Person-centred perspectives in medicine

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"IT may be more important to know what kind of person has the disease than to know what kind of disease he has." These words variously attributed to several famous medical authors, express the essence of my theme. It is, of course, quite obvious that good medicine has always depended on a proper balance between the doctor's concern for the treatment of disease on the one hand, and for his management and help of the sick person on the other. Although the need for this balance is recognised, it is not nearly so easy to achieve. Each generation and each individual has to work this out. The solutions of yesterday are no use for today, our problems are different—so must our answers be. We must be effective scientists in our understanding and treatment of disease, but we must also be effective in our management of the personal problems created for human individuals by illness, distress, infirmity, disability and death.

Today we are becoming uncomfortably aware that we have lost a proper balance between the disease-centred perspective in medicine and the person-centred perspective. We have to achieve a new balance. We cannot do this by resurrecting the solutions of the past, we have to find a contemporary answer using the knowledge and language of our day.

I like to think that such an endeavour would have excited the enthusiasm of Dr Gale in whose memory this lecture is given. As an epidemiologist he saw very clearly that the concentration of so much of medicine's intellectual and physical resources on the treatment of disease in hospital left many needs of the population not only unanswered but unanswerable. He recognised also the need to strengthen the contribution to medicine of those doctors whose field of work and methods of thinking were not orientated towards hospital medicine—witness his championship of general practice at a time when such views were neither common nor popular in the corridors of the medical establishment.

Historical view

Before we try to answer the question of what kind of person-centred perspectives are now needed in medicine I think it is helpful to take a historical view which may help to explain our position today.

For thousands of years men have sought help for a diversity of ills from those wise enough, or convincing enough to persuade them that they were able to provide the goods.

Looking back with the pruning knife of time we can see that a very little knowledge went a long way and that whatever the patients may have believed, the interventions of their physicians were seldom decisive for good, and rather too often the reverse!

Indeed, we now find it hard to take seriously those earnest doctors and anxious patients lost in a world of bleedings, poultices, cordials and concoctions. And yet the reputation of these physicians was generally high despite what we now see as ineffective or even dangerous treatment. Sometimes no doubt the reason for this was simple credulity. People have always needed to invest those that have power over them with magical and hopefully benign qualities. But often I suspect it was that the successful

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doctor learnt by necessity to understand the needs of his patient as a person, and to meet at least some of those needs. If not to cure at least to comfort and to make the experience of illness more tolerable even when there was no cure for the disease. He was practising effective patient-centred medicine even if he did not know it.

What the Americans call ' the name of the game ' has changed completely in our lifetime. The long struggle to understand the processes of nature that became a central concern of man's intellectual efforts at the time of the renaissance, has borne its full fruit for medicine in our own century. We now have a positive embarrassment of riches. Embarrassing because both we and our patients have come to expect that science will provide an answer to all problems. To a very remarkable extent, of course, it has. The infectious diseases that decimated populations, the ignorance that made childbirth a mortal hazard and infancy a fifty-fifty chance of survival, have become facts of history. It is now difficult to imagine a world ignorant of the germ theory of disease or without antibiotics, immunisation, safe anaesthesia, and competent surgery.

We have won a mighty triumph for medicine and for humanity, but of course to do this has demanded a tremendous concentration of thinking directed towards disease-centred medicine. The result has been that medical education has been more and more concerned with teaching and demonstrating the scientific disease-centred perspectives of medicine.

Imbalance in perspectives

The huge success of medicine might seem an ample justification for this state of affairs, and so to a large extent it is. And yet as we look at medicine today we see, I think, an imbalance between medicine's conception of itself and its role, and the true contemporary needs of our patients. We are living longer and therefore more subject to the degenerative diseases for which there are no simple cures. The stresses that now afflict us and make us ill are not the same as 50 years ago, we are left with more intractable problems, emotional illness, psychosomatic and auto-immune disorders, and the neoplastic diseases. These are all relatively chronic conditions in which the personality of the individual patient is of great importance in their treatment and management.

