

ANALYSIS OF THE *DISCUSSION PAPER* "THE CARE OF THE PATIENT AND THE SOUL OF THE CLINIC: PERSON-CENTERED MEDICINE AS AN EMERGENT MODEL OF MODERN CLINICAL PRACTICE" BY ANDREW MILES AND JUAN E. MEZZICH, *IJPCM* 2011; 1 (2) 207-222

Is "scientifically informed, yet humanistic medicine" the solution to the crisis of modern medicine? A friendly corrective to the emergent model of Person-Centered Medicine

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Introduction

In Miles and Mezzich's programmatic paper "The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice" [1], the authors draw from a wide variety of sources to frame a theoretical underpinning for the emerging concept of "person-centered medicine" as a model of clinical practice. The sources include humanistic and phenomenological medicine, the biopsychosocial model, evidence-based medicine, critics of evidence-based medicine and patient-centered care. Each offer commendable *desiderata*, which Miles and Mezzich selectively integrate into their burgeoning theoretical framework. My concern is that the selective uptake of desirably qualities from such diverse resources in order to progress person-centered medicine's developing vision of "medicine *for* the person, *by* the person and *with* the person" obscures important theoretical differences among these sources that will likely result in difficulty for the concept of person-centered medicine. These diverse theoretical resources offer competing correctives to the problems with medicine. Some of these differences are irreconcilable and need to be highlighted in order to avoid creating conceptual confusion and allegiance to unproductive theoretical commitments at this critical point of framing and developing this emergent model of modern clinical practice.

Person-centered medicine joins a growth field of academic literature attempting to solve the problem of modern medicine. Typically employing the stronger language of "crisis", modern medicine has been

characterized by a variety of critics since the mid-twentieth century as technologically inspiring, but humanistically bereft. The evidence-based medicine (EBM) movement notwithstanding, numerous philosophically interesting and intellectually searching efforts have been made to humanize scientific medicine. Proponents of humanistic medicine [2], the biopsychosocial model [3], phenomenologically-oriented "intertwined medicine" [4], patient centred care [5] and the like, often point to antiquity to ground medicine's compassionate core, suggesting that the staggering scientific advances of biomedicine since the early 20th century have distracted us, narrowing medicine's focus from "care" to "cure" [1], to the detriment of the profession and to the patient suffering from dis-ease.

In this commentary, I will argue that these critical calls for humane medicine, while rightly pointing to the need for empathy, understanding and compassion within any healthcare transactional relationship, inappropriately leave the technical/curative side of medicine untouched. By characterizing medicine as incomplete, the humanistic model of medicine that is proposed tacitly endorses a parallel relation of *curing* and *caring* in biomedicine - specifically, a coupling of impersonal and rigorous technical application alongside personal and attentive therapeutic relationships. I recommend that person-centered medicine disown this parallel formulation. Drawing from recent scholarship critical of evidence-based decision-making, I will demonstrate that the technical "side" of medicine requires humanistic consideration as well. Therefore, what we need is more than a mere union of the art and science of medicine. Instead, we need a synthesized humane and personalized, caring and curing

(or *managing*, as chronic and non-acute conditions necessitate) practice.

Person-centered medicine, as a new and therefore still underdeveloped theoretical framework for medicine, is ambiguous in its orientation towards either art/science union or synthesized whole. This is seen in Miles and Mezzich's [1] analysis of the model, as the authors seem to mistakenly ally themselves with both competing visions of medicine. I will demonstrate this inconsistency and suggest that person-centered medicine's orientation must be sharpened and directed towards the latter holistic thesis, a position that has been variously described as "interpretive medicine".

The problem with Medicine

Miles and Mezzich [1] characterize the crisis of modern medicine as follows:

"Medicine today is not what it used to be. Exponential increases in technological and biomedical advance over the last 100 years or so have radically transformed the scope, possibility and power of clinical practice, driving enormous shifts in individual and population health. Yet despite such staggering progress, there is a growing and pervasive sense of unease within medicine...that all is not entirely well..." ([6] in [1])

One might feel a sense of *déjà vu* upon reading these lines. Writing 26 years earlier, Schwartz and Wiggins [2] similarly proclaimed:

"A compelling paradox confronts present-day medicine. Major advances in medical technology are proclaimed almost daily. Built on this flourishing technology are equally significant gains in the physician's ability to understand the mechanisms of illness, devise new treatments, prolong life and cure disease more often. Inexplicably, dissatisfaction with medicine grows despite this real progress."

