

ANALYSIS - II 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

The precarious future of the discourse of person-centered medicine

Miles Little MD MS FRACS

Emeritus Professor, Centre for Values, Ethics and the Law in Medicine, Sydney School of Public Health, University of Sydney, Sydney, NSW, Australia

Abstract

Discourses are more than just patterns of words. For discourse communities, they express ideologies and provide meanings that can be translated into action. They are vehicles for reform when they thrive. The discourse of person-centered medicine has had a vigorous start, with identifiable leaders, a vocabulary which has situated meanings, institutions such as meetings, letterheads and a Society and a group of adherents that constitute a discourse community. For a discourse to thrive, its founding problematic has to be perceived as 'real' by its target audience — in this case, presumably, healthcare workers. Real in this sense can be defined as something perceived to have an influence on foundational values, for better or for worse. It is not yet clear that the discourse of person-centered medicine has convinced its target audience of the 'crisis of knowledge, care, compassion and costs' that it invokes to justify its proposed paradigm shift. In order to make it thrive, those who drive the discourse will need to 'realise' both the crisis it addresses and the outcomes it may achieve.

Keywords

Contemporary medicine, discourse, discourse community, entropy, evidence-based medicine, founding problematic, patient-centered care, person-centered medicine, types of discourse

Correspondence address

Emeritus Professor Miles Little, Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW, 2006, Australia. E-mail: miles.little@sydney.edu.au

Accepted for publication: 23 August 2012

Introduction

Person-centered medicine has rapidly become - among other things - a name for a discourse, where a discourse is taken to be a structured use of language with situated meanings, embodying an ideology, together with symbols and acts which translate the ideology into the real-world of interaction [1-4]. In other words, a discourse is a way of talking, a way of thinking and a way of acting that puts the talking and thinking into action. Medicine is a discourse; so is quilting or cricket, law or journalism. Each discourse has its vocabulary, values, displays and ways of acting. The word 'shock' will evoke widely different meanings and responses when used by family and friends, doctors, electricians, seismologists and military tacticians. Each group represents a discourse community that shares meanings, understandings and learned responses. Discourses can be expert or Type 1 (such as evidence-based medicine or equity law), public or Type 2 (such as the war on terrorism) or discourses about discourses Type 3 (such as critical discourse about evidence-based medicine (EBM)). Person-centered medicine, for this

discussion, can be treated as a Type 1 sub-discourse situated within a much larger Type 1 discourse of medicine generally. Discourses in cultures, societies and groups intersect with one another and draw terms and meanings from one another. Their overall structure resembles a sponge, with the cavities of various sizes representing discourses and discourse communities, surrounded by and communicating with the other cavities.

All discourses have characteristic evolution in similar stages over different timescales. This pattern has been described elsewhere [3-7]. Discourses begin with a founding problematic, which provides them with their initial energy. A problematic is not the same as a problem. It consists of a problem or problem-set *and* the discourse used at a particular time to address it. A discourse is commonly driven by an ideology¹ and it defines meanings,

¹ Ideology is used here in the neutral or descriptive sense (Geuss, R. (1982)). The Idea of a Critical Theory: Habermas and the Frankfurt School. Cambridge, Cambridge University Press) of a 'style of thought' common to a group with similar interests, or a system of symbols that encodes the group's common interests (Geertz, C. (1964). Ideology as a Cultural System. Ideology and Its Discontents. D. E. Apter. Free Press of Glencoe: (47-76). It avoids the pejorative and positive uses examined by Geuss (1982).

ways of talking and acting in relation to the problem. Hartwig [8] defines it thus:

A problematic is the structured field constituted by philosophies, philosophical traditions, theories, etc., within which alone meaningful questions can be asked or problems posed. It will screen out or occlude some questions and problems [9].

Althusser, in one of the early clarifications of the problematic, wrote:

What actually distinguishes the concept of the *problematic...is that it brings out...the system of questions commanding the answers given by the ideology. If the meaning of an ideology's answers is to be understood at this internal level it must first be asked the question of its questions...it is not the interiority of the problematic which constitutes its essence but its relations to real problems... (italicisation on original)*

EBM, for example, began with a recognition that only a minority of medical interventions could be justified by numerical data and that this shortcoming needed to be corrected by privileging certain kinds of evidence in order to enhance medicine's claims to 'scientific' status. This combination of problem and projected response constituted EBM's problematic.