The very success of scientific medicine is forcing doctors back into an area of work where the answers provided by the biological sciences are not by themselves enough. In that sense we are back where medicine found itself before the huge therapeutic triumphs of this century. Back to a position where we have to attend much more specifically to the individuality of the ill person. This way of looking at medical care, by paying particular attention to the person in relation not only to his disease but also to his total environment can be called the person-centred view. It can be contrasted with the disease-centred view where the central concern is the disease process itself.

However, the satisfactions of scientific medicine are very great. To be able to understand pathological processes and to intervene rationally and successfully is an immensely satisfying activity for the doctor. It is also, of course, very pleasing for the patient! It is not therefore surprising that both doctors and patients have come to feel that to put a proper diagnostic label on an illness and to treat it 'scientifically' is the way to cure all.

In appropriate situations this is, of course, true but I think we are now seeing the disease model of medicine extended into areas where it is not only inappropriate but perhaps even dangerous. There is what almost amounts to a mutual conspiracy between doctors and patients to turn all symptoms and all problems into diseases as if by doing so they will become amenable to the wonder treatments of modern science. I think for instance that future generations will see some of our present treatments in psychiatry as not very different from bleedings and poulticing. We should recognise that there is

a natural resistance among doctors and patients to give up a disease-centred view of medicine where the answers seem so attractively simple and effective in exchange for a person-centred view where the answers are often far from clear.

The need for training in the person-centred aspects of medical care

We have become aware that medical education despite its great successes now has some serious defects. It tends in the words of the Royal Commission on Medical Education (1968) to " produce doctors who are highly competent scientists but who are not interested in or suited to handle the day-to-day needs of patients ". That is a serious charge. What does it mean? The statement certainly is not intended to suggest that we do not need highly competent scientists in medicine. No—the nub of the problem lies in the last words, " handling the day-to-day needs of patients ".

It is largely the changing needs of patients and the changing patterns of behaviour the of patients that have presented us with new challenges: these new challenges are making it necessary for us to develop new skills and new ways of working. Medical education is largely failing to prepare doctors for these new and different problems. This deficiency in the way we educate doctors has been recognised, particularly by those doctors who are most exposed to the unfiltered needs and demands of their patients. It is thus not surprising that general practitioners have been among the most active members of our profession both in exposing the problem and more recently in concerning themselves with possible answers.

Problems of life

The Royal Commission on Medical Education in collecting the evidence for its report made particular comment on, " The many witnesses who pointed to the increasing frustration and dissatisfaction of many general practitioners at their inability to deal with a substantial proportion of patients whose difficulties are psychological or social in origin ".

These new challenges for medicine have coincided with the introduction of systems of comprehensive medical care, offering patients open access to medical advice. Furthermore they come at a time when the prestige, or accessibility of other traditional kinds of help for those people troubled in spirit or afflicted with problems beyond bearing have largely disappeared. These " problems in living " very often find their way to doctors, because there seems no alternative source of help, acceptable to the individual. Often, as we know, such problems are presented as symptoms in order to elicit the doctor's concern.

All this presents the primary care physician with a difficult task. He clearly has a great responsibility to diagnose disease and to see that his patient receives the scientific medical care he needs, but he has to do this against a background which presents him with many other problems and symptoms that cannot be understood in terms of disease and the processes of pathology in which he was trained as a student. He has to sort out what kind of problem he is facing. Ian McWhinney has put it well when he said that, " The consultation in general practice is often not so much concerned with establishing a diagnosis as in exploring a situation in all its dimensions, physical, psychological and social." It is an ability to do this competently that we wish medical education to give to all doctors.

