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Section on International Organization Perspectives on Person-centered Medicine

World Organisation of Family Doctors (Wonca) perspectives on person-centered medicine

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The acronym Wonca stands for the World Organisation of National Colleges and Academies of General Practice/Family Medicine. This has now been shortened to the World Organisation of Family Doctors although we retain the rather endearing acronym.

Wonca is indeed a global organisation with 119 member organisations in 116 countries across every continent. The stated aspiration for Wonca is "A family doctor for every family in the world" and, by implication, because not everyone lives in a conventional family, "A general practitioner for every person in the world".

When, as an adolescent, I was first thinking of studying medicine, my own family doctor told me that:

"In hospitals, the diseases stay and the people come and go; in general practice, the people stay and the diseases come and go."

In this sense, general practice is fundamentally person-centered and it is Ian McWhinney who has pointed out that [1, p. 433]:

"[General practice] is the only discipline to define itself in terms of relationships, especially the doctor-patient relationship. … Clinicians in other fields form relationships with patients, but in general practice, the relationship is usually prior to the content. We know people before we know what their illnesses will be."

In A Fortunate Man, his magnificent account of the work of a rural family doctor, published in 1967 [2], John Berger described the "individual and closely intimate recognition" which is necessary. He explains the need for the doctor to come close enough to see and to hear and so to recognise the particular suffering individual. It is this recognition that underpins the commitment to person-centered medicine. The practice of medicine depends on the ability to make a connection between the generalisations of biomedical science and the unique individual experience of illness and disease. In Doctor Zhivago, Boris Pasternak wrote [3]:

1. the mystery of the individual is precisely what must be put into the facts to make them meaningful.

The interface between illness and disease is the point at which the vast undifferentiated mass of human distress and suffering meets the taxonomy of scientific medicine which have been developed to enable humanity, to a still very limited extent, to understand and control the experience of illness. Illness is a perception of something being wrong, a sense of unease in the functioning of the body or mind; disease is a theoretical construct which offers the

benefits and risks of scientific medicine. General practitioners have learnt from experience the benefits, to both the individual and to society, of holding the border between subjective illness and the disease categories recognised by biomedical science; of confining people within diagnostic categories only when such labelling will be positively useful to them; and of deliberately minimising exposure to the harms of medical technology. In this way, general practice directs both the power and the rising costs of biomedical science where it can help rather than where it harms.

The grounding reality of medicine is the patient's subjective story of their symptoms. Everything that comes after is an abstraction from, and an approximation to, that reality. Illness belongs to individual patients; disease belongs to science. The former is subjective, the latter ‘objective’. The patient tells us the story of their illness; we must then summon our knowledge of biomedical science, which by its very nature turns the patient into a standardised human object, and make a judgement as to whether the patient's illness fits into a useful model of disease. The expectation is that such a model will offer effective treatment or even cure.

Medicine aspires to be a science whose object is also a subject, and there is great danger in turning a human being into an object [4]. The dangers are already great with physical illness where the patient can very readily feel that the particularity of their experience has been lost and that the doctor can no longer see the person behind the mask of the disease. But, at least in physical illness, the objectification of the body is a process that is already familiar to the patient. The sick body obtrudes into consciousness in a way that the healthy body does not. The body becomes an object which impedes the person's planned or desired activities. There can be no exact parallel in mental illness—no one can perceive their own mind as an object. The mind is essentially and inevitably subjective. We experience our own minds as subjects and we also experience the minds of others not as objects or as third persons but as a second person—a you—as another and autonomous subject. This essential subjectivity seems to me to undermine the application of the biomedical model of science in psychiatry in a very fundamental way. The steps of objectifying and generalising are inevitably partial in the face of the unique individual subjectivity of each human mind.

In the wonderful and inimitable Tristram Shandy, Laurence Sterne describes the relationship between body and mind [5, p. 114]:

“A man's body and his mind, with the utmost reverence to both I speak it, are exactly like a jerkin, and a jerkin's lining; rumple the one, you rumple the other.”

The Cartesian distinction of mind and body has had extraordinary reverberating consequences in the centuries since the French Enlightenment. Many have increased our understanding but some remain profoundly troublesome. Biomedical science assumes the validity of such a split but almost all experience of illness denies it. All bodily illness has consequences for the mind and all mental illness affects the body.

I want to cite just one paper by van Os et al., communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment [6] to demonstrate the overwhelming importance of the quality of the personal relationship between doctor and patient. An optimal outcome for the patient requires not only sound medical knowledge but also a good relationship between doctor and patient.

However, I also want to mention the work of Heidi Bøgelund Frederiksen to show that the much valued continuity of care, which is a defining feature of general practice/family medicine, only adds value if the patient feels seen and recognised as a person, with a body, a mind and a social setting, during the first encounter.

The Norwegian philosopher Arne Johan Vetlesen argues that empathy can only exist between two subjects—between Martin Buber's I and Thou [7].

"… whereas there is such a thing as self-pity or self-love, there is no self-empathy. In empathy there is always a thou, never only a me. Empathy sets up, indeed helps produce and sustain, a relation a between, involving one subject's relating to another …" [8].

Empathy is a precondition of person-centered medicine.

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