Those who first define the problematic become leaders, who attract followers to form the initial discourse community [1,7,10]. Discourse communities produce texts which define particular terms (such as 'evidence') in particular ways that confer on them specific situated meanings. These texts may be spoken or written. Particularly influential writings become iconic texts (such as those by Guyatt and colleagues on EBM [11]). At the same time, the discourse community and its leaders develop master narratives that tell the interpreted story of the discourse's evolution. EBM's master narrative could be abbreviated thus:

'It begins when a few mindful leaders perceive the weakness of having too little evidentiary support for dangerous and expensive modes of treatment; it grows because this weakness is perceived as real by many medical practitioners and policy makers; it grows rapidly into an influential movement in medicine, changes attitudes to practice, spins off associations, journals, medical teaching and justification. It has its detractors, but is resilient enough to provide answers to their criticisms, to continue to flourish and exert influence. It survives because its cause is just and sensible people can see that its justification is self-evident.'

Successful discourses also thrive because they translate words into action. They offer opportunities to people who join the discourse community. EBM offered a framework that allowed researchers and policy makers to speak in particular ways in medical journals and at meetings. The Cochrane Collaboration became a public face for EBM. Like all discourse communities, EBM offered a sense of belonging to those who subscribed to the

discourse and generated a sense of exclusion directed toward critics.

All discourses generate responses that reinforce or transform them reflexively. Universities offer courses in EBM and healthcare workers pay to attend those courses. The University of Oxford, for example, (see www.cebm.net) currently offers a five-day course in Teaching Evidence-based Practice for £1200. Someone who attended a previous course left a comment that reads:

The plenaries were outstanding, participant's level and enthusiasm was superb. I am taking away a lot of ideas and tools to apply to my setting. Every moment was well spent both academically and socially.

The academic rewards and sense of belonging to a discourse community emerge strongly. The 'ideas and tools' earn respect and the writer expects concrete results and improvements in teaching when they are applied in his or her particular setting. Successful discourses lead to changes and reforms. They lead also to critiques and the critiques lead to dialectic that often modifies the original discourse. In the case of EBM, counter-discourses (see, for example, [12-23]), have meant that the early privileging of numerical data [24-26] has had to be softened so that experience and informed professional opinion can be included in the hierarchy of levels of evidence [27-29]. EBM has survived in part because it has been prepared to compromise, to allow back into its fold the kinds of evidence that it initially criticized and rejected.

Whether they succeed in producing reform or wither under the influence of critiques, discourses are subject to a form of entropy [30-35]. The initial energy stalls under the weight of argument and the labour of justification, unless new negentropy comes from finding new problems to manage. EBM has confronted its critics and managed to re-energise its discourse by changing its criteria for evidence and by continuing to demonstrate contentious and important results (see, for example, [36]). Mao Tse Tung (following Trotsky) recognised the importance of negentropy when he advocated "perpetual revolution" [37], knowing that revolutions ran out of energy with time and the achievement of original purpose. Mature discourses need the energising effect of challenges and the means and will to meet them.

Humanising discourse in medicine

Person-centered medicine is the latest in a long succession of discourses that have sought to deal with the humanistic aspects of healthcare. The received form of the Hippocratic oath, for example, takes a realistic view of human nature, enjoining the physician not only to act compassionately and professionally toward the patient, but also to rise above common humanity and avoid sexual opportunism in the practice of healing. The Oath of Maimonides calls for the physician to consider the patient always as a fellow human in pain. Osler wanted physicians to be broadly cultured and widely read, so that they could bring greater awareness and sensitivity to clinical practice [38]. The

bioethics movement suggests that ethical thinking will bring clinical practice to a new and reflective level, while protecting people from paternalistic exploitation [40-42]. EBM itself has claimed that ethical practice is practice supported by evidence [11,18,19,22,23,42,46,47]. Humane medicine seems to have come and gone as the name for a discourse [48-50]. Patient-centered care is still active [51-55], whereas narrative medicine seems to be declining [56-60]. Epstein's mindful practice remains influential [61,62]. Values-based medicine is still little more than a proto-discourse [63-69]. Much energy seems now to be invested in person-centered medicine [70-72]. This is the new discourse in a long line of discourses designed for reform.