Two fallacies

In 1967 Dornhorst and Hunter wrote *Fallacies in Medical Education.* They identified two fallacies which they described as the 'scientistic fallacy' and the ' pastoral fallacy '. The scientistic fallacy suggests that the only proper kind of scientist is the full-time research worker in one of the basic sciences and that medical students should be taught the true

scientific method by such people rather than by clinicians whose scientific pedigree is of doubtful purity.

The pastoral fallacy on the other hand suggests that medical students should pay less attention to scientific subjects and more to the ' whole man '. The authors note with evident disapproval the concern of people interested in this approach with the psychological and social components of human behaviour, rather than with the traditional medical basic sciences.

This article illustrates the danger of thinking in ' either, or ' terms. We must have science, but we must have something else as well—the one does not exclude the other. Lion Hudson said in words that cannot be bettered, " I wish to ignore a line of academic distinction as tiresome as it is arbitrary, to do not biological science nor social science but human science."

Here then is a problem. How are we to introduce this new dimension into medical education and to make sure that our doctors learn human science? Most of the answers so far are not so much answers as high sounding declarations of good intent. Fairly typical of such statements is that by the General Medical Council in its recommendation on medical education in 1967, " Medical students should be instructed " it said, " in those aspects of the behavioural sciences which are relevant to the study of man as an organism adapting to his social and psychological, no less than to his physical environment ".

Behavioural science

No one can yet say exactly what *behavioural science* is, and yet there is a dangerous assumption in medical educational circles that it not only exists but if asked to do so it can in some way provide us with that balance in medical education that will answer all our problems. The group of social and other sciences included under the term behavioural science clearly have an important contribution to make to medicine and to medical education, but I believe that there are also great difficulties in doing this and that there is some danger that we could make matters worse rather than better by the wrong use of the behavioural sciences.

I also think that general practice could make a most useful contribution to medical education in this area of work in a way that might avoid some of the dangers.

The scientistic and the pastoral fallacy in teaching behavioural science

If changes are needed in medical education, and these changes should seek to increase the competence of doctors in dealing with the person-centred aspects of medical care, we then have to decide how this is to be done. We have to decide what should be taught, how it should be taught and by whom.

I now want to consider two solutions to this problem that are quite often advocated and are both I believe likely to prove unsatisfactory.

Echoing the article by Dornhorst and Hunter we might call these false solutions the scientistic and the pastoral fallacy.

The scientistic fallacy

The scientistic fallacy goes like this. Medicine is a science; it is grounded and dependent on its basic sciences. Doctors now need to know about behavioural science which means psychology, social psychology, and perhaps some forms of anthropology. We will therefore hire some respectable academic workers in these fields. They can then teach their subjects to medical students who will then apply it to their clinical work.

This is no caricature. Such an answer has already been introduced in many medical centres, particularly in North America. It is a pattern of problem solving in medical

education that has become firmly established during the last half century. It is seductively easy to do and seems logical and academically respectable.

But medical students are already intolerant of basic science knowledge, that they cannot see as relevant to their needs as doctors. And they are quite right. They can be made to learn almost anything by the fear of examination failure but their revenge is inevitable. It is all promptly forgotten.

Behavioural science subjects taught as pure science by academic specialists in the field are very likely to be rejected as irrelevant by a large section of medical students. Such teaching is also commonly misunderstood, ignored, or resented by the clinical teachers in medical schools. Any form of behavioural science teaching that is not supported and reinforced in the clinical experience of the students has very little hope of succeeding in influencing their behaviour as doctors. We cannot shop around the behavioural sciences choosing a lecturer in sociology here, and social anthropologist there and a clinical psychologist for good measure, and then expect them to devise a teaching programme for preclinical medical students which will give us what we want. To believe in such a solution is to indulge in the scientistic fallacy.

Pastoral fallacy

The pastoral fallacy takes the opposite view. It rejects the whole idea of teaching medical students the more academic aspects of psychology or sociology or other behavioural sciences. It believes instead that all that is required is a good dose of the ' art of medicine ' as taught by physicians who not only know all about disease but all about people as well.

