

## EDITORIAL INTRODUCTION

# Contextualizing science in the aftermath of the evidence-based medicine era: on the need for person-centered healthcare

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## Introduction

How are we to deal with what Charon [1] has called “the vexing failures of medicine, its relentless positivism, its damaging reductionism, its appeal to the sciences and not to the humanities in the Academy and its wholesale refusal to take into account the human dimensions of illness and healing”? Why is it that the ability of doctors to care for their patients as individuals has been lost in what the former Regius Professor of Medicine at Oxford University, David Weatherall [2], refers to as “a morass of expensive high technology investigation and treatment”, so that modern medicine has become a “failure”? For what reason has medicine entered, as Miles [3,4] claims, “a crisis of knowledge, care, compassion and costs?” The *European Journal for Person Centered Healthcare* and indeed the newly instituted European Society for Person Centered Healthcare [5,6], is embarking on a quest to answer such questions, but will pose, in addition, an overarching fourth: ‘How do patients respond to a significant or a catastrophic diagnosis and *how should* clinicians respond to such a response?’ Until we are prepared to admit, comprehend and answer these questions, authentic progress within global healthcare systems will remain impossible and patient care will remain compromised and impoverished as a direct result.

The questions we pose are undoubtedly monumental in their nature and of undeniable complexity [7], but they can no longer be avoided, indicating, perhaps, that a juncture has been reached where medicine in particular and the healthcare professions more generally, would do well to reflect on the current standards of care to which patients

are exposed and from there to commence a period of intensive self-examination. We take it as read that international medicine still holds fast in theory to the ultimate goal of healthcare: to attend to the person who is sick with all of the resources, intellectual and practical, that we have at our disposal, in order to care, comfort and console *as well as* to ameliorate, attenuate and cure, restoring to the human individual, wherever and whenever possible, a state of positive health, wellbeing and flourishing [8]. In practice, however, there is a clear mismatch between what medicine claims to believe and how it operates in the context of everyday practice. Indeed, in apparent defiance of those values which have historically been foundational to notions of healing, medicine appears to have chosen *limitation*, rather than what we will call *encompassment*. By limiting himself to the task of diagnostic categorisation and to the use of pharmacological and other interventions in the investigation, treatment and follow-up of the patient, the modern clinician becomes easily characterised more as a technician in applied bioscience, delivering modalities dictated by algorithmic guidance and commissioner/reimbursement-dictated protocols, rather than by acting as a caring professional with the particular requirements of the unique individual at the forefront of the ‘clinical mind’.

## Reductionism in healthcare

We see medicine’s reductionism from the initiation of the clinical ‘work up’, where diagnostic categorization is first

employed in order to determine how ‘well’ a given patient fits into a given diagnostic category for nosological purposes. And we see it again when EBM principles are employed in attempts to extrapolate the conclusions of epidemiological population-based studies to the individual patient in a series of inferential leaps based on the results of methodologically limited population-based studies. Medicine has long since viewed this general, indeed highly convenient and pragmatic approach, as essential to determining ‘what is wrong’ and then ‘how to treat’, so that the question to the patient: “Who are you and what is important to you” has become optional, not primary. Yet diagnostic classification, while essential, on its own and in isolation from wider approaches to diagnosis, categorises a disease only and says *nil* about the *person of the patient* and his or her wider needs, the satisfaction of which increase the speed of recovery and level of satisfaction [8].

It is here, then, that we see a tension between the need to de-emphasise the uniqueness of the individual patient in order to be able to fit him or her neatly into a given classificatory box and the need to see the patient as a person in all his or her biographical richness, indeed uniqueness, a living entity that cannot be ‘remaindered’ into a highly circumscribed compartment. The reductive focus of modern medicine with its fascination with the cellular or molecular basis of disease needs, then, urgently to be widened to a fascination with the *person* of the patient, so that a proper understanding of how the disease is affecting the patient’s psychology, emotions, spirituality and lifestyle/social functioning, can be gained and practically utilised. It is salutary, here, to keep firmly in mind the undeniable truism that the disease is part of the person, not the person part of the disease, a vital distinction that modern medicine increasingly neglects to acknowledge as a direct function, perhaps, of our preoccupation with the biological and classificatory systems already discussed and from which we need urgently to retreat.

