usefulness and necessity by that point having become mercifully defunct.

A WORKING DEFINITION

Some of the key principles of person-centered care have been advanced as follows, describing it as: (1) a wide, biological, psychological, socio-cultural and spiritual theoretical framework; (2) an approach which attends to both ill health and positive health; (3) a system which advocates person-centered research and education on the process and outcome of the patient-family-clinician communication, diagnosis as shared understanding, and treatment, prevention and health promotion as shared commitments; (4) a model of respect for the autonomy, responsibility and dignity of every person involved in the care process and (5) a philosophy of partnerships at all levels.111,112 The fundamental need for contextualization, cross-sectionally and longitudinally, is fully in accordance with the philosopher Ortega y Gasset’s dictum: ‘I am I and my circumstance’.

Employing these principles and drawing on others, Miles has defined person-centered medicine as:

“A system of care which allows continuing and affordable advances in biomedicine and technology to be delivered to patients within a humanistic framework that recognises the patient as a person and which takes full account of his stories, values, preferences, goals, aspirations, fears, worries, hopes, cultural context and which responds to his psychological, emotional, spiritual and social necessities in addition to his physical needs with empathy and compassion in a shared decision-making and ethically intimate clinical relationship”.1,4,11,13

While the complexity of such a definition is fully acknowledged, it is contended that the definition does nothing more than reflect the complexity and dignity of the human person in all his richness, laying out the fundamental principles and imperatives of medicine while at the same time identifying the individual indices for attention and action within the diagnostic and therapeutic process and the basis for continued dialogue, understanding and follow-up when the person of the patient experiences illness and presents asking for help. The definition, though substantive, is nevertheless provisional and thus remains subject to modification as learning progresses in the usual manner.

THE WAY FORWARD

The person-centered model of clinical practice envisaged by Miles1,4,11,13 is intended to progress the concept of a ‘person-centered’ approach to illness beyond a purely theoretical framework dominated by the repetitive institutional rhetoric of recent years, towards the debate and development of illness(es)-specific models of care that can be formally evaluated for use in practice. Having established the International Journal of Person Centered Medicine as the major organ of international communication in PCM and having launched the International Conference and Publication Series on Person Centered Healthcare,113,114 two flagship developments intended to drive major progress in the debate and realisation of pragmatic models of PCM for operational implementation within health services, sustained attention must now be devoted to the development and use of person-centered teaching programmes within the medical undergraduate and postgraduate training years and in clinical curriculum more generally. Since evidence suggests that the early idealism associated with medical school entry begins to diminish in Year 3,11 the importance of employing appropriate teaching interventions before this time is self-evident. In addition, it has been suggested that more sensitive entry selection criteria might also be substituted for those that are currently in place, so that only those students with a high degree of commitment to humanistic healthcare are selected from the large body of students that apply for entry.1,11 Such initiatives are already underway within Europe and will be documented within the IJPCM shortly. In addition, it will be important for the PCM community to become more actively involved in the updating process of national, European and International illness-specific clinical practice guidelines, so that person-centered medicine prompts and audit of use indices are included in these guidelines alongside their biomedical and technical prescriptions.

Taking all of the above into full account, it becomes clear that person-centered medicine is, above all, a moral enterprise and that all those who are involved in developing and practising it are, de facto, part of a moral community. As a function of the development of its moral community, PCM is evolving its own lexicon to complement and add to that which modern medicine has accumulated throughout its history. Here, words and phrases such as ‘wellbeing’, ‘positive health’,

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episteme, techne and phronesis

association of

to be found, enabling, as it does, a functional approach reconnects the science, humanism and aspects of care for the patient and his/her personal circumstances than can either EBM or PCC functioning separately, so that none a reductive anatomico-pathological, disease-centric model of illness (EBM), nor an aggressive patient-directed, consumerist form of care (PCC), is allowed continued dominance within modern healthcare systems. The mechanics of how such an ‘integration’ or ‘coalescence’ might take place are currently the subject of intensive philosophical and methodological enquiry, but the overall aim is to create a model of medicine which “enables affordable advances in biomedicine and technology to be delivered to patients within a humanistic framework of clinical practice that recognises the patient as a person and which takes full account of his stories, values, preferences, goals, aspirations, fears, worries, hopes, cultural context and which responds to his psychological, emotional, spiritual and social necessities in addition to his physical needs with empathy and compassion in a shared decision-making and ethically intimate clinical relationship”.

PCM should not be superimposed on current practice, less so juxtaposed alongside it. Rather, the aim is to transform healthcare, so that current practice is not modified or contrasted in this way, but rather transformed. It is the tenacious pursuit of such transcendent humanism in healthcare that must remain a key feature of the PCM movement. In addition, we must strive to demonstrate empirically what we believe probabilistically to be the case – that PCM is a superior model of care to the EBM and PCC models in their current forms. For this, primary and secondary research and the development of the necessary evaluative methodologies will be crucial. There is no suggestion that the person-centered care movement seeks to establish one, singular, rigid, superior and ‘unified’ model of clinical practice that can be formulaically described, prescribed and commissioned. On the contrary, medicine works best as a practice informed by a variety of sources of knowledge and warrants for decision-making and the profound heterogeneity of the individuals and populations it serves utterly precludes a ‘one size fits all’ model, much to the frustration of those who would seek to impose a standardised form of clinical action in the interests of reductions in clinical practice variations and cost containment and control.