It is often part of this fallacy to believe that general practice is full of such men, and that no more is required than an increased exposure of medical students to their influence to give the students all they need in the person-centred perspectives of medical care.

Neither of these fallacies are entirely without some truth. It is their unbalanced one-sided view that render them fallacies and therefore dangerous. The truth is that we as doctors and medical educators have to create what we want. There are no ready made answers. We do need to use the great amount of new knowledge about human behaviour discovered by the social and behavioural sciences. But we have to apply such knowledge to the practical business of medicine and we have to show how this is done. If doctors can show students how they really use the knowledge, skills and insights gained from the behavioural sciences in the care of their patients, then students will quickly and eagerly accept such teaching. Indeed they are by natural inclination hungry to do so. Given the right food I believe their appetite would be surprising.

What to teach and how to teach

We can accept that medical education does require reform, if it is to fit doctors for the needs of contemporary society. We must incorporate into the curriculum of medical schools teaching in the behavioural sciences. This must, however, be done so that the medical student can see how this knowledge will be applied to his work as a doctor. We cannot ignore the new knowledge and insights offered to us by the behavioural sciences, nor can we absorb them undigested into the conceptual system of medical practice.

How then should we teach person-centred perspectives in medicine? Can general practitioners make an important contribution to that teaching; not of course as reactionary advocates of the pastoral fallacy but as a branch of medicine that has a particular need to understand and apply the concepts and insights of the behavioural sciences to medical care?

But first I want to say something in general terms about behavioural science and its inclusion into medical education.

Let us take a look at a list of subjects that have at different times and at different places been included under the umbrella of the behavioural sciences.

TABLE 1
SOURCE SCIENCES CONTRIBUTING TO BEHAVIOURAL SCIENCE

Biological	Behavioural genetics Psychophysiology Psychopharmacology Psychology
Psychological	Dynamic psychology Social psychology Ethology
Sociological	Anthropology Sociology
Humanities	History, Politics, Economics Philosophy, Ethics, Theology

This is a daunting list indeed, yet one can think of relevant aspects of each of the subjects shown here. Are we to have a lecturer in each—perhaps a professor in each? Of course not, but what do we do? The answer I fear is that doctors themselves must work with social and behavioural scientists, to produce a digestible diet for medical education. A process of selection and integration has to take place (figure 1).

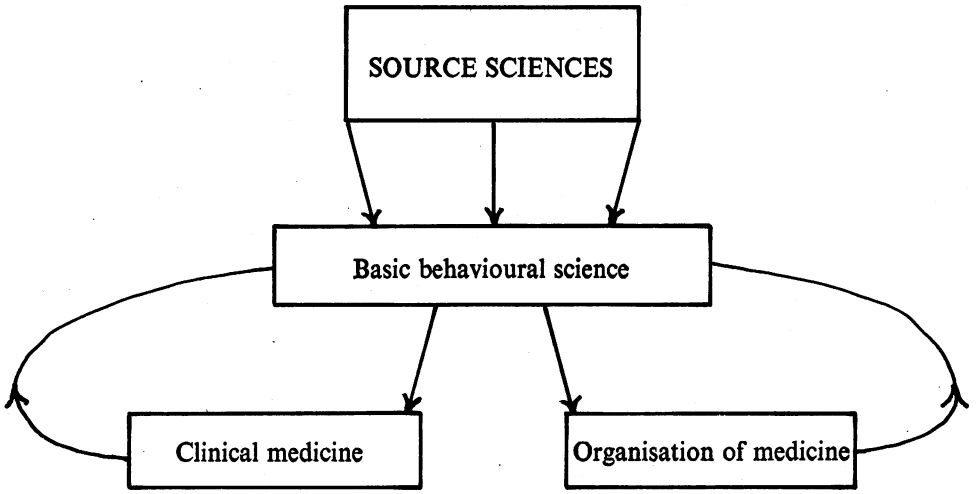


Figure 1 Integrating behavioural sciences into medical care.