That sense of dissatisfaction despite biomedicine's impressive technological feats is a common sentiment similarly articulated in the well known writings of Stan Reiser [7] and Richard Zaner [8], among other so-called "medical humanists" writing in the late 1970's and 1980's (see [9], pp. 43-45, for a brief recount of this scholarship) and is still expressed today [1,10,11]. With the rise of technology came the ills of reductionism, scientism and technocracy in medicine [10,12,13], which resulted in the patient as person becoming marginal to the clinical encounter [1,14,15]. In the decades that span these writings about the "current state" of medicine, the diagnosis and prognosis have remained the same. With the lack of humanity and compassion experienced by so many patients receiving what might be technologically-optimal healthcare, the privileging of "cure" over "care" (as Miles and Mezzich [1] call it) has resulted in high patient dissatisfaction and disaffected or disillusioned healthcare workers. Medicine, it was and is still argued, needs to rediscover its compassionate core.

Humanistic and phenomenological solutions to the problem with Medicine

Miles and Mezzich date the now standard humanist critique of scientific medicine back earlier than I have done, citing Francis Peabody's 1927 paper, "The Care of the Patient" [16]. Peabody writes that the most common criticism made by older practitioners is that junior physicians have been taught a great deal about the mechanism of disease, but very little about the practice of medicine - that is, "they are too 'scientific' and do not know how to take care of their patients" [1]. In Peabody's writing, Miles and Mezzich [1] see the origins of the wider "patient as person movement" that grounds person-centered medicine [17].

Peabody charged medical schools with being overly consumed with teaching students new scientific knowledge, while forgetting that "the application of the principles of science to the diagnosis and treatment of disease continued to represent only one aspect of medical practice" [1]. That missing component of the marvels of scientifically-advanced medicine was humanity in clinical practice. For Peabody:

"The practice of medicine was an entirely personal matter. Indeed, he was clear that while the treatment of a disease may be entirely impersonal, the care of the patient must be completely personal" [1].

This bifurcation of the science-informing practice and the humanity that administers it similarly appears in the "intertwined medicine" of scientific evidence and patient's experience, values and concerns proposed by medical phenomenologists [18-23]. Building on a phenomenological theory of illness that focused on the patient's experience, rather than a scientific description of the event, an alternative medical model was formed that aimed to capture both scientific and experiential layers of description - an "intertwining" of physiology *and* intentionality, empiricism *and* phenomenology. Scientific perspectives were not disavowed, but their presumed descriptive and explanatory completeness were challenged. Rather than serving as the singularly correct interpretation of the nature of things, scientific findings "must be intertwined within a broader phenomenological framework, where scientific references contribute to rich experiential understandings" of complex phenomena such as illness and disease [9].

In both Peabody's precursor to person-centered medicine and in phenomenological medicine, we see a call for uniting the impersonal and the personal, or the intertwining of science and narrative, with no consideration of whether the status of the technical features of medicine are accurately described as "impersonal". Both phenomenologists and Peabody charged that scientific medicine is incomplete insofar as it is impersonal and inhumane. But more contemporary critiques of the 'evidence-based' turn in medicine have challenged the

accuracy of the claim that applied science is or should be impersonal. Against the claim that medicine can and should be evidence-based, numerous critics have denied the plausibility of medicine having scientific evidence as its foundation (or ‘base’). This is because the application of clinical evidence to individual patient care is not properly characterized as a procedural or systematic inference from trial data to a particular patient. The (actual) analytic work of diagnosing a condition or making a treatment recommendation based on the best clinical evidence cannot be captured in a set of formal rules of application. Rather, the process of incorporating and differentially weighing disparate warrants for action is a **highly interpretive practice** requiring a more complex skill set than the ability to rank studies according to an evidence hierarchy. Those skills include introspection, compassion, understanding, interpersonal skills and sound clinical judgment.

The interpretive nature of clinical reasoning

Evidence-based medicine, for all its faults, invited much needed debate and discourse to theoretical medicine by calling attention to medicine’s unquestioned benefactor: applied science. The evidence-based medicine movement’s trumpeted claim to provide the best evidence for clinical use in achieving optimal patient care prompted healthy reflection within medicine and medical studies regarding how evidence is derived and applied to patient care. The resulting critical investigations into the proper nature and goals of medicine changed in tone and focus from previous humanistic critiques, not insofar as medicine’s humanity became less important, but rather because medicine’s epistemic grounding in biomedical science (the “evidence-base”) and the presumed highly rational application of clinical evidence to patient care, was recognized to be far from obvious.

