EDITORIAL INTRODUCTION & VIEWPOINT

Person-centered medicine - at the intersection of science, ethics and humanism

Andrew Miles MSc MPhil PhD

Editor-in-Chief, *International Journal of Person Centered Medicine* & *Journal of Evaluation in Clinical Practice*; Director: International Conference and Publication Series on Person Centered Healthcare; WHO Collaborating Centre for Public Health Education and Training, Faculty of Medicine, Imperial College London UK & Visiting Professor: University of Milan Italy & Medical University of Plovdiv and University of Sofia, Bulgaria; Distinguished Academician, National Academy of Sciences and Arts of Bulgaria & New York Academy of Medicine, United States of America.

Keywords
Biomedicine, ethics, guidance, hermeneutic of continuity, hermeneutic of rupture, humanism, informatics, information systems, leadership, medical education, methods, person-centered care, person-centered medicine, research, science, scientism, technology, tools

Correspondence address
Professor Andrew Miles, WHO Collaborating Centre for Public Health Education and Training, Faculty of Medicine, Imperial College London, c/o P. O. Box 64457, London SE11 9AN, UK. E-mail: andrew.miles@keyadvances.org.uk

Accepted for publication: 4 September 2012

Introduction

Modern medicine places great emphasis on the study of organ systems and the use in practice of objectively measurable biological indices of dysfunction and disease. While no one lucid would argue against the fundamental importance of such an approach, a point can be reached where such an emphasis becomes disproportionate in the sense that this so-called objectification of the somatic ignores (or rejects) the human dimension of illness and risks reaching a point where the patient is seen as part of the disease, rather than the disease being seen as part of the patient. Western medicine has ventured dangerously close to precisely such a point.

Yet a knowledge of illness in purely biological terms cannot but fail to understand the essence of the human person and the totality of 'what is wrong', so that without an understanding of the 'embodied life', medical knowledge is *ipso facto* incomplete. Such arguments remind one of Tournier whose writings are clear that a reductionist approach to clinical practice restricted to biomedicine alone is a dangerous activity, lacking an essential insight into the unified dimensions of being that constitute the human individual, so that there is a need in practice to augment a biomedical knowledge of the patient with knowledge of a different order, a knowledge which rejects the idea of the patient as an object or subject, but instead understands the patient as a *person* [1-4]. Certainly, not all physicians will agree with the claim 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, "modern scientific medicine is a *failure*" (italicisation mine) [5]. 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 the description "failure" might seem exaggerated, 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" [6].

An amnesia in medicine

If this contention – or observation – is accepted, then what precisely is it of which medicine appears to have become amnesic during this particular interval in its long history? In short, it is asserted that medicine has forgotten that it is primarily a human endeavour, a moral enterprise which employs science, but which does not equate to it [1,7,8]. The modern misrepresentation of medicine as science has, without doubt, directly driven the de-personalisation of the clinical encounter and has led to an incremental degradation of the doctor-patient relationship. With relationship-based practice so insulted by such developments, it is unsurprising that clinicians now concentrate preferentially on the biological body in isolation, 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, values, preferences and psychology, emotionality and spirituality and who presents at the consultation from a cultural context and a social situation [3]. We learn increasingly from patients themselves, as well as from our own daily observations, that this contextual reality, which is by its nature ‘immediate’ upon the experience of the individual patient, is routinely ignored by perhaps even a majority of today’s doctors. Indeed, when patients themselves resolve to disclose such person-related factors, the reaction experienced is often one of a startled clinician, sometimes visibly embarrassed or essentially mute. Yet these richly biographical data need not just be listened to avidly; rather, they should be directly elicited from the patient and fused with the results of biomedical investigation in the gradual building of the tapestry of the clinical picture. Without such an approach, a completeness of understanding with which to construct a meaningful, individualised care plan is impossible and the Oslerian teaching that “medicine begins with the patient, continues with the patient and ends with the patient”, becomes redundant, dismissed as a quaint aphorism, an understanding of medicine whose time has passed.

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 [10], for example, has argued, with others [7,8], 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 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.