Having extracted from a large number of separate disciplines a core of knowledge, we then have to apply this to the needs of medicine. There are two directions in which this knowledge is to be applied. The first is in our clinical work with patients, and the second is in what I have called the organisation of medicine.

Medicine and society

The behavioural sciences and particularly sociology, has made extensive studies of the social aspects of medicine, of medical care systems, of the professions and of the social processes that influence the behaviour of patients and doctors. Today the medical needs of society, and the political and social structure within which medicine operates,

are all changing at an alarming rate. Decisions of decisive importance for the future of medicine and society await all of us. If doctors wish to play a responsible and respected part in finding successful answers to these new conditions, they will need to do so in a world where their opinions do not any longer enjoy an automatic authority by virtue of their medical qualifications.

Medicine is now demanding and getting into its medical schools, some of the best intellects amongst our school leavers. Society has some right to expect that such a group should be educated up to their full potential. Their education should not be confined to the personal clinical problems of medicine, important as these are, but should also attend to the larger issues of health and medical care that concern society. That task will require an appreciation of the methods of work of the social sciences, and of the contribution they can make in finding answers to the problems that medicine will have to solve.

Increasingly we see that the answer to these problems in contemporary societies, involve political and social decisions that extend way beyond the areas controlled by the professional organisation of medicine. Our present medical education tends to make doctors feel threatened and inadequate when confronted with these wider issues of social policy and social decision making. They all too easily retreat into an ivory tower of professional superiority, and indulge in various forms of shroud waving. This response will not solve anything. But I must now return to the central theme of medicine which is of course the relationship between a doctor and his individual patient.

Teaching the person-centred perspective in medical care

Proper medical care clearly involves both an understanding of the disease process, in terms of the biological sciences, and an understanding of behaviour and the needs of the sick person in terms of the behavioural sciences. Can we then begin to define more clearly what this latter kind of understanding involves? What do we need to know about our patients as individuals and as members of social groups, in order to guide our medical management?

In simple language I think we could express it in terms of a progressive source of questions that the doctor has to ask and answer for himself.

What kind of person (strengths and weaknesses)?
faces
What kind of situation (supports and stresses)?
making
What kind of adaptive responses (appropriate or inappropriate)?
calling for
What kind of help (from self or others)?

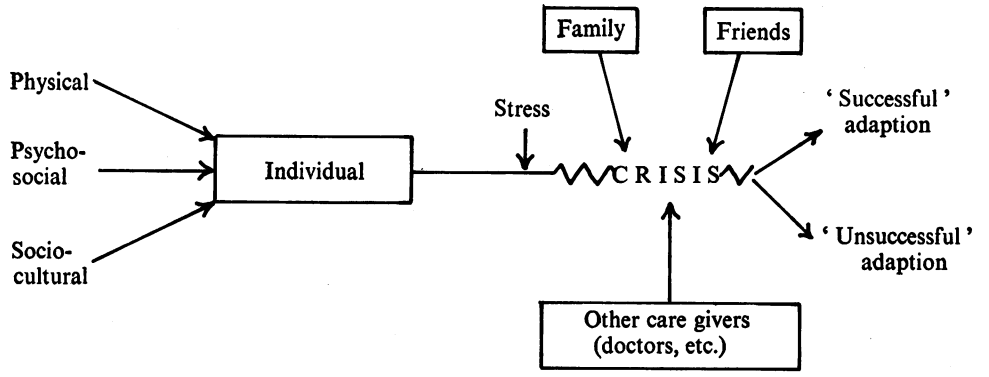
Although such questions cover the ground, they do not indicate what kind of behavioural science will be needed to enable the doctor to answer these questions. The next diagram is an attempt to restate this theme in a way that may make it easier to see how a variety of behavioural sciences could be applied to our work.

