

EDITORIAL INTRODUCTION

Advancing the global communication of scholarship and research for personalized healthcare: *The International Journal of Person Centered Medicine*

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Introduction

A simple *Google* search using the phrase ‘The Foundational Philosophy of Medicine’ yields 1,510,000 results. If one omits the word ‘Foundational’, then the search result yields 11,900,000 items. Certainly, much material of varying scholarship and complexity has been written over the course of two millennia on this very particular subject, not all of which is immediately accessible, not even through *Google*. Yet the fundamental philosophy of medicine can also be articulated very simply and indeed has been and in the following few words: ‘to cure sometimes, to relieve often, to comfort always’. Originally attributed to Hippocrates, this striking maxim has become more closely associated in recent times with Edward Livingstone Trudeau, a nineteenth Century physician who, retiring to Saranac Lake in the Adirondack mountains of New York in order to palliate his tuberculosis, founded several important health facilities during his remaining lifetime which continue in existence today.

In our more modern times, the original maxim must surely be prefaced with ‘To prevent illness where possible’ and may also come with time to be concluded with: ‘To assist death when necessary’. If we accept the imperative for the former as universally established (the latter remaining the subject of intensive ongoing ethical, legal and emotional debate), then are we able to say that modern medicine fulfils these four conceptually different, though highly interrelated missions? It would be difficult, in our view, to answer correctly and honestly in the affirmative. Certainly, since Fleming’s discovery of penicillin in 1928 and the publication of the science

underlying the clinical use of radiation by Marie Curie for which she achieved the Nobel Prize in Physics in 1903 and for Chemistry in 1911, there have been staggering advances in pharmacotherapeutics and medical technology that have revolutionised the scope, possibility and power of clinical practice. Yet despite such unprecedented and astonishing progress, it would be difficult to deny that modern medicine has not entered into crisis: a crisis of caring, a crisis of compassion and a crisis of costs. Indeed, the perception that major distortions have occurred in the understanding of the purpose of modern medicine [1], has been accompanied by much soul searching, leading Miles, in an address to La Sapienza at Rome, to pose three distinct and initially startling questions: ‘What is Medicine for?’ ‘Where has Medicine gone wrong?’ ‘What can we do to put Medicine right again?’ [2].

In our view, it is not the case that modern medicine is ineffective (although its limitations have become starkly exposed in the treatment of chronic conditions which now pose one of the greatest challenges to global economics and wellbeing), but rather that it has become depersonalised. The purpose of this *Editorial Introduction* and the space allocated to it, do not allow a full exposition of our reasoning at the time of writing, though this will be made in extensive detail within the next issue [3] and very soon elsewhere [4,5]. Suffice it is here to advance our contention that the crisis in medicine is worsening, not improving and that the institution of a new periodical specifically dedicated to the development of a higher level of personalisation of clinical services than that which currently exists, is therefore not only timely, but *urgently necessary*, if medicine is to regain many of the fundamental characteristics of humanity and

professionalism that it has progressively lost over a century of empiricism, scientism and technocratic reductionism in health care [2, 6,7]. It is these observations and arguments which constitute, then, the *primum movens* for the conception and launch of the *International Journal of Person Centered Medicine* (Int J Pers Cent Med; IJPCM: www.ijpcm.org), the official journal of the International Network for Person Centered Medicine (INPCM) (www.personcenteredmedicine.org).

Scholarly interchange in PCM.

To date, the international communication of ideas in person-centered medicine (PCM) has taken various forms, principal among them the publication of articles of varying nature and focus in specialty and subspecialty medical journals and within the periodicals of related clinical and academic disciplines. However, many of these journals are overloaded with manuscripts and are associated with long delays in the publishing process. In addition, many are preferentially concerned with experimental medicine, often appearing less interested in the innovations in clinical practice that are designed directly to increase patient and clinician satisfaction with care and the generation of enhanced clinical outcomes using currently available knowledge. The IJPCM does not intend to redirect the publication of PCM and PCM-related articles within the existing medical literature, despite the limitations we detail, but rather aims to complement and augment specialty publication by adding a distinctive and powerful voice to general discourse in the field and to methodological development and evaluation of the effects of PCM in particular, vital functions to which we will return in some detail below.

Person-centered clinical practice and people-centered public health

Despite its title, the IJPCM will not focus *exclusively* on the individual patient, decontextualized from his social setting. To do so would be highly erroneous and would justifiably lead to the *Journal* being accused of the very reductionism in modern health care that it seeks to reverse. On the contrary, the IJPCM recognises that individuals exist within their circumstances and that these circumstances involve the patient's living with other individuals in Society as well as in his own internal milieu. For this reason, the *Journal* will be as concerned with people-centered public health (PeCPH) as it is with person-centered clinical practice. Here, we aim to make a very specific contribution to medical progress, by arguing that the design and development of impersonal public health strategies should move away from the utilitarian application of methodologically limited, biostatistically dominated studies conducted in epidemiological

subpopulations, towards a more humanistic model of care based on science and humanity, for the individuals who, together, collectively constitute the social communities in which they are born to live and in which, later, they will come to die.

