

EDITORIAL INTRODUCTION

Modern healthcare: a technical giant, yet an ethical child?

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Introduction

Within our healthcare systems, avoidable error rates and medico-legal bills are soaring, care home and hospital scandals are frequent and patient-reported consternation and even frank distress with the inhuman way they are routinely 'dealt with' are all now so commonplace as to be almost normative. All of these things - and more - vividly illustrate that much is wrong within modern medicine and healthcare and that much, therefore, needs to be put right. If Society continues to tolerate this crisis of disregard and neglect and if it does not urgently take the time necessary to consider why and how we have arrived at where we currently are - in order to take corrective actions - then we will have reached a very sad point in human history indeed [1].

There are many factors which underlie the current healthcare system crisis in care, compassion and costs. Economic constraints are themselves major drivers, downwards, of healthcare quality outcomes, with manpower deficiencies and high clinical workloads contributing to increasing levels of flame and burnout syndrome in healthcare professionals [1]. But there is another factor which is actively driving the depersonalisation of healthcare and which is mediating the continuing disintegration of professionalism. Those readers familiar with the life and work of Francis Peabody and others in the 'patient as a person' movement during the course of the last Century [2], will be aware of Peabody's specific 'diagnosis', in the 1920's, of the same aetiology which confronts us today: a reification of medicine's ability to treat biological disease with accumulated and accumulating science at the direct expense of a concern to treat the broader illness which results from the initial

pathology(ies) and which arrests or diminishes the capacity of the patient to flourish.

EBM and healthcare de-personalisation: 1994 - 2014

In advancing a wholly inauthentic account of the nature and purpose of medicine and lacking any epistemological or empirical justification, the evidence-based medicine (EBM) movement has, over the last two decades, accelerated the rate of de-personalisation in healthcare by reducing clinical practice to the application of technical procedures and pharmacotherapeutics concentrated solely on the mechanistic treatment of organic disease. No explicit concern with the multiple other dimensions of human suffering, illness, functioning and flourishing, has ever been convincingly demonstrated by EBM, pointing vividly to the ideological and scientific nature of the movement itself and of its supporting protagonists. In fact, in insisting on its singular vision of clinical practice as appropriate for all healthcare systems and patient circumstances in a 'one size fits all' approach, EBM has gravely distorted the historic nature of medicine and has occasioned great violence to clinical professionalism [3-17].

EBM's two decades of dominance within international health systems provides much experience for comment and analysis - indeed, it has excited an extensive amount of such commentary, polarising medical understanding and debate and resulting in an extensive number of visceral critiques. During this time, EBM has shown itself to be population-based medicine. It is not and never has been *clinical* medicine and its attempts to transfer the principles

of the former to the latter have proved notably unsuccessful. Having been forced through no less than four serial re-constitutions of concept and methodology in order to survive [1,2,18], EBM nevertheless continues to insist on a vertically ordered Hierarchy of Evidence which claims that statistical effect sizes derived from inherently methodologically limited epidemiological study designs employing highly selected, rarified, trial populations, can navigate the inferential leap to particular individual patients with particular problems in the clinic. Such a belief was always and remains, a manifest absurdity and to make sense of the statistics always required a contextual interpretation of the results by experts and the use of judgement, experience, expertise and intuition in an attempt to particularise generalities to specific clinical situations - all of the characteristics of medicine that EBM sought to eradicate [3-17].

EBM's foundationalism is incompatible with the personalism of an authentic clinical practice

Scientific knowledge - the singular basis of EBM - is indispensable to medicine and healthcare and we do not argue against its importance within clinical medicine and healthcare more generally. How could we? To do so would be manifestly absurd. But while science is powerful in modifying biological disease trajectories and has directly enabled medicine to achieve huge shifts in individual and population physical health, it is significantly limited in its ability to treat the myriad components of human suffering that either result from disease or indeed themselves can precipitate it in the longer term. Properly understood - and employed - science *informs* medicine, it does not dictate to it. It is *one* form of knowledge for clinical practice among many others. It sits *alongside* all of these other sources of knowledge and *not on top* of them. Efforts to assert a superiority of science above all other sources of knowledge for the care of patients are, as these terms are understood within the Academy, anti-democratic, tyrannical and highly symptomatic of scientism - the greatest of the intellectual sins [17].