The concept of crisis

I have used the concept of crisis to illustrate this theme. Crisis as Caplan has stated, " Occurs in any situation where there is an imbalance between the difficulty and importance of the problem and the resources immediately available to deal with it ".

In a sense every doctor-patient contact can be thought of as concerned with a crisis, since the patient seeks help for a situation in which his own personal resources, whether they be physical, psychological, material or social, are proving inadequate to cope with the problem facing him—or at least he believes this to be so. In this situation

Inherited and acquired characteristics:



it is the doctor's task to assess the problem in all its dimensions. To define his patient's needs and to see what action can most appropriately be taken to help him. This surely is the essence of person-centred medicine. The diagram suggests specific areas which are of importance for the individual in coping with crisis. These areas, of course, suggest points where the knowledge derived from the behavioural sciences are of relevance in helping the doctor to understand his patient's needs and the ways in which he might be able to help him.

In general, the way in which an individual copes or tries to cope with stress depends on inherited characteristics and acquired habits of thought and behaviour. His strength and his weaknesses are already there. In the diagram I have suggested the main components of this physical and cultural inheritance.

His physical inheritance provides a biological framework which he cannot escape. How he uses it, however, will depend on complex psychological, social and cultural factors that have moulded his personality. In human behaviour these acquired characteristics will often be decisive. How a person feels, how he behaves when ill, how and when he seeks help and how he responds to help will be largely decided by these factors. The behavioural sciences have much to teach us here and we should be able to apply this knowledge to our understanding of patients.

The individual confronts his life with this personal equipment for coping. He faces, " a physical, psychological and social environment ", and this environment continually challenges him. Any of these challenges may overwhelm a person's ability to adjust successfully. If this happens he finds himself in crisis, as defined by Caplan. Crisis is thus an unstable psychological state where old methods of coping have to be rejected and new ones found. The individual always comes out of crisis, but the vital point is how he gets out. There is a good way out and a bad way out. In terms of our thinking as doctors we can call a good way out, health and a bad way out, illness.

In deciding the all important question of the quality of the resolution achieved in crisis situations, much will depend on the ' strengths ' the individual already possesses, but much too will depend on the help he can get, and get at the right time. I have indicated those social and professional groups which are of most importance in influencing the outcome of crisis. The doctor is, of course, only one among many influences, and generally because his contacts with his patients are relatively brief, not the most important. But I think it is also true that the general practitioner is often in a strong position to evaluate the effect of the various groups on his patients, and if possible to see that their influence favours a ' good ' outcome.

Case history

A 55-year old foundry worker had a coronary. It was not severe as judged objectively by his physical signs and E.C.G. changes. There was no problem and he appeared to have recovered. This was the general feeling about him shared by his doctor and the staff of the hospital ward. He was interviewed one afternoon by one of the doctors on our vocational training scheme, during our training seminars. The objective of this interview was rather different from the ordinary medical reason; it was to find out what this man felt about having a coronary, and what his experience in hospital had really been like for him. It was a great surprise to all of us, not least to the doctor who was looking after him on the ward, to discover just how surrounded by unsolved personal difficulties this man was and how incomplete was his recovery from his heart attack from a person-centred point of view. He belonged to a family where toughness was the only quality respected. It was the same among his workmates. To be respected it was necessary to work harder, drink harder, swear harder and if necessary hit harder than anyone else. Our patient it seems was uncrowned king of this tough but immature world. He earned an extremely good wage, and he used money to control his family. There was no overt affection or tenderness but a lavish supply of consumer goods of all sorts was almost aggressively thrust upon the household. Communication between members of the family seemed to be minimal, but " they have to come to me for money " he said. The effect of the coronary on this man's self image and life style, had, it became clear, as we talked to him, been devastating. How could he possibly go on? How could he hold his own at work if he could not work the hardest, and if he thumped someone his heart might give up? If he did not get all that money how could he control his family? How could anyone be caring and tender to him who had always rejected such things? It turned out that this man spent sleepless nights choked with silent tears of despair. No one knew of course, it was not in his style to tell but it became very clear that from the person-centred point of view he was very far from well, and even from a disease-centred point of view his feelings were all too likely to contribute to pathological physical changes.