What brings all these movements under one rubric of (re)humanising medicine? First, they have all asked, in their different ways, for clinicians to value certain virtues, such as wisdom, equanimity, kindness, concern, respect and empathy. Second, they have suggested that clinicians should act in certain ways, adopting behaviours appropriate to the settings of illness, bearing themselves with dignity, listening respectfully and responding to the illness narrative with insight and understanding. Third, there has been an emphasis on human breadth, on wisdom [73] and the cultural sensitivity that has been linked to knowledge of the humanities. Latin and Greek were once pre-requisites for entry to a medical course. Osler [38] encouraged his students to read the classics and medical humanities courses are more commonly joined to more scientific medical teaching. So there is nothing new in our crisis of medicine, nor are the contemporary discourses picking up on problems without precedent.

Do they reflect real failings? And who should define those failings? There is a long history of sociologists, philosophers and thoughtful physicians seeking to find inconsistencies, weaknesses and outright failings in the practice of medicine and in its philosophy, without achieving a Kuhnian paradigm change [74]. There is a message here that has to do with the object of discourse. Several different entities seem to fall under the reforming critiques. These are, for instance, the philosophy of medicine, the health system, the delivery of care and the attitudes and conduct of individual healthcare practitioners.

Much of the re-humanising discourse is meant to be therapy for public dissatisfaction with and distrust in 'medicine', but it is not always clear whether the reform is designed to fix medicine's philosophy, practice, systems or practitioners. This is the more challenging because what is known about public perceptions of 'medicine' and doctors suggests a relatively even persistence of quite high trust and satisfaction, at least in Western countries see, for example, [75-77] (<http://www.ipsos-mori.com/researchpublications/researcharchive/2818/Doctors-are-most-trusted-profession-politicians-least-trusted.aspx>). And interviews with doctors suggest that they already value humane feelings and behaviours in significant ways and are quick to condemn the insensitive or selfish behaviour of colleagues. They have a good appreciation of what constitutes good and bad behaviour [78,79].

There is, however, evidence that supports public and medical dissatisfaction with the *systems* that are supposed to deliver healthcare in a number of Western countries

[78,80]. Our own work suggests that doctors are dissatisfied because of perceived mismatches between the fundamental humanity of medicine and the constraints that the medical system places on medical practice, between the possibilities of technology and the rationing that constrains those possibilities. Sen's capabilities approach [81] is an illuminating way to examine illness, disability and disadvantage. It is equally useful in illuminating the frustrations that follow the denial of the capabilities of doctors.

Some discourses, like that of EBM, achieve considerable market penetration and drive paradigm change. Others appear, gain some following and then decline entropically within a relatively short time. They dwindle for various reasons — they may simply be wrong (focal sepsis); their success eliminates the founding problem (tuberculosis eradication in Australia) or the founding *problematic* is not seen to be 'real' by too many members of the target audience (narrative medicine).

But what does 'real' mean in the context of a discourse? Thomas and Thomas [82] talked about the perceived 'reality' of any situation that a person encountered and it is clear from the context of their famous proposition that they construed reality to imply the situation's capacity to influence the survival, security or flourishing of others — at least in the assessment of someone involved in the situation. The Thomases' own words clarify what they meant (p. 572):

To take an extreme example, the warden of Dannemora prison recently refused to honor the order of the court to send an inmate outside the prison walls for some specific purpose. He excused himself on the grounds that the man was too dangerous. He had killed several persons who had the unfortunate habit of talking to themselves on the street. From the movement of their lips he imagined they were calling him vile names and he behaved as if this was true. If men define situations as real, they are real in their consequences.

The total situation will always contain more and less subjective factors and the behaviour reaction can only be studied in connection with the whole context, that is, the situation as it exists in verifiable, objective terms and as it has seemed to exist in terms of the interested persons.

The warden of the prison acted on the precautionary principle, perceiving the real risks to others of allowing the distorted reality of the prisoner back onto the streets. Reality, in such a context and in the context of an evolving discourse, emerges from the joint perceptions of a potential discourse community that there exists a possibility of benefit or harm to the foundational values that they hold and may consider themselves to hold on behalf of others.

There is an axiom that I would like to propose about evolving discourses: *A discourse community will only thrive if the founding problematic is perceived as real.* An example of a discourse whose founding problematic was soon recognised to be 'unreal' is Fletcherism, a doctrine proposed by Horace Fletcher [83] that aging could be reversed and health preserved by the meticulous and thorough mastication of food, including fluids. Fletcherism

enjoyed support from eminent people and enjoyed a fashion for about 15 years, but its appeal fell away because its rationale was precarious, its benefits inobvious and other dietary fads (such as calorie counting) seemed more appealing. In other words, the founding problematic was not real enough to sustain the discourse against competition. The founding problem of aging may be real, but the discourse of mastication lacked logical connection and convincing outcomes. Entropy was too strong for negentropy, because the answer encapsulated by the discourse was not seen to be a real answer. The perceived 'reality' of a problematic depends on the extent to which the emergent discourse catalyses understanding and action that meet the challenges of the defining problems.