The rigid foundationalism of EBM has had - and continues to have - considerable implications for patients. Patients present for assistance not as a collection of organ systems, one or more of which may be dysfunctional requiring scientifically indicated technical and pharmacological interventions, but rather as integral human beings with narratives, values, preferences, psychology and emotionality, cultural situation, spiritual and existential concerns, possible difficulties with sexual, relational, social and work functioning, possible alcohol and substance abuses and addictions, worries, anxieties, fears, hopes and ambitions - and more. This fact, and it *is* a fact, requires careful attention. It cannot be ignored if clinical professionalism is not to be severely compromised [2].

Nevertheless, within secondary and certainly tertiary medicine in particular and as a function of the long trend in de-personalisation accelerated by the EBM thesis, a view has become prevalent that such factors are of secondary importance to the deterministic treatment of the primary pathology(ies) and that they are 'someone else's concern' and not that of the attending clinician. Such a view, where it occurs, is profoundly mistaken: the disease is part of the person and not the person part of the disease. Either medicine pays complete attention to the disease *and* all of its secondary manifestations and how these are affecting the patient's suffering and flourishing, or it does not. And not to do so is to practise an incomplete and de-humanised medicine. In a word, such medicine would be a failure - rich in technical skill and poor in humanity. Indeed, actively to practise such a medicine raises significant ethical questions in addition.

We do not suggest that clinicians are able to spend inordinate amounts of time listening to narratives, merely that such narratives can contain important diagnostic and other clues that may be pivotal to diagnostic accuracy and therapeutic success. Active listening also develops the clinical relationship and its shared decision-making and is associated with increased adherence to therapies and with decreased exacerbations, clinic visits and hospitalisations. Neither do we suggest that clinicians have a duty to attend personally to each and every possible manifestation of illness, some examples of which we have referred to above. Rather, we advocate that they retain a duty to note any symptoms of the broader illness that may be present and indeed to enquire about problems that may be present but which are not easily physically observable and then to arrange, *via* the health system, the management of the illness through appropriate referrals. To conclude this section, we will say merely this: there is technical skill in medicine and there is technical skill delivered humanistically. Likewise, there is competency or high competency in medicine and there is something called 'excellence'. And it is the last which every clinician should strive to work towards and ultimately to achieve. Who will be content with 'second best' and to be described as such?

Clinical medicine *versus* EBM

Unlike EBM (which is a phenomenon in current decline, as is the fate of all insubstantial fashions) and notwithstanding the observation immediately above, clinical medicine has always been and will remain primarily a human endeavour with a moral character. It is a service to the sick, with an imperative to relieve, on request, human suffering *in all of its forms* [2]. In order to fulfil this endeavour and to attend to its imperatives, medicine needs to be able, completely freely and without restriction, to draw on *any one* of its multiple knowledge sources with direct reference to the specific needs of the individual patient. Rigid foundationalism, such as in EBM, where medicine is theoretically based on only *one* of its knowledge sources, scientific knowledge, directly interferes with medicine's ability to function as it must. It

is toxic for medicine, because by its nature foundationalism robs medicine of its essential flexibility and its essential character. It cannot enhance medicine, it can only restrict it.

For this reason, person-centered healthcare argues, on the contrary, that the vertically ordered EBM Hierarchy of Evidence should be ‘collapsed’ into a horizontally ordered library of knowledge sources - both objective and subjective in nature - from which the wise and experienced clinician can draw with specific reference to the needs of the particular individual patient who suffers. Here, no one source of knowledge is hegemonically privileged above any other, because the needs of the individual patient prevent such exclusivity [19].