Causative factors

How do we understand the transformation in medicine that may be causative in this context, which has brought modern medicine to a juncture where clinicians have ceased to be concerned with their patients as *persons*, as unique individuals with unique needs? Modern attempts at explication have concurred with previous ones in asserting (and as is referred to in outline above) 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 scientific medicine with scientistic medicine and an accompanying collapse of humanistic values in the profession of medicine [3]. It appears that as a direct consequence of phenomenal scientific and technical advance, medicine has decided that now that it can ameliorate, attenuate and cure, it has no need to care, comfort and console. Certainly, it has been contended that physicians are inherently humanistic in their understanding of the aims of medicine, but that overly bureaucratized and economically constrained health systems actively inhibit the exercise of this function. While there is little doubt that such factors contribute to the current crisis in medicine, studies have shown that today’s clinicians are wary of introducing empathetic and compassionate approaches into their care even when there is adequate time and opportunity to do so. Instead, they appear more inclined preferentially 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 [9].

A hermeneutic of discontinuity

Given that the science of medicine has become progressively *dis*connected from the humanistic understanding and framework in which it is properly and most effectively applied, we might argue that the progress of medicine has witnessed a ‘hermeneutic of rupture’, a ‘discontinuity’. If this is indeed the case, then what is correspondingly required – and urgently so – is a concerted effort to re-institute the previously operational ‘hermeneutic of continuity’, in order to re-orientate medicine to its fundamental mission and to eradicate from medicine the dehumanisation that has progressively occurred over latter years. What is implied here is not a ‘turning back of the clock’ to times, for example, where physicians relied uncritically on the “received wisdom that permeated the medical profession for so many centuries” [11]. On the contrary, properly understood, the suggestion is one aimed at the *re-sensitization* of medicine to the notion of caring, of humanism, while at the same time continuing vigorously to promote models of practice that allow continuing scientific advance to be incorporated into practice for the direct benefit of disease control and illness attenuation, through manipulations of patient biology aimed at modification of the trajectory of illness, assisted by other relevant therapeutic exercises. In this sense, it could cogently be argued that the *future* of medicine (continuing scientific and technological advance) is also to be found in its *past* (the humanistic method of care through which advances in science are most effectively applied to individuals). The usefulness of such a process of *re-sensitization* hardly argues for some sort of wholesale, alien or radical change to the character of medicine. On the contrary, it urges an *anamnesis* in the sense of a ‘remembering’ of what has been forgotten - or put aside -

with the aim of strengthening medicine and safeguarding its development within the utilitarian and economically driven systems that now typify current health services provision in the Western world.

Models of practice

Physicians, medical sociologists, philosophers of medicine and others have attempted to address all of the issues that have so far been discussed [12]. The biopsychosocial model has landmark status in this context, to be followed by relationship-based models of practice, the narrative model and a great deal many others [3]. All such attempts have been laudable, indeed entirely so, but have adopted an essentially singular approach to the problem, from the standpoint of a specific discipline or insight. It has been suggested that no one element of humanistic care can, in isolation, bring about a re-humanisation of medicine in the manner which has been suggested urgently necessary and that, on the contrary, a wide variety of humanistic components of care need to be brought together and integrated if real progress is to be achieved in, as it were, 'taking medicine *back* as well as *forward*'. It is person-centered medicine, as an emergent model of modern medical practice, which appears currently best placed to achieve this result [3].

Five ways forward for 2013 - 2017

Leadership

Firstly, in taking the global PCM *agendum* forward, strong, appropriate and above all a fully collegial international and regional leadership is necessary. Here, the ongoing development of the International College of Person Centered Medicine should consider the institution of an extended management structure (from a fixed term presidency downwards) consisting of the full range of clinical and academic disciplines that are essential for shifting PCM away from repetitive institutional rhetoric towards a measurable reality. For many clinicians, trainees and managers worldwide, PCM is directly associated with the specialties of psychiatry and family medicine, running the very real risk of a perception developing that PCM is of relevance only to these disciplines, rather than to medicine at large. It must be emphasised that person-centered medicine not only equates to good medicine, but predisposes to excellence in clinical practice and that this approach to care is therefore of immediate value to all areas of medicine, even though it has very particular importance in the care of long term chronic illness, the greatest challenge of our times [13,14].

