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WHY DO WE TAKE CARE OF OTHERS?

Personalized medicine is the evidence based medicine saved in the right horizon

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Abstract A growing body of evidence indicates that effective medical treatment depends on personalized care. However, to focus on the person, to consider the other as a "person", requires a special commitment, which corresponds to our expectations and it is mandatory for an effective medical approach, but it is not spontaneous and it does not hold automatically. The entire discussion on humanization of medicine relates to this question. At present, we are observing a cultural shift which risks destroying some essential aspects of the medical profession that contribute to high-quality health care. How to overcome this cultural shift which substantially impairs a personalized approach? Starting from a question posed by an editorial of the Journal and describing our teaching experience, we analyze recent Literature to contribute to this discussion.

Keywords Personalized medicine · Evidence based medicine · Self-referencing · Humanization of medicine · Scientific culture

One of the recent editorials of *JMAP* has posed a question that cannot be eluded. Commenting an article by Annunziata et al. [1] which was reporting a documentation of the effectiveness of a personalized approach to the patient, the Editor Balducci was stating that such "a patient–physician relationship purports a vision of human life as sacred that is as something unique that cannot be reproduced." This means a vision of profound respect for every human being that affects our technical action and motivates our dedication. In fact, sacer in Latin means reserved for a special function that only that "person" can accomplish, sacredness is a statement of uniqueness [2]. Balducci was then asking: "is a vision of sacredness essential to the practice of personalized medicine?" [3].

Several factors in our professional scenario indicate that at present this is the question we are facing. Starting from our teaching experience (described briefly ahead) and analyzing recent Literature, we would like to submit for discussion some considerations which may contribute to the path indicated by Balducci's address.

First of all, why is this the critical question today? The observation of our professional reality may explain this priority.

1. Effective medical treatment depends on personalized care. Making the person the center of medical care is mandatory to obtain adequate diagnostic clues, treatment adherence, better outcomes, in other words: an effective medical approach [4]. Coordinating care on the basis of the individual needs and values of the patient leads to significant improvement of the therapeutic approach and reduced cost [5–7]. This is not solely the opinion of a forefront journal as *JMAP*, or the result of pilot studies, but it is the alert of many authoritative international panels. Altruism and collegiality contribute to high-quality health care: "extending oneself to patients, families, trainees, and colleagues not only is a traditional element of medicine but translates into

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more effective care" [8]. "To face the question of the deterioration of the relationship between health professionals and patients will strengthen the efficiency of the medical profession" [9]. Similar considerations may be found in many calls from international medical authorities and they significantly express an awareness which recently was further outlined as part of the professional consciousness itself [10].

2. However, to focus on the person, to consider the other as a "person", requires a special commitment [11]. It needs to be aware of patient's reality, it asks for effective communication, to privilege the patient over the disease, to pay attention to "soft variables" [4]. It requires an effort to negotiate medical decision to consider the patient's own values and spirituality [6, 7, 12]. It demands placing the interests of patients above those of the health professional [3]. It means that you would not abandon the patient who is "incurable".
All this does not mean emotional engagement, which may corrupt our judgment [3], but it means to consider the patient in a communal/familial relationship [8]. In a few words it requires to consider the patient in a "professional" and "fraternal" way [13]. As said, this approach purports a vision of ourselves and of the patient as a "person", that is a vision of human life as sacred, therefore deserving our commitment. Only from this it stems a fraternal vision of interpersonal relationships.
3. In fact, this vision is not an "opinion", a subjective persuasion, rather it indicates an expectation proper and common to each human being. Nobody, regardless of differences in space or time, would desire to be offended, treated as an object, not considered as a person. Therefore, this vision indicates an objective, not subjective, horizon.
4. This approach corresponds to our expectations (we would like to be approached in this way) and it is mandatory for an effective medical approach, but it is not spontaneous and it does not hold automatically. The entire discussion on humanization of medicine relates to this question.
At the beginning of the millennium a physicians' charter was prepared by the members of the Medical Professionalism Project. In a crucial passage it was stating that the practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies, like the temptation for health professionals to forsake their traditional commitment to the primacy of patients' interests. Many health professionals wind up having no desire to do more than the minimum required. This cultural shift risks destroying some essential aspects of the medical profession that contribute to high-quality health care, including pride in profession, sense of duty, altruism, and collegiality [10].
5. This "cultural shift" is everyday experience in our work. It is a major cause of escaping a personalized approach. It is not the case now to analyze in detail the causes of this phenomenon, we contributed to this discussion elsewhere [14]. Briefly, the technical-scientific culture claims to be the only approach which can generate reasonable conclusions. This self-limitation of the reason confines to "subjectivity" all the considerations on the complex unity of the human being and its absolute value ("person"), which are absolutely reasonable, although not demonstrable by experiment. Main consequence is the mechanistic reduction of our profession that confines the medical action to a neutral technique which is ineffective and against the spirit of the experimental method.
6. The question is: how to overcome this cultural shift which substantially impairs a personalized approach? Where does it come from a fraternal vision of ourselves and of the patient, a vision of ourselves and of the patient as a "person"? How can we sustain it?
More money, organization changes? These instruments have been analyzed and are absolutely necessary but evidently insufficient [8]. By the way, the major alerts about this temptation for health professionals to forsake their traditional commitment to the primacy of patients' interests do not come from depressed and disorganized areas, but from the regions the most advanced from an economical and organizational point of view.
Professional values? A generic reference to professional values (altruism, collegiality, commitment to the primacy of patients' interests) may remain ambiguous and end up reinforcing the attitude of self-referencing in our field. In fact, as documented by the observed "cultural shift", professional values do not survive when it is denied that objective horizon represented by the awareness of the complex unity of the human being and its absolute value ("person"). They are abandoned or fall prey of those who have the strength every time to redefine their content, preventing any real confrontation, debate and mutual learning. At times, the specific reference to the professional "values" can also become an antiscientific attitude, as a suggestion to move away from the experimental method, out of nostalgia for the "artistic" or "poetic" profession that once used to be. This position sometimes seems to wink to