Moving from concepts to practice: IJPCM and methodological progress

Now that the philosophical basis of person-centered clinical practice and people-centered public health has been coherently described and that their relationship as entirely complementary and mutually reinforcing models of healthcare is increasingly well acknowledged, the time has come to move these clinical philosophies away from their current status as universally recognised *conceptually optimal models of care* to the status of *operationally normative models of care*. Here, the design and development of detailed methodologies aimed at translating PCM and PeBPH into routine clinical practice is of pivotal importance and has become an urgent international priority. To be sure, the challenges involved in doing so are formidable and should not be underestimated. They include not only the necessary realisation of core methodologies to enable operational implementation of PCM and PeBPH models of modern care, but also the design and operation of systematic audits aimed at the quantitative measurement as well as the qualitative description of improved health outcomes from PCM and PeBPH interventions. It is more than gratifying to note that this work has, in fact, already commenced. Indeed, of relevance here is the prominent example of the recently instituted INPCM-WHO Project on *Developing Measures to Assess Progress Towards People-centered Care*. The IJPCM looks forward to the publication of the results of this important initiative and to commissioning and considering for publication in its pages further such important work.

The need for the developments we detail is, certainly, of fundamental importance. Indeed, while it is by no means a dominant position, there are nevertheless those working within international health services research that view PCM as 'well meaning', but disconnected from the operational realities of health services, where patients' demands meet economic constraints, insufficiencies of clinical time and manpower, coupled with the rationing of, or denial of access to, the benefits of therapeutic and technological advance. Here, the need for humanity in clinical practice seems increasingly viewed as entirely optional and begins to appear as something which can safely be consigned to the history of medicine. After all, some argue, medicine cared when it could not cure, but now that medicine can cure, does it really need to care? To us, this is an example, *par excellence*, and spectacularly so, of a false dichotomy and one capable of occasioning great violence to the historic mission and Hippocratic nature of

medicine – if, that is, Society allows it to continue unchecked. Likewise, there are those colleagues who view the reawakening of humanity in medicine in an age of major scientific advance as an anachronism at best or as a form of inappropriate, anti-science sentimentality at worst. The IJPCM views such cynicism, misunderstanding and lack of human insight and imagination as deeply disappointing, indeed positively alarming.

In its simplest description, to care for someone is to want and to do what is best for them. In this context, what is best for patients is to be treated as persons, not diagnostic codes or statistical units. Medicine has the unalterable imperative to care, comfort and console as well as to attenuate, ameliorate and cure. A preferential concentration on either care *or* cure, rather than on a search for a means of integrating both, risks the creation of an ethical and moral chaos in medicine that can only result in the maintenance of the crisis in clinical professionalism to which we have already made reference in outline above and which will, without hyperbole, prove a disaster for patients. It seems to us incontrovertibly clear from raised voices worldwide, that patients are no longer prepared to be 'dealt with' or 'processed' by technicians in applied bioscience, but rather to be attended by scientifically trained advocates who recognise their problems not only at an organic, but also at emotional, social and spiritual levels and who, in addition, then proceed through shared decision making to tailor treatment for the patient through a medicine *of* the person (of the 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 clinicians) [8-10]. The IJPCM is committed to urging such an understanding of medical philosophy, knowledge and action and we are confident that the ongoing paradigmatic shift towards personalisation – and the reengineering and reconfiguration of clinical services that it will necessitate – will, sooner rather than later, come to result in better care for all. This is not an ideology expressed as a vain hope, but rather as a statement of the energy and conviction with which the members of the Editorial Board of this journal and many of its readers are greatly infused.

Raising the international awareness of the IJPCM and promoting its use

If the IJPCM is to make the difference to healthcare which we hope it will and to which it is enthusiastically wed, then a key challenge during the infancy of the *Journal* will be the need to ensure the success of the advertising and marketing of the IJPCM, where the principal aims are continuously to raise the profile of the *Journal* and to

generate revenues in support of the growing work of the International Network itself. At the time of writing, we are actively considering the methods by which to achieve these aims, using the well established techniques of sales and marketing campaigns, as well as novel approaches. Relevant here, and complementing the annual Geneva Conference on Person-centered Medicine are the plans in gestation for an annually recurring programme of international PCM conferences commencing in 2012 and which are aimed at elucidating key methodologies for the development of person-centered models of care by specific disease and condition. These initiatives will also directly assist IJPCM advertising, since journal marketing information can easily be included in the extensive e-mail and postal advertising programme that will be necessary to achieve awareness of and attendance at the international conference programme series. It is anticipated that each conference will not only generate a specific and sponsored *Supplement* of the IJPCM which will function primarily as a major educational resource in describing what constitutes a PCM model of care for the given disease/condition (e.g. Diabetes, the whole range of solid tumours and haematological malignancies, HIV/AIDS, CF, MND, PD, MS, etc.), but that the conferences and their published IJPCM supplements will also generate a significant share of revenue for the INPCM through delegate fees and sponsorship agreements, the latter directly enabling the special *Supplement* to be made freely available as an Open Access document on-line.