The discourse of person-centered medicine

Person-centered medicine seems to have all the attributes of a successful discourse. It has effective, informed, committed and energetic leaders. And the number of followers is rapidly increasing, so that a clearly identifiable discourse community is already present. The discourse community is producing plenty of text in its journal and at its meetings. Iconic texts and master narratives are readily available. It has its own offices, Society and letterhead. It has started with great energy. And it has set out to define its founding problems with clarity.

How 'real' is its founding problematic? Miles and Mezzich [71] and Miles and Loughlin [70] write of the crisis confronting 'medicine' — 'a crisis of knowledge, compassion, care and costs - ...which risks a grave outcome for patients and clinicians alike.' Miles and Mezzich also write of the 'rise of scientific medicine and the advent of depersonalisation', citing particularly the writings of Francis Peabody from 1927 [84]. They are not explicit, however, about the locus of depersonalisation, whether it refers to medicine's philosophy or education, its systems of practice, its involvement in care, to its practitioners or perhaps to all of these. Yet we have already seen that the perceptions of patients and doctors in general do not single out all these failings as 'realities' demanding immediate remedies. There is considerable agreement in our own work between patients and doctors that the bureaucratised *systems* of healthcare diminish the capabilities of doctors to deliver optimal care and to behave virtuously in each clinical context. But that is a long way from proving that doctors — a major part of the target audience for the discourse of person-centered medicine — perceive person-centered medicine as the best answer to the shortcomings of medicine, whatever medicine is taken to mean in that particular context. There may be a crisis of compassion and knowledge, but what draws comment from patients and doctors are the shortcomings of systems and of particular practitioners rather than 'medicine' in general. Person-centered medicine's promise of attention to issues of equity within and between countries and socio-economic groups is one of its most attractive features. Global inequity in the availability and delivery of healthcare is inarguable. The

crisis of costs, both nationally and internationally, is certainly seen as real by practitioners and as part of the discrepancy between the potential to provide the full range of possible services and the actuality of rationing, but person-centered medicine will not solve the 'ethnomic' [85] issues of healthcare. It *might* teach public and practitioners to step back from the technological and institutional imperatives and re-categorise (in a Kantian sense) the imperative of care, but such a turnaround would take much persuasion and much time.

The discourse of person-centered medicine, like all its humanising kindred, will flourish if — and only if — it can discursively 'realise' its problematic. It needs to work with a consistent basis that avoids internal contradiction. It needs better definitions of the concepts of its basic philosophy, including such essentials as personhood, anti-foundationalism and emergence, 3 fundamental terms in its discourse. It would also benefit from much clearer evidence for the specific shortcomings that it proposes to redress and from a more conscious matching of the discourse to shortcomings that the target audience perceive as real. To convince Western doctors, weary of repeated injunctions to **better their attitudes, behaviour, achievements, communications and economic responsibility**, the discourse needs to define criteria for success that mean something to the target audience. And it will need to define programs of education, monitoring and ways of demonstrating better outcomes (however defined). Measures of compliance with person-centered medicine's guidelines will certainly not be enough. There is early evidence that patient-centered and person-centered care can improve outcomes for some kinds of patient within Western healthcare [86-88]. Even that has not allowed either to become a new paradigm for medical practice. Person-centered medicine will need to do much more than provide an appealing theoretical rationale for medical practice.

There is still uncertainty about the ability of educational programs to change doctors' attitudes, behaviours, communications and practices and about the effects of all these things on patients [89,90]. There is just as much doubt about the possibility of teaching wisdom [23,91] and it seems that wisdom in 'medicine' and its practitioners is a virtue sought by many reform movements [73,92-97] — and also by current practitioners [79]. And there is reason to believe that the endless formulation of guidelines, rules and other quasi-legal substitutes for ethical intuitions and moral standards will lead to a decrease, rather than an increase, in humankind's moral reasoning abilities [98].

Conclusion

Kant famously wrote that 'out of wood so crooked and perverse as that which man is made of, nothing absolutely straight can ever be wrought' [99]. Doctors, patients, families, administrators, economists, policymakers, philosophers, politicians — we are all humans and persons and imperfect. Aspirations for reform are always worth following and to the making of discourses there is no end.