Numerous commentators writing on the nature of clinical reasoning have described the process as a necessarily *interpretive* activity. Against the simplistic understanding of the evidence-based formulary of applying relevant trial evidence to individual patient care, the physician faced with producing accurate diagnostics, prognostics and clinically-appropriate treatment recommendation engages in a **nuanced process of gathering information from a plurality of sources, assigning relevance and synthesizing those inputs in order to come to a reasonable and well-reasoned conclusion**. Tanenbaum [24] characterizes this non-algorithmic process of deciding which information matters, how much and how they should be combined, as “telling interpretive stories”.

When a physician deliberates over medical diagnosis, she is amalgamating many sources of information, which include: (1) the patient’s report of symptoms; (2) the physician’s observations of the patient; (3) the physician’s knowledge of the patient’s history; (4) background medical

knowledge; (5) test results.¹ Following Tanenbaum’s metaphor, the physician fits these pieces together in order to make an “interpretive story” that begins (once upon a time...) with a specific patient with a certain medical history presenting with certain complaints, develops into a clinical work-up where a battery of tests are ordered, revealing certain findings that are deemed by the clinician to be significant or marginal for certain reasons and ends with a reasonable diagnostic conclusion. Treatment recommendations similarly require interpretation - to decipher which clinical trial evidence is relevant to the patient’s condition and circumstances, how to weigh those evidentiary warrants and how applicable those specific findings are to the individual patient. Those distinct units then need to be integrated into further consideration of the patient’s preferences, goals and values as well as systemic and logistical considerations, such as whether the clinical setting can support the recommended treatment regimen and whether the patient will likely comply with the course of therapeutic action.

The stories must be coherent insofar as the conclusion must fit with the informational inputs, but it is a “story” nonetheless insofar as gaps in the logic of evidence must be filled by interpretive content. Even a sophisticated decision-making tool, while potentially helpful in ruling out certain options or highlighting missing information, could not guide the cognitive integration of such qualitatively diverse inputs. For this we need the contribution of subjective, partial, bias-prone and non-systematic “clinical judgment”.

Greenhalgh [25] similarly invokes the concept of stories or narratives when she describes the clinical method as “an interpretive act which draws on narrative skills to integrate the overlapping stories told by patients, clinicians and test results”. Specifically:

“. . . It is only within such an interpretive paradigm that a clinician can meaningfully draw on all aspects of evidence, his or her own case based experience, the patient’s individual and cultural perspectives and the results of rigorous clinical research trials and observational studies to reach an integrated clinical judgement” [25].

Against the divided picture of ‘cure’ and ‘care’ - with the technical or curative side of clinical practice being impersonal, while the caring component requires humanism - both Tanenbaum and Greenhalgh recast the former as requiring much of the same self-reflective attention to context as the latter.

There is common use of the descriptor “interpretive” by Greenhalgh, Tanenbaum and others to denote a non-systematic synthesis of diverse information sources. These commentators agree that clinical decisions cannot be determined in entirely rational and reproducible terms when integrating warrants as diverse as clinical trial data, patients’ values and beliefs, clinical judgment, expert opinion and so forth, some of which lend themselves more

¹ Note that the decision regarding which tests to order required another layer of interpretation by the physician of the patient’s situation in consideration of the diagnostic resources available.

easily to quantification, while others figure into decision-making more descriptively. Instead, scientific reasoning must include some degree of non-systematic “tacit knowledge” [26]. Tonelli coined the phrase “clinical casuistry” to capture the practical reasoning or *phronesis* required to integrate diverse evidentiary warrants [27],² Shaughnessy *et al.* liken clinical reasoning to “improv” in jazz music [28] and Wartofsky [29] equates it with the “aha!” moment when you “get a joke”. The importance of interpretation in medicine prompted Hunter to argue that medicine is not a science. She explains that medicine does not fit the criteria for science because it lacks generalizable rules that can be applied unconditionally to every case - even every case of a single disease [30]. For instance, only 10% of patients in primary care have the sort of isolated, uncomplicated form of hypertension that lends itself to management by a standard evidence-based guideline ([31] in [25]). Horton sees clinical medicine’s lack of explicit rules for generalizing or inferring from trial data to specific patients to be the obstacle that keeps clinicians from incorporating research findings into their daily patient care practices [32]. Some evidence-based medicine proponents admit to this problem of application, yet offer no solutions [33,34].