What is the way forward?

So what, then, is to be done if we are to take a proper account of the patient as a person and to respond to his/her multiple needs that are additional to or derive from the given pathology(ies) and which give rise to a broader *suffering* and limit the patient’s capacity to flourish and to live well - for themselves, but also for their family and friends? The way forward, we believe, is to enable a frank and critical reflection on the relative merits and weaknesses of EBM in direct comparison with those of the new movement in international healthcare to which we have already referred: person-centered healthcare (PCH). In this way, clinical, academic, policy and political colleagues are all, individually and together, able to begin a formal consideration of which model is likely to prove ‘fit for purpose’ in our current age of patient power, economic constraint, clinician disillusionment, chronic long term co-morbid illness and the rise of private healthcare systems which increasingly provide high levels of PCH, but where State-funded systems appear powerless, for one reason or another, to do so similarly.

How can such a comparison be achieved for the reasons given? Certainly, of the questions that we have been asked personally, in view of our respective positions at the European Society for Person Centered Healthcare, the following have proved the most frequent: “What is the difference between EBM and PCH”. “Are not PCH and EBM so complementary as to be two sides of the same coin?” “But isn’t EBM person-centered?” “Can’t we just decide on ‘knowledge-based’ care?” “Are PCH and EBM irreconcilable?” “What is the future, then, for patients and their clinicians, indeed health systems: EBM or PCH?”

These are complex and timely questions which need urgently to be addressed. For our part, we have considered them in detail within a major *Discussion Paper* to be published in the next issue of the EJPCH [20]. The *Discussion Paper* will respond to some 18 commentaries [21-38] on an earlier such article by Miles [2] and will critically analyse the significance of two recently published papers from highly prominent members of the EBM Community [32,39]. Furthermore, it will discuss how the philosophical systems of personalism and non-foundationalism can help clinical practice and healthcare

systems move away from the scientific, non-personalist, rigidly foundationalist EBM, towards a far more anthropocentric model of healthcare for the future. A move of this nature has become more necessary now than ever before, in order for Medicine to be able to respond to two recent major developments that are currently shaping the face of modern medicine and ‘directing’ its future: (1) the rise of the patient empowerment movement and the ‘Century of the Patient’ and (2) the global epidemic of long term chronic and co-morbid illness. EBM, by its nature, is powerless to address these developments, but PCH, by its own nature, is well equipped to embrace them.

Conclusion

Within international - and *certainly* in Western medicine - our concern with values has evolved much more slowly than our concern with empiricism. Here, the technical advancements of modern medicine, in separation (if not in a radical isolation) from a proper concern with the patient’s subjective experience of illness and its effects on his/her everyday life and functioning, has resulted in the creation of what might be described as an ‘artificial’ model of healthcare, a form of ‘supra’ healthcare, which privileges the biomedical model of understanding and treating disease above all others. Such a model - in becoming more and more incrementally established - has in turn progressively precluded from medicine a quintessentially human understanding of ‘what is wrong’ and therefore a proper understanding of ‘how to proceed’.

Modern healthcare: a technical giant, but an ethical child? Yes, we think so. It would be foolish of us to suggest that medicine does not have an Ethical Code - indeed it does, one that dates back to and remains in large measure based upon the historic Hippocratic ideals. But can we really describe medicine as comprehensively and foundationally ethical if it fails to understand and treat the patient as a person? If ethics are indispensable to medicine, then do they not pull medicine ‘gravitationally’ to an understanding of the patient as a person and the construction of treatment plans accordingly? [40]. If so, then surely the time has come to raise medicine’s ethics to the level of its technology? After the damage occasioned by EBM only person-centered healthcare can respond well to the current deficit of humanity in healthcare practice and delivery.

Conflicts of Interest

The authors of this Editorial Introduction declare no conflicts of interest.

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