## Restoring humanism to healthcare

If it is accepted that medicine has ‘gone wrong’ in the ways in which Charon [1], Weatherall [2] and Miles [3] claim, then what can be done to put medicine ‘right’ again? The EJPCH will discuss over its forthcoming second volume – and beyond - a new way of ‘thinking and doing’ in clinical practice which we already term ‘person-centered healthcare’. This new model of practice, we contend, will allow medicine successfully to address its “vexing failures ... relentless positivism (and) damaging reductionism” [1], enabling medicine to understand “the human dimensions of illness and healing” [1] and to “care for ... patients as individuals” [2]. We argue that its development and use will help resolve the current “crisis of knowledge, care, compassion and costs” [3], directly enabling clinical practitioners and healthcare systems to respond with science and humanism to the distress of acute and chronic illness and to retreat from the “failure” that Weatherall describes [2,8].

## The philosophical basis of person-centered healthcare

From a conceptual perspective, person-centered healthcare draws on a range of traditions within the Philosophy of Medicine, some of which are established and many of which remain provisional. If we are able to proceed on provisional understanding, then we are able at least to begin to explore the concept of person-centered healthcare in all of its richness. In order to do so, the EJPCH will posit and discuss two philosophical systems of importance to person-centered healthcare. These are the philosophies of (1) personalism and (2) non-foundationalism, two substantially influential systems of thought that, by their nature, contribute enormously to the coherence and durability of the philosophical underpinnings of the person-centered healthcare thesis. The EJPCH will examine the basic tenets of these philosophical schools of thought and how a clearer understanding of the thinking of each school can directly enable the operational implementation of person-centered healthcare approaches within everyday ‘hands on’ clinical practice. A forthcoming paper within the EJPCH will be illustrative in this context [8].

## Conclusion

Medicine, then, does science well, but humanism badly. Yet science is not an end in itself and in medicine the ultimate destination of science is the patient. The patient is not an object or subject, less so a complex biological machine to be ‘fixed’ by the technical application of specific procedures aimed at the modification of disease trajectories - as if anatomy, biochemistry and physiology were the sole concerns of clinical practice. Rather, the patient is a person with dimensions which extend well beyond the purely physical and which include the psychological, emotional, existential/spiritual and social components of human existence which add layer upon layer upon layer of complexity to the biology of the patient and which collectively, not separately, constitute the magnificence, even mystery, of the being and relating of the individual human person. Any form of intervention or practice that considers only one of these components in isolation from the other is therefore *ipso facto* reductionist, accidentally or deliberately rejecting a deeper, more complete understanding of the totality of what is wrong. It is the need to consider the higher dimensions of *suffering* and the concern to understand the effects of the organic disease on the *overall functioning of the patient* that distinguishes the *clinical professional* from the *technician* in applied bioscience and technology. Indeed, technical competence, even high technical competence, is technical competence or high technical competence only. It is the application of science *in the context of the patient and clinician as persons* that raises clinical technique to a nobler level, a level which allows excellence in clinical practice to be actively pursued and eventually achieved.

Evidence-based Medicine has *singularly failed* to equip clinical practitioners with all such abilities and skills, attempting, as it has, to reduce the healing nature of medicine to the common denominator of scientific intervention based on epidemiological averages, wilfully ignoring the subjective experience of wider illness by the human individual. Recognising and admitting the same, we contend that person-centered healthcare should – *and must* – become the dominant system of healthcare provision for 2014 and beyond.

## References

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# SOCIETY ANNOUNCEMENT



**The President and the Senior Vice President are delighted to announce the following further appointments to the Special Interest Groups of the Society**

**Special Interest Group – Diabetes and Nutrition**

Professor Paolo Pozzilli MD, Professor of Diabetes and Clinical Research, Centre for Diabetes and Metabolic Medicine, Institute of Cell and Molecular Science, Bart's and The London School of Medicine and Dentistry, London, UK & Professor of Endocrinology and Metabolic Diseases, Università Campus Biomedico, Rome, Italy.