As mentioned, the amassing of non-systematic informational sources into similarly non-systematic warrants is commonly referred to as “clinical judgement”. This “know-how” that comes from a physician’s relationship with the patient, observational capacities and clinical experience, was initially maligned by the evidence-based medicine movement [35] for its lack of rigour, systematicity and its vulnerability to bias. The evidence-based medicine founders soon conceded that clinical judgment was an inescapable dimension of clinical method and therefore brought it back into the fold [36]. Critics have been unimpressed by this concession, as the change in definition was not accompanied by any change in method or knowledge-translation effort. Greenhalgh, the one defender of evidence-based practice among proponents of “interpretive medicine”, is a lone voice in her claim that evidence-based medicine is consistent with this interpretive practice that she calls “narrative-based medicine” insofar as “even ‘evidence based’ clinicians uphold the importance of clinical expertise and judgment” [25] and “genuine evidence-based practice actually presupposes an interpretive paradigm” [25]. This apologetic does not explain away the discord between evidence-based practice’s pledge to “de-emphasize intuition [and] unsystematic clinical experience” [35] and the movement’s more contemporary concession that those qualities are part of clinical reasoning. Buoyed by open admissions within the evidence-based medicine camp that

the movement has made little progress in articulating how such disparate warrants as trial evidence, clinical judgment and patients’ preferences can be successfully integrated [37,38], Upshur [39] has wisely asked, if EBM now concedes that medicine is informed not only by evidence, but also by clinical judgment and also patient values,³ is there any sense in claiming medicine is evidence-based? If we understand a “base” to be the foundation upon which medical practice is built, the answer, by evidence-based medicine’s own admission, seems to be ‘no’. Clinical reasoning and the medical practice that it supports, is better characterized as pluralistic, rather than singularly *based*.

With some of the conceptual work in place, Richard Horton, Editor-in-Chief of the *Lancet*, was able to call for an “interpretive turn” in medicine, coin the phrase “interpretive medicine” and offer this definition:

“Interpretive medicine is neither the privileging of a single ideal method for conducting clinical research nor the abandoning of reason for the freedom of arbitrary clinical judgment. Rather, it reflects a recognition that clinical decisions are made through a plurality of means, each of which requires profound interpretive scrutiny in its own right. This broader view of how we construct and apply medical knowledge allows us to fuse evidence with experience and to make connections between apparently incommensurable disciplines - for instance, medicine and humanities, epidemiology and basic science...” [41]

Interpretive medicine thereby stands in opposition to evidence-based medicine with respect to the latter’s over-privileging of evidence from randomized controlled trials, but shares its concern that clinical judgment can admit bias and result in poorly justified clinical decisions. Its naturalized look at the cognitive processes actually involved in clinical reasoning leads interpretive medicine away from fantastical calls to rid medicine of clinical judgment. Furthermore, clinical judgment provides the interpretive tools required by physicians to navigate the limited evidence that even rigorous clinical trials offer for patient care.

Against Peabody’s view of diagnosis and treatment determinations being ‘impersonal’ in character, the interpretative turn just described grounds clinical decision-making in humanity. The patient is not assumed to be more or less commensurate with the “averaged” patient represented in clinical trial evidence (undistinguished by all pertinent subgroups and “soft” data relevant to treatment decision-making) [42], but rather assumed to be variable in condition, treatment response, comorbidities and life circumstances. Her values and preferences are not ‘further considerations’ once the most medically appropriate course of treatment has been established. Instead, they are crucial to the establishment of those recommendations. The physician engaging in clinical reasoning is similarly assumed to exercise humane and

² Tonelli’s [27] important account of clinical reasoning as a *casuistic* process similarly invokes these interpretive features required for integrating different information sources (or “warrants for action,” as he calls them). The casuistic process of analogical reasoning from paradigm cases deemed to be most similar to the case at hand to the actual case and the integrating of warrants without any pre-set hierarchy (since the case dictates the relevance and sufficiency of each warrant), requires attentive and nuanced interpretive skills.