alternative medicine and to the related anthropological visions, not recognizing the actual reason of the appeal of these approaches which is an incorrect use of the evidence based medicine (EBM) method. Ethical teaching? UNESCO Chair in Bioethics at the International Center of Health, Law and Ethics, of the University of Haifa carried out international researches with the aim of checking whether the lack of proper study of ethics in medical schools was one of the reasons for the phenomenon of deterioration of the relationship between doctors and patients [9]. The research on the importance and quality of education in ethics in medical colleges and faculties all over the world was performed in 110 medical institutes. The subject of ethics was found to be taught in 105 (95 %) of these institutions. The research indicates that 9 % of the institutions devote up to 10 h to tuition of the subjects; 29 % 10–20 h; 33 % teach between 20 and 50 h; 7 % between 50 and a 100 h, while in 8 % of the institutions over 100 h are taught. In 88 % of the medical institutions the ethics courses are compulsory. Although this situation is almost ideal, Authors conclude that this imposition showed to be ineffective to face the question of the deterioration of the relationship between health professionals and patients which impairs the efficiency of the medical profession [9]. Therefore, these data suggest that, while ethical teaching is certainly mandatory, it is not sufficient.

7. To overcome this cultural shift that is a main obstacle to personalized medicine, we need to recognize the problem caused by the substantial claim of self-sufficiency of our field [14]. Therefore, we need, instead, to open up the doors of our profession and let resources of reality to oxygenate, nourish our field, relying on reason and laicity.
   First of all “reason”. Actually, a simple fact needs to be acknowledged: life is made of communicating compartments. What is true in our human experience is not alien or irrelevant in our work, and vice versa. We should reasonably recognize that our profession is lying, as our life, in that same “objective” (and therefore mandatory) horizon indicating the person as an absolute value. Therefore, we need to open the doors of our profession to the cultural and educational relations that express the full extent of our human experience. These resources of the reality can actually judge, innovate and sustain the demanding task of personalized medicine.
   In second place, “laicity” which is not indifference, but acknowledgement of full right of citizenship for positions that openly express their motivations, recognizing their value as resource and their social relevance [15]. This does not limit anyone’s freedom: rather, it represents the willingness to put at everyone’s disposal all the available energy. On the opposite, laicity meant as concealing personal motivations, considered relative after all, ends up giving in to superficial reference, to “common values” (without support or criteria) of a self-referencing professionalism.
8. This opening is an extremely important cultural step, with important “operative” consequences. Opening wide the doors implies giving value to the possibilities and resources that are before our eyes. In particular, the Christian experience is undoubtedly an essential resource for the world of health care, both from a historical and a personal point of view [13, 16]. The contribution of the Christian experience to professionalism in the field of health care is not a mere idea, it is rather an educational relationship, a fellowship that makes reasonable—and, therefore, tends to make permanent – what everyone hopes for in our field: considering the other (patient, colleague) in its wholeness, as a “person”.
9. The experimental-biological model, the EBM, remains a valid instrument (which, as history teaches, stems itself from a vision of life as sacred) [13]. The point is placing the technical-scientific knowledge in the objective reference context that would make it effective, and that medical science alone is unable to generate. Therefore, the progressive exponential unveiling of biological complexity does not mean the failure of the scientific approach to medicine. We do not need an “alternative” medicine. Personalized medicine does not mean to abandon EBM (whose advantages are self evident), but it means to open up our field, to put it in the right horizon, do not forget “person” complexity [17].
   Personalized medicine *is* EBM in the right horizon, that is: not self-referencing, but open to the resources of reality in its wholeness, recognizing the objective sacredness of the person.
10. Which is our task?
    a. We are called to carefully apply the scientific, evidence based, method. If medical history has to be taken, we must do so, as required, personally, carefully [18]. And so on, applying it in all the other steps required in all the different phases of the patient/health professional interaction, considering the other as a “person” to obtain an effective medical approach.
       This will happen to the extent we will let the different fields of our life interact; to the extent we will let resources of our real life impact our

