

## EDITORIAL INTRODUCTION

### Person-centered medicine: identifying the way forward

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Dear Reader

While preparing the current issue of the *Journal* to go to print, 7 ‘hot off the press’ publications of direct relevance to the development of person-centered medicine were presented for our attention, the implications of which for the re-personalisation of clinical services we highlight here in welcoming you to the present edition.

The *first* paper, authored by Richard Frankel and his colleagues [1] and entitled ‘Crossing the patient-centered divide: transforming health care quality through enhanced faculty development’, appeared within *Academic Medicine*. Referring to the widely cited and influential 2001 Institute of Medicine (IoM) report ‘Crossing the Quality Chasm’, Frankel *et alii* remind their readers of the IoM’s assertion that patient-centered care remains one of the six central determinants of quality with clinical medicine and that an absence of patient-centeredness within the clinical consultation continues to be associated with poor outcomes in terms of patient satisfaction, reduced adherence to medical recommendations and an increased likelihood of medical malpractice suits. The authors review the philosophical and scientific foundations of patient-centered care (PCC) and relationship-centered care (RCC), suggesting that faculty development in three areas: mindful practice, formation and also training in communication skills, are all necessary to achieve desirable clinical outcomes. They first present concrete examples of teaching methods in these three areas, before offering five recommendations for faculty development, concluding with an examination of the link between patient-centeredness and the medical education revolution initiated by Flexner over a century ago.

The *second* paper, authored by Ronald Epstein and Richard Street [2] and entitled ‘The values and value of patient-centered care’, appeared within the *Annals of Family Medicine*. Similarly referring to the IoM’s ‘quality chasm’ report, the authors note that patient-centered care has now ‘made it’ to centre stage in discussions of medical quality, so that health care institutions, health planners, congressional representatives and hospital public relations departments all now include the phrase within their lexicons, with insurance payments increasingly linked to its provision. They emphasise that patient-centered care is a quality of personal, professional and organisational relationships and that helping patients to be more active within the clinical consultation can change centuries of physician-dominated dialogues. Training physicians to be more mindful, informative and empathic, they contend, transforms their role from one characterised by authority to one that has the goals of partnership, solidarity, empathy and collaboration. Emphasising the necessity for the development of indices with which to measure the extent of person-centeredness of clinical encounters and interventions, the authors conclude their paper with a range of recommendations for what now needs to be done in order to achieve patient-centered care within everyday clinical practice, listing the relevant stakeholders whose participation is vital in ensuring the success of such initiatives.

The *third* paper, authored by Cathy Charles and her colleagues [3] and entitled ‘The evidence-based medicine model of clinical practice: scientific teaching or belief-based preaching?’ appeared in the *Journal of Evaluation in Clinical Practice*. The authors argue that the sequential revisions of the initial 1992 EBM thesis 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’. In an extended analysis, they 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.

The *fourth* publication, a short monograph authored by Jeremy Howick of the Oxford Centre for Evidence-Based Medicine in the UK [4] and entitled 'The Philosophy of Evidence-based Medicine' and published by *Wiley-Blackwell/BMJ Books*, argued for a continued conceptual and methodological dominance of the EBM 'paradigm' within modern medicine, a thesis examined in our *fifth* publication by Tonelli [5], appearing in the *Journal of Evaluation in Clinical Practice*, who dismisses Howick's argumentation as 'not a philosophy of clinical medicine'.

Our *sixth* and *seventh* publications are represented by two articles examining the health economic implications of personalised approaches to clinical care. In the first of these, appearing in the *Journal of the American Board of Family Medicine*, Bertakis and Azari [6], employed an interactional analysis instrument with which to characterise patient-centered care in the primary care setting and to examine its relationship with health care utilisation. The investigators were able to document a decreased utilisation of health care services and lower total annual charges associated with their patient-centered medicine intervention. In the second paper, Ekman and her associates [7], in an article appearing within the *European Heart Journal*, evaluated the clinical and service outcomes of person-centered care approaches in patients with chronic heart failure (CHF) in terms of length of hospital stay (LOS), activities of daily living (ADL), health-related quality of life (HRQL) and 6-month readmission rate. The authors' findings directly suggest that a fully implemented person-centered care approach shortens LOS and maintains functional performance in patients hospitalized with worsening CHF without increasing risk of readmission or jeopardizing patients' HRQL.

What analysis might we formulate when considering this small selection of recently published 2011 papers? Importantly, the first two recognise that both patients and clinicians are *persons* within the clinical encounter, emphasising the essential humanity of medical practice and proposing interventions and measures to operationalize a more acceptable model of clinical practice than is perceived to exist at present and one that is in conformity with medical tradition, patient requirements and government recommendations. The third and fifth papers, having examined the propositions laid out within the defence contained in the fourth, find it wanting, suggesting that even in its current and fourth revision, EBM fails to represent a coherent and therefore acceptable model of clinical practice for our times. The sixth and seventh papers provide early evidence that patient-centered approaches to care, rather than increasing the costs of healthcare, may actually cause a reduction in resource utilisation, contributing important proof of concept data of immediate relevance to health economic studies of healthcare re-personalisation strategies. Taken together, then, these seven articles contribute yet further evidence to the literature that argues for the reformulation of medical practice in a manner which adopts the strengths of the EBM and PCC models, while rejecting their weaknesses. For us, such an emergent model of clinical practice is represented by Person-Centered Medicine [8].

We have categorised the 26 full papers of the current issue of the *Journal* into five subsections: (a) Evidence-based Medicine and Personalised Healthcare; (b) Women's Health and Person-centered Medicine; (c) Person-centered Healthcare Research; (d) Patient Preferences and Needs and Shared Decision Making & (e) Information Technology and Personalised Healthcare, concluding with an *Essay Review* on spirituality and personhood in Dementia. The individual papers speak for themselves and need no commentary from us here. We welcome a full and frank exchange of views and an active debate on the contributions published within this issue, not least on the *Discussion Paper* that we, as Editors and co-authors have contributed, in any of the usual formats of the *Journal*.

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