Research

Secondly, qualitative investigations of the value of PCM dominate the evidence landscape and there is an urgent need to complement this form of research, though extremely valuable, with quantitative study designs. Such studies, in addition to demonstrating measurable changes in service utilisation such as frequency of consultation, hospital admission/re-admission rates, length of hospital stay and clinical indices such as illness exacerbation and medication adherence, etc., should also build in economic evaluations, so than cost measures of altered processes and outcomes of care can be generated. This particular dimension of experiment and analysis is of considerable importance, given that evidence is gradually accumulating which demonstrates the ability of PCM and PCM-type approaches to reduce overall healthcare resource utilisation rather than, as some colleagues assert, to increase it. A greater emphasis on research of this nature will bring PCM to the closer attention of health policymakers, commissioners of health services and reimbursement agencies, since a maintenance or increase in patient and clinician satisfaction with care in association with a containment or decrease in costs is an irresistible combination for politicians and institutional budget holders alike. If such 'hard' data remain elusive, no amount of conceptual rumination or rhetoric is likely to convince service managers and payers to consider a reconfiguration of services according to the PCM model and patients will continue to be denied access to the type of care that they self-express as highly desirable [3,4].

Education

Thirdly, much greater attention needs to be given to clinical education in PCM at the undergraduate as well as postgraduate level. With regard to the former, rather than aiming solely for students with extremely high educational achievement, undergraduate admission boards should aim also at assuring themselves, through the availability of hard evidence, of the humanistic qualities and humanistic personality traits of prospective students with an inability to demonstrate such qualities resulting in axiomatic disqualification from medical school entry. The enormously competitive admissions process would easily allow the selection of students *combining* such high qualities, rather than exhibiting one of the two, so that candidates are selected not only in accordance with what is in their heads, but also, as Cohen has put it, in terms of what is in their hearts [15]. Following admission, such students should be exposed to a far more person-centered study and training than is currently the case and which inculcates a profound respect and empathy for the human condition of the patient. Without this, medical practice is destined to become a purely intellectual exercise, rather than a human and moral one, an observation which has considerable implications for professionalism and the service of the sick.

Humanism, by its nature, animates medicine and demonstrates that science is not an end in itself, but is, rather, a tool of medicine, never its soul [7,8]. While opinion differs as to whether the nurturing of nascent humanism in students should begin in the first year of

entry or later, it has been shown that a significant decline in empathy, for example, occurs during the third year of medical school, a somewhat ironic and counter-intuitive observation, since this is precisely the stage at which the curriculum shifts to patient-related education [16,17]. The introduction of person-centered teaching into the undergraduate curriculum should therefore commence at the beginning of Year 3 at the very latest.

With training of this nature appropriately commencing in the undergraduate curriculum, it should, to maintain effectiveness and enhance clinical formation, continue through the postgraduate years, with humanistic approaches to care included in professional training and specialty membership exams and board certification. In terms of continuing professional development (CPD), the new International Conference and Publication Series on Person Centered Healthcare, launched in Geneva on 1 May 2012, is one contribution to increasing the visibility of, and emphasis on, person-centered medicine, enabling scholarly debate on the design of illness-specific models of person-centered care and the availability of published materials to aid CPD studies.

Professional and institutional guidance

Fourthly, appropriate guidance is necessary for currently practising clinicians. General, generic guidance on ‘Making clinical services more person-centered - a stepwise approach’ would certainly represent a valuable activity, affording a heightened awareness of the need to do so. However, perhaps more powerful, either alternatively or certainly in addition to general advice, would be the implementation of person-centered guidance into existing, illness-specific professional clinical practice guidelines. Algorithms have their place in planning care and assisting decision-making and are certainly here to stay following 20 years of evidence-based medicine. To negotiate with the specialist societies and government agencies that produce such illness-specific guidelines based on systematic reviews of the literature with the aim of introducing person-centered medicine prompts alongside biomedical and technological prescriptions, may well represent one highly important way forward. Additionally, guidelines, by their nature, easily allow for the development of audit indices as mechanisms to determine what was done or what was not done and the specific circumstances guiding clinical decisions. Likewise, such indices can be developed for the person-centered care prompts within guidelines and valuable clinical and research information gained as a result. Such information could help rate the person-centeredness of clinical services and eventually become linked to service commissioning and re-imbursement processes in order to help drive change implementation within healthcare institutions.