profession and generate that peculiar commitment required by personalized medicine. These educational relationships (that is the resources of our life) should be constantly cultivated and should interact with our profession up to the technical details.

b. The experience we derive from this interplay must become part of the professional dialogue. This interplay (which is also at the origins of our profession) must be communicated. We should describe how it affects, innovates and sustains our profession.

   We should favor communication and encounters with effective professional experiences that do not deny the relevance of motivations and their impact on the technical action, that do not disown them as subjective or irrelevant; otherwise, the risk is communicating only an impression of personal ability, which does not produce culture but cultivates self-referencing.

   In this context, the considerations about Christian experience are never an "a priori" element which may exclude someone, but these considerations always emerge as a result of the search for reason and laicity.

   As an example, at medical school and in CME programs for health professionals, we perform the optional course "The contribution of Christian experience to health professions", followed by dedicated periodical laboratories. These lessons are not courses on ethics, but investigate the themes we are discussing here. Program and contents, described in detail elsewhere [13, 19], want to favor positive interaction among professionals. They aim at expressing judgments and initiatives on issues dealing with our profession, having as starting point the broadness of reason, without confining to subjectivity the most important aspects of human experience (substantially declassing or excluding them as "relative" in the confrontations and the decisions that involve our professional domain) in a spirit of proper laicity. The confrontation that stems from such aperture is then made methodical, on a voluntary basis, by periodical laboratory meetings.

   This is an example that wishes to stimulate similar and plural contributions. It would be noteworthy to launch an international educational initiative taking the opportunities offered by the available institutional spaces.

c. We should foster all those conditions which may favor the realization of what is described in points A (method) and B (formation). This means giving value to professional associations, not only in terms of representativeness, but also as a domain where this fostering can be performed systematically and critically. Crucial questions need to be addressed: young health professionals education, "gender revolution", aging, defensive medicine [20]. In addition, several organizational problems are growing and need to be faced. Associations should focus on professional liberty. The strict collaboration with health service administrations should warrant: prescription freedom, conscientious objection, sufficient time to devote to the patient in the visit, more adequate definition of health outcomes [21]. The latter may help to define clinical pathways (rather than "guidelines") which may direct health professionals and patients toward the most cost-effective form of treatment in individual circumstances [2, 12]. Medicine organization should not minimize the opportunities of human interactions [22]. Associations should contrast reduction of health professionals to clerks who apply guidelines and should help recovering our role as "professionals", i.e. (according to the meaning of the word) people capable of bringing out in their work their complete humanity [23]. Again, the crucial step is continuous education to open up our cultural field to reason and laicity, so all these questions may be addressed without participating in the general self-referencing climate.

In conclusion, the question posed by the Editor Balducci concerning a vision of sacredness of human life as essential to the practice of effective (i.e. personalized) medicine is a strong provoking opportunity. It points out the unprecedented challenge we have before, paradigmatic of a difficulty that involves the whole modern world. However, it is these crucial steps that provide the opportunity for resumption innovative. If we open the vast sectors of our cultural field by drawing on the resources of the whole life, not only we will be more effective in our service, but we will represent a reference point and a suggestion for the entire society.

Conflict of interest None of the authors had conflicts of interest.

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