But as Garvin [100] wrote in 1953, "Norms or ideals or values that are not held, that don't become peoples' interests, will be peculiarly valueless, no matter what inherent validity they may possess." I would like to be a member of the discourse community of person-centered medicine, but I would also like to be a member of a discourse community that sets paradigms and shows that those paradigms matter - shows, in short, that they will provide the foundations for the amelioration of *real* shortcomings in whatever parts of contemporary medicine are actually failing.

Conflicts of Interest

The author declares no conflict of interest.

References

- [1] Swales, J.M. (1990). *Genre Analysis: English in Academic and Research Settings*. Cambridge: Cambridge University Press.
- [2] Gee, J.P. (1999). *An Introduction to Discourse Analysis: Theory and Method*. London: Routledge.
- [3] Little, M. & Lipworth, W. (2008). *Focused Discourse*. Sydney: Centre for Values, Ethics and the Law in Medicine.
- [4] Little, M. (2010). Is there a real nexus between ethics and aesthetics? *Journal of Bioethical Inquiry* 7, 91-102.
- [5] Little, M., Jordens, C.F.C., Paul, K. & Sayers, E-J. (2002). Survivorship and discourses of identity. *Psychosocial* 11 (2) 170-178.
- [6] Little, M., Jordens, C.F.C., Paul, K., Sayers, E-J., Cruickshank, J.A., Stegeman, J. & Montgomery, K. (2002). Discourse in different voices: Reconciling n=1 and n=many. *Social Science & Medicine* 55 (7) 1079-1087.
- [7] Little, M., Jordens, C.F.C. & Sayers, E-J. (2003). Discourse communities and the discourse of experience. *Health* 7 (1) 73-86.
- [8] Hartwig, M. (Ed.). (2007). *Dictionary of Critical Realism*. London: Routledge.
- [9] Althusser, L. (2005). *For Marx*. London: Verso.
- [10] Berkenhotter, C. & Huckin, T.N. (1995). *Genre Knowledge in Disciplinary Communication: Cognition/Culture/Power*. Hillsdale: Erlbaum.
- [11] Guyatt, G., Cairns, J., Churchill, D. *et al.*, ('Evidence-Based Medicine Working Group'). (1992). Evidence-based medicine. A new approach to teaching the practice of medicine. *Journal of the American Medical Association* 268, 2420-2425.
- [12] Green, J. & Britten, N. (1998). Qualitative research and evidence based medicine. *British Medical Journal* 316 (7139) 1230-1232.
- [13] Kerridge, I., Lowe, M. & Henry, D. (1998). Personal paper: Ethics and evidence based medicine. *British Medical Journal* 316 (7138) 1151-1153.
- [14] Harari, E. (2001). Whose evidence? Lessons from the philosophy of science and the epistemology of medicine. *Australian & New Zealand Journal of Psychiatry* 35, 724-730.
- [15] Upshur, R. (2002). If not evidence, then what? Or does medicine really need a base? *Journal of Evaluation in Clinical Practice* 2, 113-119.
- [16] Worrall, J. (2002). What Evidence in Evidence-Based Medicine? *Philosophy of Science* 69 (3) S316-S330.
- [17] Little, M. (2003). Better than numbers...: A gentle critique of evidence-based medicine. *Australian & New Zealand Journal of Surgery* 73, 177-182.
- [18] Kravitz, R.L., Duan, N. & Braslow, J. (2004). Evidence-Based Medicine, Heterogeneity of Treatment Effects, and the Trouble with Averages. *The Milbank Quarterly* 82 (4) 661-687.
- [19] Goldenberg, M.J. (2006). On evidence and evidence-based medicine: Lessons from the philosophy of science. *Social Science & Medicine* 62, 2621-2632.
- [20] Grossman, J. (2008). A Couple of the Nasties Lurking in Evidence-Based Medicine. *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22 (4) 333-352.
- [21] La Caze, A. (2008). Evidence-Based Medicine Can't Be.... *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22 (4) 353-370.
- [22] Lipworth, W., Carter, S. & Kerridge, I. (2008). The "EBM movement": where did it come from, where is it going, and why does it matter? *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22, 425-431.
- [23] Miller, C.G. & Miller, D.W. (2011). The Real World Failure of Evidence-Based Medicine. *International Journal of Person Centered Medicine* 1 (2) 295-300.
- [24] Eddy, D.M. (1992). Medicine, money and mathematics. *American College of Surgeons Bulletin* 77, 36-49.
- [25] Eddy, D.M. (1997). Balancing cost and quality in fee-for-service versus managed care. *Health Affairs* 16 (3) 162-173.
- [26] Eddy, D.M. (1998). Performance measurement: problems and solutions. *Health Affairs* 17 (4) 7-25.
- [27] Unit for Evidence Based Practice and Policy. (1997). Fourth UK workshop on teaching evidence-based practice study pack. London: University College London Medical School.
- [28] Guyatt, G.H., Meade, M.O., Jaeschke, R.Z., Cook, D.J. & Haynes, R.B. (2000). Practitioners of evidence based care: Not all clinicians need to appraise evidence from scratch but all need some skills. *British Medical Journal* 320 (7240) 954-955.
- [29] Mykhalovskiy, E. (2003). Evidence-based medicine: ambivalent reading and the clinical recontextualization of science. *Health* 7 (3) 331-352.
- [30] Darrow, K.K. (1944). Entropy. *Proceedings of the American Philosophical Society* 87 (5) 365-367.
- [31] Shannon, C.E. (1948). A mathematical theory of communication. *Bell System Technical Journal* 27, 379-423, 623-656.
- [32] Wicken, J.S. (1987). Entropy and Information: Suggestions for Common Language. *Philosophy of Science* 54 (2) 176-193.
- [33] Bailey, K.D. (1990). Social Entropy Theory: An overview. *Systemic Practice and Action Research* 3 (4) 365-382.