**Special Interest Group – People-centered Public Health and Person-centered Medicine**

Professor Gualtiero Walter Ricciardi MD MPH, Vice Dean, Faculty of Medicine and Professor of Public Health, National Catholic University of Italy at the Policlinico Gemelli, Rome, Italy, & President, European Public Health Association, Utrecht, The Netherlands.

**Special Interest Group – Personalized (translational) Medicine**

Professor Emanuela Signori MSc PhD, Lead, Laboratory of Molecular Pathology and Experimental Oncology, National Research Council of Italy Institute of Translational Pharmacology & Professor of Pathology, Università Campus Biomedico, Rome, Italy.

**Special Interest Group – Person-centered Care of Drug and Alcohol Addiction**

Professor Michael Musalek MD, President, European Society on Treatment of Alcohol Dependence and Related Disorders; General Director, Anton Proksch Institute, Vienna, Chairman, EPA Section of Psychopathology; President, European Society of Aesthetics and Medicine, Past-President, European Society for Dermatology and Psychiatry; Secretary for Sections, European Psychiatric Association; Vice-Chairman, Section for Clinical Psychopathology, World Psychiatric Association.

The newly appointed SIG chairmen increase the number of appointed SIG chairmanships from 20 to 24. The President and Senior VP congratulate the new chairmen and continue to welcome applications for the SIG chairmanships remaining. SIG chairmanship applications currently being considered will be announced, if successful, in Volume 2, Issue 1 of the EJPCH.

## SOCIETY NEWS

1. Dr. Drossi Stoyanov MD PhD, Vice President of the Society for Eastern Europe & Associate Professor in the Faculty of Medicine of the Medical University of Plovdiv, Bulgaria, has been elected a Full Professor of Psychiatry of the University. The Society warmly congratulates Professor Stoyanov and wishes him well in the exercise of his new duties.

## Appendix

2. Mr. Rudolf Raducan has been appointed full time Administrator of the ESPCH, working directly with the President and Senior VP in the ongoing growth and development of the Society. He replaces Mr. Andrew Williamson who acted as interim Administrator to the Society.

3. Mr. Marcos Maseda has been appointed full time Project Manager for the Person-centered HIV/AIDS Care project of the Society, working directly with the President and the Senior VP in the planning and delivery of the European Conference, the generation of its publication and the subsequent international dissemination of the findings and recommendations of the project. Mr. Maseda will function additionally as Production Editor for the forthcoming *European Journal for Person-centered HIV/AIDS Care*.

4. Mr. Andrew Williamson has demitted his interim appointment as Administrator to the Society and has been appointed full time Director of Operations and Finance to the Society. He maintains his role as Senior Production Editor of the *European Journal for Person Centered Healthcare*, the Society's official journal.

5. Professor Andrew Miles MSc MPhil PhD DSc (*hc*), Senior Vice President and Secretary General of the Society, was awarded the Faculty of Theology Medal of the National University of Bulgaria, Sofia, following his *Lectio Magistralis* on 'The Intersection of Medicine and Theology' delivered in Sofia on 20 December 2013. Professor Miles has also delivered plenary lectures on person-centered care and presented the work of the Society at DEGAM 2013 Munich Germany on 13 September 2013, at the Official Opening of the University Year at Francisco de Victoria University Madrid Spain on 26 September 2013, at the annual meeting of the Italian Society of Medicine and the Person, University of Milan Italy on 12 October 2013, at academic conferences in Rome Italy on 14 October 2013 and at the 14<sup>th</sup> European AIDS Conference on 17 October 2013, Brussels, Belgium.

6. Professor Sir Jonathan Asbridge DSc (*hc*), President and Chairman of Council of the Society, delivered invited plenary lectures on person-centered multi-disciplinary acute home care and on person-centered nursing education, practice and employment, at the Medical University of Plovdiv, Bulgaria on 29 October and 18 December 2013 respectively.