In seeking to apply science with humanism, via clinical judgement, within an ethical framework, PCM can legitimately claim to be evolving consequentially out of the intersection of all four components of an authentic medicine. Such a new model of practice aims to be far more ‘fit for purpose’ and responsive to the needs of the individual patient and his/her personal circumstances than can either EBM or PCC functioning separately, so that none a reductive anatomico-pathological, disease-centric model of illness (EBM), nor an aggressive patient-directed, consumerist form of care (PCC), is allowed continued dominance within modern healthcare systems. The mechanics of how such an ‘integration’ or ‘coalescence’ might take place are currently the subject of intensive philosophical and methodological enquiry, but the overall aim is to create a model of medicine which “enables affordable advances in biomedicine and technology to be delivered to patients within a humanistic framework of clinical practice that recognises the patient as a person and which takes full account of his stories, values, preferences, goals, aspirations, fears, worries, hopes, cultural context and which responds to his psychological, emotional, spiritual and social necessities in addition to his physical needs with empathy and compassion in a shared decision-making and ethically intimate clinical relationship”.

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In conclusion, it is contended that by attempting to arrest the depersonalisation and dehumanisation of clinical practice and then to reverse it and by being, fundamentally, a moral enterprise\textsuperscript{11}, the development of PCM may come to warrant Pellegrino’s description of a model of care that represents ‘the most humane of the sciences, the most scientific of the humanities’.\textsuperscript{115-117} With such notions duly considered, it is confidently predicted that the development and operationalization of PCM as an authentically anthropocentric model of healthcare, is set to become one of the defining features of 21st Century Medicine.\textsuperscript{1} The Medical University of Plovdiv of Bulgaria, in assimilating such arguments and in instituting person-centered medical teaching within the University, is to be commended and it is hoped that such noteworthy and laudable efforts will provide salutary examples to other medical schools within Europe and elsewhere.

ACKNOWLEDGEMENTS

I thank Professor Stefan Kostianev, Editor of \textit{Folia Medica} and Rector of the Medical University of Plovdiv for his interest in my work and for commissioning the current opus. Personal gratitude is also due to Associate Professor Drossi Stoyanov for his unfailing collegial encouragement and support and for our many stimulating and informative discussions on person-centered medicine that have greatly assisted my thinking in the field. The current work has drawn substantially and directly on numerous works of previously published scholarship by Andrew Miles in the \textit{International Journal of Person Centered Medicine} and the \textit{Journal of Evaluation in Clinical Practice} and on the published content of plenary lectures delivered by that author to learned clinical associations and societies in Rome, Milan, Madrid, Vienna, New York, Washington DC, San Francisco and London.

DEDICATION

Ad majorem Dei gloriam

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Наука, гуманизм, преценка, этика, пациент. Гуманизм в медицина - новая модель в современной клинической практике

Андрю Майлз

Резюме

„Посвященные гуманизму“- это девиз Медицинского университета, Пловдив. Но что такое гуманизм в современной медицине? Разве возможна медицина без гуманизма? В настоящей работе утверждается, что современная медицина все больше практикует деперсонализируемую модель, т.е. на пациента глядят не как на уникального человеческого индивида, а скорее как на субъект или объект, как на сложную биологическую машину. Утверждается также, что медицина удалилась от своей обязанности создавать комфорт, утешать, как и ухаживать за пациентом, ослаблять страдание, лечить, и как и не пародоксально, но главный виновник этому - это быстрое развитие научного медицинского знания. Рассматриваются сигнальные события в движении „пациент как личность“ вместе с появлением доказательственной медицины, как и действия, направленные на уход за пациентом. Отмечаются и описываются характеристики модели в медицине, развивающейся в ответ на ее сегодняшние недостатки. Истинное здравоохранение должно быть направлено на пациента как личность. Посредством стремления применять науку вместе с гуманизмом и посредством клинической оценки пациент-ориентированная медицина оказывается намного более отвечающей потребностям отдельного пациента по сравнению с имеющимися моделями в практике. В современных системах здравоохранения нельзя доминировать ни одна редуктивная анатомо-патологическая, направленная на болезнь модель, ни агрессивная и направленная на пациента потребительская форма ухода.

В заключение утверждается, что направленная на пациента медицина приведет к вполне возможному прогрессу в биомедицине и технологиях. Такой прогресс предоставил бы пациентам гуманные рамки клинической практики, т.е. смотреть на пациента как на личность, принимать во внимание его историю, ценности, предпочтения, цели, стремления, надежды ... Такая гуманная медицина реализовала бы не только на психологические, эмоциональные, духовные и социальные потребности пациента, а и на его физические потребности. МУ Пловдив является автором замечательной похвальной инициативы и введения преподавания медицине, направленной на личность пациента, Университет будет полезным своим примером для других медицинских училищ в стране и в Европе.