- [34] Huet, M-H. (1997). Social Entropy. *Yale French Studies* 92, 171-183.
- [35] Bailey, K.D. (2008). Boundary maintenance in living systems theory and social entropy theory. *Systems Research and Behavioral Science* 25 (5) 587-597.
- [36] Yank, V., Tuohy, C.V., Logan, A.C., Bravata, D.M., Staudenmayer, K., Eisenhut, R., Sundaram, V., McMahon, D., Olkin, I., McDonald, K.M., Owens, D.K. & Stafford, R.S. (2011). Systematic review: Benefits and harms of in-hospital use of recombinant factor VIIa for off-label indications. *Annals of Internal Medicine* 154, 529-540.
- [37] Schram, S.R. (1971). Mao Tse-tung and the Theory of the Permanent Revolution, 1958-69. *The China Quarterly* 46, 221-244.
- [38] Osler, W. (1948). *Aequinimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine*. London: H K Lewis & Co.
- [39] Rutstein, D.D. (1969). Ethical Aspects of Experimentation with Human Subjects. *Daedalus* 98 (2) 523-541.
- [40] Katz, J. (1992). Abuse of human-beings for the sake of science. In: *When Medicine Went Mad: Bioethics and the Holocaust*, pp. 233-270. (A.L. Caplan, ed.). Totowa, NJ: Human Press.
- [41] Weindling, P.J. (2005). *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent*. Basingstoke: Palgrave Macmillan.
- [42] Guyatt, G. (1991). Evidence-based medicine. *ACP Journal Club (Annals of Internal Medicine)* 14 (Supplement 2) A-16.
- [43] The Evidence-Based Medicine Working Group. (1992). Evidence-based medicine: a new approach to teaching the practice of medicine. *Journal of the American Medical Association* 268, 2420-2425.
- [44] Sackett, D.L., Rosenberg, W.M.C., Gray, J.A.M., Haynes, R.B. & Richardson, W.S. (1996). Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312 (7023) 71-72.
- [45] Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W. & Haynes, R.B. (2000). *Evidence-Based Medicine: How to practice and teach EBM*. New York: Churchill Livingstone.
- [46] Ellrodt, G., Cook, D., Lee, J., Cho, M., Hunt, D. & Weingarten, S. (1997). Evidence-based disease management. *Journal of the American Medical Association* 278, 1687-1692.
- [47] Derkatch, C. (2008). Method as Argument: Boundary Work in Evidence-Based Medicine. *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22 (4) 371-388.
- [48] Skrabanek, P. (1994). *The Death of Humane Medicine*. Bury St Edmunds: Social Science Unit.
- [49] Little, M. (1995). *Humane Medicine*. Cambridge: Cambridge University Press.
- [50] Kerridge, I., Jordens, C. & Sayers, E-J. (Eds.). (2003). *A Miles Little Reader: Restoring Humane Values to Medicine*. Sydney: Desert Pea Press.
- [51] Mead, N. & Bower, P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine* 51, 1087-1110.
- [52] Keirns, C. & Dorr Goold, S. (2009). Patient-centered care and preference-sensitive decision making. *Journal of the American Medical Association* 302, 1805-1806.