³ Evidence-based medicine’s definition has evolved from its initial emphasis on the best research evidence to incorporate other clinically important features: “the integration of the best research evidence with clinical expertise and patient values” [40].

practical judgment, rather than limit this cognitive exercise to logical inference from the medical literature (for instance, in establishing whether the patient is characteristically similar to the trial subjects). The full humanity of both parties - patient and physician - is thereby required, as clinical reasoning is now grounded in the clinical situation, rather than the search for evidence or, in Peabody's day, knowledge of disease mechanisms. The need for clinical dialogue between patient and physician in order to accomplish this healthcare transaction further grounds what I understand to be a "medicine for the person, by the person, with the person", or "person-centered medicine".

Interpretive medicine's solution to the problem with Medicine

While some efforts to articulate this interpretive clinical exercise have been descriptive and phenomenological insofar as they work to deeply describe how medical knowledge is constructed and applied [26,28], others have been prescriptive in their efforts to lay down the rules of argumentation for *justified* clinical reasoning in light of its interpretive dimensions and the limits of each of its warrants for justified clinical beliefs. This effort speaks to the worry shared by proponents of evidence-based medicine and its critics that clinical judgment is prone to bias. The critics reject the evidence-based solution, however, as they maintain that any effort to restrict clinical reasoning to the application of clinical trial evidence is disingenuous. This method provides no rational framework for inference from those findings to the individual patient [42]: even the epistemically conservative approach of making the inferential leap *if* your patient fits the inclusion criteria employed by the trial is limited in terms of justification *and* provides no guidance to clinicians and patients who cannot (and characteristically do not) wait until the relevant trial addressing the treatment protocol or patient population in question gets published [32].

To better articulate and justify actual clinical reasoning, argumentation theory has been investigated, with some convergence on Charles Pierce's [43] theory of abductive reasoning [32,44]. Against Jenicek and Hitchcock's proposal that evidence-based practice ought to be paired with formal logic in order to strengthen physicians' decision-making powers [45], the theory of abduction is preferred by proponents of medicine's "interpretive turn", because it offers a strategy for incorporating diverse warrants - some qualitative, others quantitative, some clinically derived, while others subjective - and making sound clinical judgments given the circumstances. This method of incorporating and interrogating limited warrants does not provide the security that the evidence-based reliance on clinical data supposedly offered (disingenuously). Instead, abductive reasoning is employed by the physician to critically incorporate those warrants and make the best judgment for those specific circumstances.

It is with this interpretive framework in mind that Horton [46] offers "4 simple steps" for handling evidence in a clinical consultation:

"First, establish the warrant. Given the available information about the patient and the claim being made in the light of that information, why do I think this claim is justified? (Experience? A published study?)
Second, clarify the backing. How reliable are these justifications? Could they be wrong? Can I find any better justification? (Through a literature review?)
Third, qualify the claim. How certain is my claim? What sources of error could jeopardize its validity?
Finally, define the conditions for rebuttal. What evidence would refute or rule out my claim? Can I find such evidence?" [46]

Rather than offering a step-by-step procedure for coming to justified clinical decisions, these steps initiate a process of questioning our claims and assumptions, thereby making *critical thinking* the essential skill for clinical decision-making.

Returning to Pierce's model of abductive reasoning, Pierce [43] recommended the use of internally valid clinical trial evidence as the starting point for clinical application. From there, a generalized hypothesis can be offered (i.e., the thesis that the trial findings is applicable to the particular patient) and all efforts are then made to falsify that claim.⁴ If one can find no reason to exclude one's patient from the proposed action endorsed by the trial findings, then one proceeds with justification. This abductive method requires a 'leap' from limited trial data, incorporating many non-systematic warrants that may support or deny the generalized hypothesis and, by doing so, it encourages action rather than inaction in the face of incomplete findings in the trial literature [32]. With a broader range of acceptable warrants than evidence-based medicine permitted, Tonelli [27] offers these 5 warrants: (1) empirical evidence; (2) experiential evidence; (3) pathophysiologic rationale; (4) patient values and preferences; (5) system features. The critical appraisal of the relevant "evidence" (broadly construed) is more robust and the conclusions drawn, it is proposed, more justified than the conclusions drawn from a narrow focus on the trial methodology's place on the hierarchy of evidence.