It is also hoped that the various senior national and international professional bodies and scholarly associations actively associated with the support and progress of the annual Geneva Conferences will also assist the raising of journal awareness through their membership databases when sending routine e-mails to members and also through carrying details of the *Journal* on their respective websites. Moreover, social media such as *Facebook* and *Twitter* are also likely to prove useful in bringing a knowledge of the *Journal* to the attention of physicians, health professionals in practice and training, to health journalists and medical librarians and also to so-called expert patients and to the general public itself.

While we are clear that these campaigns will be conducted primarily in the developed world in the first instance in order to generate the revenue necessary to establish the *Journal* as a viable financial entity as quickly as possible, we wish to confirm our unequivocal commitment to ensuring early, subsequent access to the *Journal* in the libraries and public institutions of low and middle income countries as a vital and indispensable part of the global dissemination of important health data. For example, the IJPCM plans to make itself available, as resources allow, through the Research4Life Initiative (HINARI). This project, managed by the World Health Organisation in partnership with Yale University Library, is important, given that 3,300 public institutions in 108 eligible low and middle income countries benefit directly from the free or very low cost access to clinical and

scientific journals via its work. Relevant here too is the IJPCM's intention to become part of the PERii initiative (Programme for the Enhancement of Research Information) of the International Network for the Availability of Scientific Publications (INASP). Further plans involve, in addition, joining the Emergency Access Initiative (EMI), a partnership of the National Library of Medicine, the National Network of Libraries of Medicine and the Professional/Scholarly Publishing Division of the Association of American Publishers, which ensures free access to journal content in the wake of natural disasters and in times of humanitarian crisis. Furthermore, we aim to make journal content that is at least one year old available to small and/or specialist libraries that lack the resources necessary to purchase a full subscription, via the EBSCOhost databases. In terms of bibliometrics, a high impact factor and a healthy citation rate will develop naturally as the IJPCM progresses from infancy to adolescence, rising in international stature and importance as part of this process.

Aims and scope of the IJPCM and Editorial Governance

Person-centered Medicine is a broad field of study. It draws on the knowledge base of all of the medical specialties, health professions and on the scholarship and research of a wide variety of academic disciplines. The interests of the IJPCM are therefore correspondingly broad, but centre particularly upon core areas of study such as: (a) medical epistemology and the nature of knowledge for the individualisation of clinical practice; (b) reductionism and complexity in clinical care; (c) methodologies for the individualisation of clinical practice and for the evaluation and development of person-centred medicine; (d) methodologies for the development, use and evaluation of person-centered history taking, diagnosis, prognosis and follow-up; (e) clinical practice recommendations and guidelines for PCM; (f) narrative-based medicine; (g) values-based medicine; (h) cultural medicine; (i) psychosocial and psychosexual medicine; (j) social and environmental care in PCM; (k) spiritual and religious care; (l) economic aspects of PCM and policies for the funding of PCM; (m) individualised/personalised (genomic) medicine; (n) sociological aspects of PCM; (o) the medical humanities and PCM; (p) ethical and medico-legal implications of PCM; (q) the role of the family and of friends in caring and decision making; (r) the development and use of information technology and medical informatics for the development, application and evaluation/audit of PCM; (s) person-centred design and operation of healthcare facilities; (t) health service policies and policy-making for PCM; (u) the national and international health politics of PCM; (v) the role of medical education and PCM & (w) people-centred public health. We therefore welcome contributions for consideration across all of these

distinct areas of study detailed above and in the following formats: (i) Full scientific papers deriving from original research; (ii) Learned review articles presented as structured or systematic reviews; (iii) Commentaries and Editorials; (iv) Brief and Rapid Communications; (v) Essays, Opinions and Viewpoints; (vi) Critiques and Analyses; (vii) Book Reviews; (viii) Conference Reports; (ix) Letters to the Editor & (x) Research Letters.

Conclusion

In conclusion, it is our fervent hope that the IJPCM will provide an effective forum for the rapid communication of advances in PCM and a major vehicle for the stimulation of thinking, scholarly interchange and basic and applied research as they pertain to the personalization of care for the patient and the development of humanistic models of care for groups of individual patients within the context of their social settings. This function should help provide new insights into how an increasing personalisation of health services can contribute importantly to causal increases in the quality of care and to patient and professional satisfaction with health processes and outcomes in the clinic and at the bedside. A key function of the IJPCM will be to act as an impartial forum for the airing of controversies, with a particular role in stimulating the thinking necessary to resolve differences in the approach to clinical practice as the paradigm shift - from impersonal, fragmented and decontextualized treatment to personalised, integrated and contextualised care - continues to progress. We envisage that the IJPCM, functioning in this manner, will provide existing healthcare professionals with rapidly communicated, globally derived information on developments in person-centered medicine and people-centered public health and that it will furthermore act as a valuable resource for students at various points in their academic and clinical training.

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