The behavioural sciences are concerned with such things as how individuals see the world and themselves, the kind of assumptions people make about each other, the expectations that we have about other people, and the emotions that these things induce in us so they must be of importance to doctors.

The essential point is that behavioural science studies areas of human behaviour that are also our concern. But it is not enough that we are both interested in the same thing, because our methods of thinking and of expressing our findings are very different, and are designed for different purposes. We as doctors have to find the way in which the academic findings and concepts of the behavioural sciences can be applied to the clinical care of patients.

General practitioners are so particularly and inevitably concerned with the psychological and social environments of their patients that they have most to gain and perhaps most to give in finding ways in which the research results of the behavioural sciences can be applied and used in medical care.

This task has already started, and started, I believe, extremely well. The authors of the recent book by the Royal College of General Practitioners, *The Future General Practitioner—Learning and Teaching* have done something remarkable—it may be only a beginning but surely a good beginning. Similarly the first part of the latest edition of Dr Keith Hodgkin's (1973) classic work *Towards Earlier Diagnosis, A Guide to General Practice*, is another most impressive effort in this area. We are indeed on the move. No other section of the medical profession has shown itself more open to the new ideas and the new possibilities offered to medicine by the behavioural sciences.

Finally then in the light of our present knowledge how should we change medical education so as to give our medical students an adequate training in the person-centred perspectives of medical care.

There must clearly be a contribution from the behavioural sciences, which is appropriate in type and enough in quantity. In considering what this contribution should be it is easier to think in terms of areas of concern rather than the contribution of separate disciplines.

The main areas of teaching that need to be covered are as follows:

(1) Human psychosocial development and the family life cycle.

(2) Interpersonal interaction and communication.

(3) Medicine and society—sociological, historical and political perspectives.

In each of these areas some of the behavioural sciences can make contributions from the basic science point of view. But an integrating process of which I spoke earlier has to be achieved in order to produce a basic science input for each of these areas that can be taught in a unified way and does not confuse the student.

It is also important to show the relevance of this behavioural science teaching for the practice of medicine. This I believe should be going on all the time, both in the preclinical and the clinical period.

Role for general practice

I see a great potential use for general practice and other forms of medical and paramedical experience that could be given to the student outside hospital. I believe general practitioners, particularly, of course, those in contact with universities and students, should work closely with behavioural scientists to devise learning experiences that combine real life experience with a theoretical input from the basic behavioural sciences.

General practice has already demonstrated its interest in behavioural science concepts and its ability to think in those terms about the work it does. It seems to me that if behavioural scientists in medical schools, and general-practice teachers could work together they could make a most valuable contribution in teaching the person-centred view of medicine. But diffuse goodwill is not enough. Very clear specific teaching and learning situations have to be carefully planned together, and refined by hard experience. If we could only do this at all our medical schools the battle for a better balance between disease-centred and person-centred medicine would be won. We should then produce doctors truly trained to meet the day-to-day needs of patients both in disease-centred, and person-centred terms. Such students would avoid both the scientistic and the pastoral fallacy. Appropriately trained in both the biological and the social sciences they would practice the best kind of human science.

Cum Scientia Caritas.

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LIAISON BETWEEN GENERAL PRACTITIONERS AND PHYSICIANS IN A TEACHING HOSPITAL

Five years ago, five general practitioners were appointed to five medical units in a teaching hospital to assess the value of such an attachment in regard to patient care, medical education and research. The results of this experience are reported. The evidence indicates that this form of association can make valuable contributions to all three activities and that further studies of this kind should be undertaken.

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