Collecting person-related clinical information

Fifthly, the development of electronic medical records, which is gaining greater and greater momentum throughout Western health services, should actively take into account the need for flexibility in informatics design. Indeed, person-centered clinical practice requires a person-centered medical record and there is therefore a need for systems which, far from perpetuating or enhancing a disease-focussed model of practice, actively ensure instead that person-related information provided by the patient is collected as efficiently for decision-making as disease-related data are generated by the clinician and laboratory.

Person-centered medicine: a moral enterprise

Taking all of the above into full account, it becomes clear that person-centered medicine is, above all, a moral enterprise and that those who practise it become, *de facto*, part of a moral community and it is such a global moral community that the International College of Person Centered Medicine is attempting to constitute and which the *International Journal of Person Centered Medicine*, as its principal organ of communication, is assisting so powerfully. 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’, ‘burnout’, ‘resilience’, ‘recovery’, ‘illness’, ‘empathy’, ‘compassion’ and ‘integrative diagnosis’, are to be found in addition and alongside ‘effect size’, ‘relative risk ratio’, ‘absolute risk ratio’, ‘number needed to treat’, ‘odds ratio’ and ‘meta-analysis’. In recommending additions of this nature to the medical lexicon, simultaneous deletions may also be advanced. Here, the erasure of such words as ‘client’, ‘customer’ and ‘service user’ would appear particularly appropriate as might the ejection of terms such as ‘provider’ or ‘contractor’ to describe the doctor or clinician. All such words, deriving as they do from the cold and impersonal world of commerce and economic transaction, are clearly ectopic in accounts of humanistic medicine and cannot possibly describe the inherent complexities of a clinical relationship. It is certainly true that their genesis derives from the conflicts engendered by medical paternalism on the one hand and desires for patient autonomy on the other and in the middle of all this, perhaps, language appropriate to describe the objective nature of the clinical relationship has been obscured by a range of ‘politically correct’ labels and transient linguistic fashions within medical academia and health services research. Clearly, medicine is a service, but it is a service of a very different kind, a service to the sick, to people who need to be cared for and cared about and who seek help and assistance by sharing with clinicians the most

intimate details of their physical condition, emotional state and spiritual concerns.

Conclusion

Rapidly accumulating psychoneuroimmunological and genomic research is yielding a growing biological and empirical basis for the functional interrelationship between the somatic, the psyche and the spiritual dimensions of Man. If there can be no health without mental health, then there can be no physical or mental health without spiritual health. A medicine that remains fixated with the 'biological body' and which ignores - passively or actively - the status of the non-physical dimensions of the patient that impact upon biological function, may therefore be considered to be *ipso facto* incomplete as an authentic account of the human person and his needs. For these reasons, the person-centered approach within clinical practice is advanced as a core component of medical professionalism, without which, an adequate contextualisation is impossible and excellence (*versus* competence) becomes immediately out of reach.

It has been emphasised that medicine has the unalterable imperative to care, comfort and console *as well as* to ameliorate, attenuate and cure. It is vital to maintain these 2 triads in functional integration, which is to say 'yoked together', rather than allowing them to drift gradually apart as if they were polar opposites or could function in any way as alternatives [1-4,7,8]. The ability successfully to integrate these functions is precisely that which distinguishes medicine immediately from all of the other professions – its ability to *care* for the patient as well as to apply technical expertise in attending to the biological dysfunction of illness. Such an approach reconnects the science, humanism and ethics of medicine and it is at the intersection of these 3 components that person-centered medicine is to be found, enabling, as it does, a functional association of *episteme*, *techne* and *phronesis* [18-20].