- [53] Montgomery, K. & Little, M. (2011). Enriching patient-centered care in serious illness: a focus on patients' experiences of agency. *Milbank Quarterly* 89 (3) 381-398.
- [54] Raman, R. (2011). Evidence-based Medicine and Patient-centered Care: Cross-Disciplinary Challenges and Healthcare Information Technology-enabled Solutions. *International Journal of Person Centered Medicine* 1 (2) 279-294.
- [55] Epstein, R.M. & Street, R.L. (2011). The values and value of patient-centered care. *Annals of Family Medicine* 9 (2) 100-103.
- [56] Greenhalgh, T. & Hurwitz, B. (Eds.). (1998). *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*. London: BMJ Books.
- [57] Ellis, C. & Bochner, A.P. (1999). Bringing emotion and personal narrative into medical social science. *Health* 3 (2) 229-238.
- [58] Mattingly, C. & Garro, L.C. (Eds.). (2000). *Narrative and the Cultural Construction of Illness*. Berkeley: University of California Press.
- [59] Charon, R. (2001). Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust. *Journal of the American Medical Association* 286 (15) 1897-1902.
- [60] Charon, R. & Montello, M. (Eds.). (2002). *Stories Matter: The Role of Narrative in Medical Ethics*. New York: Routledge.
- [61] Epstein, R.M. (1999). Mindful Practice. *Journal of the American Medical Association* 282 (9) 833-839.
- [62] Krasner, M.S., Epstein, R.M., Beckman, H., Suchman, A.L., Chapman, B., Mooney, C.J. & Quill, T.E. (2009). Association of an Educational Program in Mindful Communication With Burnout, Empathy and Attitudes Among Primary Care Physicians. *Journal of the American Medical Association* 302 (12) 1284-1293.
- [63] Little, M. (2002). Humanistic medicine or values-based medicine? What's in a name? *Medical Journal of Australia* 177 (6) 319-321.
- [64] Fulford, K.W.M. (2004). Fact/values: ten principles of values-based medicine. In: *The Philosophy of Psychiatry: A Companion*, pp. 205-234. (J. Radden, ed.). Oxford: Oxford University Press.
- [65] Fulford, K.W.M. (2007). Values-based medicine: delusion and religious experience as a case study in the limits of medical-scientific reduction. In: *The Science of Morality*. (G. Walker, ed.) London: Royal College of Physicians.
- [66] Fulford, K.W.M. (2010). Bringing together values-based and evidence-based medicine: UK Department of Health Initiatives in the 'Personalization' of Care. *Journal of Evaluation in Clinical Practice* 17 (2) 341-343.
- [67] Little, M., Lipworth, W., Gordon, J., Markham, P. & Kerridge, I. (2011). Values-based medicine and modest foundationalism. *Journal of Evaluation in Clinical Practice* 18 (5) 1020-1026.
- [68] Little, M., Lipworth, W., Gordon, J., Markham, P. & Kerridge, I. (2011). Another argument for values-based medicine. *International Journal of Person Centered Medicine* 1 (4) 649-656.