All evidentiary claims require judgment about its relevance to the given clinical question. Neither Horton [32], Tonelli [27], or other proponents of this interpretive turn offer an explicit procedure for assigning weight to the warrants. This observation is not a flaw in either frameworks. Evidence-based medicine similarly does not offer a method for assigning weight to trial results when differences arise between trial scenario and clinical situation (as they likely will). The reasoning strategies that are offered - casuistic "triangulation" or Piercian "interrogation" of the evidence - highlight that there is no substitute for good critical thinking and argumentation. Horton's "simple steps" [46] (see also his 5 questions in

⁴ One might notice a similarity here between Peirce's abductive reasoning and Popper's theory of falsification [47].

[32]) serve as good guidelines for motivating the important considerations that clinical application requires.

A friendly corrective

I have detailed what I perceive to be inconsistency in the theoretical grounding that Miles and Mezzich [1] rely on in their explication of person-centered medicine. They begin with Peabody, whose call for reviving the *care* component of medicine relies on a theory of medical incompleteness, which I have described as problematic despite the important need for more empathy and compassion in medicine. I challenge the way that the cold technical side of medicine is not problematized. Miles and Mezzich find theoretical support for PCM in a recent editorial by Hartzband and Groopman [11], "Keeping the patient in the equation – humanism and health care reform", which echoes the humanistic themes of the early medical humanism scholarship and calls for "thoughtful collaboration between evidence-based practice and humanism". Miles and Mezzich surprisingly concur with the authors:

"We agree with Harzband and Groopman that the time has come for EBM and patient-centered care to coalesce and for precisely the reasons these authors discuss" [1].

Miles and Mezzich's accordance seems out of place in their paper, given that the previous section had detailed notable criticism to the evidence-based perspective. Furthermore, many of those critical scholarly contributions were published under the editorial directorship of Miles in the *Journal of Evaluation of Clinical Practice* and Miles has additionally authored and co-authored dozens of papers contributing to that critical discourse. Therefore, it seems justified to assume that the recognized limits of evidence-based medicine - none of which are mentioned in Harzband and Groopman's call for unity of evidence-based and patient-centred care models - deeply inform Miles and Mezzich's vision of the future of medicine. I suggest that Miles and Mezzich withdraw Harzband and Groopman and others' advocating "scientifically informed, yet humanistic" medicine from their sources of conceptual support for person-centered medicine, as the sentiments expressed by those authors do not properly reflect what I understand to be the goals of person-centered medicine. Person-centered medicine, still in its infancy, can benefit from this challenge of inconsistency in its theoretical backing, as its proponents can now sharpen its goals and its agenda.

This theoretical inconsistency probably went unnoticed by Miles and Mezzich, who drew from both Peabody [16] and from Hartzband and Groopman [11] an important call for more humane patient care. This laudable goal is rightly placed among the primary objectives of person-centered medicine. I call attention to a bi-product of this commendable goal advanced in the medical humanism literature, namely the 'scientific' aspects of medicine (whether "biomedicine" of the 1970s and 80s or "evidence-based medicine" of late) going unquestioned and

unchallenged. I propose that this uncritical acceptance of the science-informs-practice linear relation is inconsistent with other themes that Miles and Mezzich want to capture in person-centered medicine, themes that arise from the authors' expert knowledge of the shortcomings of evidence-based practice.

Conclusion

I have proposed that a focus on *interpretive* rather than *humanistic* medicine is more consistent with many of the characteristics of person-centered medicine articulated by Miles and Mezzich [1]. Both physician and patient are engaged and involved in this interpretive exercise. The argumentative strategy of subjecting clinical research evidence to rebuttals and counter-claims changes clinical reasoning and decision-making from its previous regard as a uni-directional exercise originating in the well-honed cognitive ability of the doctor and then applied to the patient (who can presumably take it, leave it, or amend it slightly). Instead, clinical reasoning occurs in a dialogic context [45].

In closing, person-centered medicine has been defined by its founders as:

"a medicine of the person (of her totality of the person's health, including its ill and positive aspects), for the person (promoting the fulfilment of the person's life project), by the person (with clinicians extending themselves as full human beings, well grounded in science and with high ethical aspirations) and with the person (working respectfully in collaboration and in an empowering manner through a partnership of patient, family and clinician)" [1].

Miles and Mezzich [1] recognize the need for conceptual development in this early stage, which is why, I take it, they are inviting commentary from a wide variety of sources. As they claimed, "the value of this definition is precisely in its ability to function as a template for ongoing methodological development in the field" [1]. To this, I hope to have contributed.

Conflicts of Interest

The author declares no conflict of interest.

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