To move the PCM *agendum* away from repetitive institutional rhetoric in the direction of a measureable reality, tangible developments are required in at least 5 principal areas: international and regional leadership, research, education, methodology and informatics. Progress in this context may be confidently anticipated to result in the operational implementation of pragmatic methods of personalisation of human healthcare which will make the technique of PCM, when acquired and employed, a high clinical skill to which all clinicians should aspire in the pursuit and maintenance of professional excellence.

References

[1] Miles, A. (2009). On a Medicine of the Whole Person: away from scientistic reductionism and towards the embrace of the complex in clinical practice. *Journal of Evaluation in Clinical Practice* 15, 941-949.

[2] Miles, A. (2009). On the interface between science, medicine, faith and values in the individualisation of clinical practice: a review and analysis of Medicine of the Person. *Journal of Evaluation in Clinical Practice* 15, 1000-1024.

[3] Miles, A. & Mezzich, J.E. (2011). The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1 (2) 207-222.

[4] Miles, A. & Mezzich, J.E. (2011). The patient, the illness, the doctor, the decision: negotiating a 'new way' through person-centered medicine. *International Journal of Person Centered Medicine* 1 (4) 637-640.

[5] Weatherall, D. (1996). Science and the Quiet Art : The Role of Medical Research in Health Care. New York: W.W. Norton.

[6] Miles, A. & Loughlin, M. (2011). Models in the balance: evidence-based medicine versus evidence-informed individualised care. *Journal of Evaluation in Clinical Practice* 17, 531-536.

[7] Montgomery, K. (2006). How Doctors Think. Clinical Judgement and the Practice of Medicine. Oxford: Oxford University Press.

[8] Miles, A. (2007). Science: a limited source of knowledge and authority in the care of patients. *Journal of Evaluation in Clinical Practice* 13, 545-563.

[9] Shapiro, J. (2012). The feeling physician: educating the emotions in medical training. *International Journal of Person Centered Medicine.* In Press.

[10] Leder, D. (1990). Living interpretation: the hermeneutics of medicine. *Theoretical Medicine and Bioethics* 11, 9-24.

[11] Weatherall, D. (2004). Scientific method and the art of healing. In: The Oxford Textbook of Medicine, 4th Edn. (Eds. D.A. Weatherall, T.M. Cox, J.D.Firth & E.J Benz, Jr). pp 10-13. Volume 1. Oxford: Oxford University Press.

[12] Marcum, J.A. (2008). Humanizing modern medicine. New York: Springer Science.

[13] Miles, A. & Mezzich, J.E. (2012). Person-centered medicine: addressing chronic illness and promoting future health. *International Journal of Person Centered Medicine* 2 (2) 149-152.

[14] International College of Person Centered Medicine. (2012). The Geneva Declaration on Person-centered Care for Chronic Diseases. *International Journal of Person Centered Medicine* 2 (2) 153-154.

[15] Cohen, J.J. (2002). Our compact with tomorrow's doctors. *Academic Medicine* 27, 475-480.

[16] Hojat, M, Mangioni, S., Nasca, T.J. & Gonnella, J.S. (2005). Empathy scores in medical school and ratings of empathic behaviour 3 years later. *Journal of Social Psychology* 14, 663-672.

[17] Hojat, M., Vergare, M.J., Maxwell, K., Brainard, G., Herrine, S.K., Isenberg, G.A., Veloski, J. & Gonnella, J.S. (2009). The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. *Academic Medicine* 84, 1182-1191.

[18] Pellegrino, E.D. (1979). Humanism and the Physician. Knoxville: University of Tennessee Press.

[19] Englehardt, Jr., H.T. & Jotterand, F. (Eds.). (2008). The Philosophy of Medicine Reborn: A Pellegrino Reader. Indiana: University of Notre Dame Press.

[20] Greenhalgh, T. & Wiering, S. (2011). Is it time to drop the 'knowledge translation' metaphor? A critical literature review. *Journal of the Royal Society of Medicine* 104, 501-509.