- [69] Little, M., Gordon, J., Lipworth, W., Markham, P. & Kerridge, I. (2014). Values as 'modest foundations' for medicine. *European Journal for Person Centered Healthcare*. In press.
- [70] Miles, A. & Loughlin, M. (2011). Models in the balance: evidence-based medicine versus evidence-informed individualized care. *Journal of Evaluation in Clinical Practice* 17, 531-536.
- [71] Miles, A. & Mezzich, J.E. (2011). The care of the patient and the soul of the clinic: person centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1 (2) 207-222.
- [72] Miles, A. & Mezzich, J.E. (2011). Person-centered Medicine: advancing methods, promoting implementation. *International Journal of Person Centered Medicine* 1 (3) 423-428.
- [73] Davis, F.D. (1997). Phronesis, clinical reasoning and Pellegrino's philosophy of medicine. *Theoretical Medicine and Bioethics* 18 (1) 173-195.
- [74] Kuhn, T.S. (1970). *The Structure of Scientific Revolutions*. Chicago, Illinois: University of Chicago Press.
- [75] Jenkinson, C., Coulter, A., Bruster, S., Richards, N. & Chandola, T. (2002). Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Quality and Safety in Health Care* 11 (4) 335-339.
- [76] Gillies, R.R., Chenok, K.E., Shorten, S.M., Pawlson, G. & Wimbush, J.J. (2006). The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction. *Health Services Research* 41 (4) 1181-1191.
- [77] Hardie, E.A. & Critchley, C.R. (2008). Public perceptions of Australia's doctors, hospitals and health care systems. *Medical Journal of Australia* 189 (4) 210-214.
- [78] Little, M., Gordon, J., Markham, P., Lipworth, W. & Kerridge, I. (2011). Making decisions in the mechanistic, probabilistic and scientific domains of medicine: a qualitative study of medical practitioners. *International Journal of Person Centered Medicine* 1 (2) 376-384.
- [79] Little, M., Gordon, J., Markham, P., Rychetnik, L. & Kerridge, I. (2011). Virtuous acts as practical medical ethics: an empirical study. *Journal of Evaluation in Clinical Practice* 17, 948-953.
- [80] Donelan, K., Blendon, R.J., Schoen, C., Davis, K. & Binns, K. (1999). The cost of health system change: public discontent in five nations. *Health Affairs* 18 (3) 206-216.
- [81] Sen, A. (1993). Capability and well-being. In: *The Quality of Life*, pp. 30-35. (M. Nussbaum & A. Sen, (eds.). Oxford: Clarendon Press.
- [82] Thomas, W.I. & Thomas, D.S. (1928). *The Child in America: Behavior Problems and Programs*. New York: Knopf.
- [83] Fletcher, H. (1913). *Fletcherism: what it is: or How I became young at 60*. London: Ewart, Seymour & Co., Ltd.
- [84] Peabody, F.W. (1927). The care of the patient. *Journal of the American Medical Association* 88 (12) 877-882.
- [85] Little, M. (2000). Ethnomics - the ethics of the unaffordable. *AMA Archives of Surgery* 135, 17-21.
- [86] Stewart, M., Brown, J.B., Donner, A., McWhinney, I.R., Oates, J., Weston, W.W. & Jordan, J. (2000). The impact of patient-centered care on outcomes. *Journal of Family Practice* 49 (9) 796-804.
- [87] Bertakis, K.A. & Azari, R. (2011). Patient-centered care is associated with decreased health care utilisation. *Journal of the American Board of Family Medicine* 24, 229-239.
- [88] Ekman, I., Wolf, A., Olsson, L-E., Taft, C., Dudas, K., Schaufelberger, M. & Swedberg, K. (2012). Effects of person-centred care in patients with chronic heart failure: the PCC-HF study. *European Heart Journal* 33 (9) 1112-1119.
- [89] Brown, J.B., Boles, M., Mullooly, J.P. & Levinson, W. (1999). Effect of Clinician Communication Skills Training on Patient Satisfaction. *Annals of Internal Medicine* 131 (11) 822-829.
- [90] Joosten, E.A.G., DeFuentes-Merillas, L., de Weert, G.H., Sensky, T., van der Staak, C.P.F. & de Jong, C.A.J. (2008). Systematic Review of the Effects of Shared Decision-Making on Patient Satisfaction, Treatment Adherence and Health Status. *Psychotherapy and Psychosomatics* 77 (4) 219-226.
- [91] Stanovich, K.E. (2001). The Rationality of Educating for Wisdom. *Educational Psychologist* 36 (4) 247-251.
- [92] Engel, G.L. (1978). The biopsychosocial model and the education of health professionals. *Annals of the New York Academy of Science* 310, 169-187.
- [93] Pellegrino, E.D. & Thomasma, D.C. (1993). *The Virtues in Medical Practice*. New York: Oxford University Press.
- [94] Doyal, L. & Gillon, R. (1998). Medical ethics and law as a core subject in medical education. *British Medical Journal* 316, 1623-1624.
- [95] Greenhalgh, T. (2002). Intuition and evidence - uneasy bedfellows? *British Journal of General Practice* 52 (478) 395-400.
- [96] Campbell, A.V. (2003). The Virtues (And Vices) of the Four Principles. *Journal of Medical Ethics* 29 (5) 292-296.
- [97] Bryan, C.S. & Babelay, A.M. (2009). Building character: A model for reflective practice. *Academic Medicine* 84 (9) 1283-1288.
- [98] Bauman, Z. (1995). *Postmodern Ethics*. Oxford: Blackwell Publishers.
- [99] Kant, I. (1824). Idea of a universal history on a cosmo-political plan. *London Magazine*. 10, 385-393.
- [100] Garvin, L. (1953). *A Modern Introduction to Ethics*. Cambridge, MA: Houghton Mifflin.