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The practice of evidence-based medicine involves the care of whole persons

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Abstract

In this issue of the Journal, Dr. Fava posits that evidence-based medicine (EBM) was bound to fail. I share some of the concerns he expresses, yet I see more reasons for optimism. Having been on rounds with both Drs. Engel and Sackett, I reckon they would have agreed more than they disagreed. Their central teaching was the compassionate and well-informed care of sick persons. The model that emerged from these rounds was that patient care could be both person-centered and evidence-based, that clinical judgment was essential to both, and the decisions could and should be shared. Both clinicians and patients can bring knowledge from several sources into the shared decision making process in the clinical encounter, including evidence from clinical care research. I thank Dr. Fava for expressing legitimate doubts and providing useful criticism, yet I am cautiously optimistic that the model of EBM described here is robust enough to meet the challenges and is not doomed to fail.

Keywords: Evidence-based medicine; Care of whole persons

In this issue of the Journal, Giovanni Fava posits that evidence-based medicine (EBM) was bound to fail, in a commentary addressed to Alvan Feinstein [1]. This follows another commentary in the Journal, addressed to David Sackett, in which John Ioannidis claimed that EBM has been hijacked [2]. Since I have admired the work of Drs. Fava and Ioannidis, since they address two people whose work has profoundly influenced me, since Dr. Fava mentions another of my influences, George Engel, and since there were no clues to the contrary, I have read and considered these texts as serious reflections from concerned thinkers and contributors to the field, rather than as satire. Both essays mention some concerns that I share, such as the influence of conflicts of interests and the consequences of ‘‘disconnects’’ that may be widespread in modern medical education. Yet I see more reasons for optimism than these commentators appear to find, and I am grateful for the opportunity to join other commentators to explain why I do.

I first came across the ideas of George Engel, Alvan Feinstein, and David Sackett, before I knew their names, during my own undergraduate medical education at Georgetown University School of Medicine in the mid-to-late 1970s. The curriculum I experienced there was imbued strongly with the Jesuit notion of *cura personalis*, the care of the whole person. We learned about systems interactions encapsulated in Engel’s biopsychosocial model and about causes and consequences of illnesses to individuals and populations, building on the clinical epidemiology of Feinstein and Sackett. The care of the whole person was further emphasized during my graduate medical education in Internal Medicine at the University of Rochester during the late 1970s and early 1980s. There I went on clinical rounds with George Engel and others in his teaching unit and saw the biopsychosocial approach in action, yet I also went on rounds with generalist hospital physicians who applied clinical epidemiology ideas to the care of patients. Later I visited McMaster University where I met and learned from David Sackett and others in EBM. I was a fortunate to be a sabbaticant with Dave at the Oxford Center for EBM in 1996, where I joined him for clinical teaching rounds.

We cannot know for sure, yet based on having observed clinical rounds with both Drs. Engel and Sackett, I reckon they would have agreed far more often than they disagreed. For both, their central teaching on rounds was the compassionate and well-informed care of sick persons. When an older smoking man expressed worry about his hemoptysis and weight loss, Dr. Engel would guide us to consider both

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What is new?

- The model of EBM is articulated in a way that highlights the many sources of knowledge and how they can be integrated with judgement in the shared decisions for the care of whole persons.

the worry and the diagnostic approach to lung cancer. When an older woman returned with recurrent heart failure, Dr. Sackett would guide us to consider both the accuracy of the clinical examination findings and the expected benefits and potential harms of treatment, as well as the social context that promoted recurrent admissions. Both were enthusiastic teachers of their subjects and skills, and both believed strongly that those skills could help us become better, faster, and happier doctors. Both had excellent situational awareness, so they stayed alert to patients, learners, and context and used this to adjust real time while teaching. And whereas both were very gentle with learners, both were also skilled at handling hecklers adroitly. The model that emerged from rounds with them was that patient care could be both person centered and evidence based, that clinical judgment was essential to both, and that decisions could and should be shared.

During the care of whole persons, this model suggests that clinical decisions can be informed by several types of knowledge (see the boxes). Box 1 illustrates some of the several sources of knowledge the clinician could bring into the shared decision-making process of a clinical encounter, and Box 2 illustrates some of the sources knowledge patients can bring to the encounter. A full discussion of the use of multiple sources of knowledge in shared decision-making is beyond the scope of this commentary, yet nine points about the clinicians' knowledge are salient here. First, each of these types of knowledge is built upon specific ways of human knowing (e.g., clinical expertise draws upon the deliberate practice of clinical skills and the experiential learning from the care of sick persons, whereas the biology of human health and disease is based on foundational studies of normal and abnormal structure and function), so these sources of knowledge represent complementary forms of clinical epistemology. Second, these sources of knowledge are also expanding collections

Box 1 Sources of knowledge to inform clinical decisions—clinicians

Clinicians can bring several kinds of knowledge into the clinical encounter to inform shared decision-making, including from these six sources (listed alphabetically):

Biology of health and disease
Includes understanding the human life cycle, normal human structure and function, the biologic and psychosocial determinants of health and disease, and the pathophysiology of disorders linked with how the tests and treatments work.

Clinical care research
Includes understanding the "anatomy and physiology" of clinical care research and its outputs, as well as being able to find evidence that is at low risk of bias, has patient important results, is applicable to the situation at hand, and where possible is usefully synthesized and summarized to inform clinical decisions.

Clinical expertise
Includes the deliberate practice of communication skills, clinical skills, and decision skills, as well as the experiential learning that comes through the care of sick persons, with the development of clinical judgment.

Patients' perspectives
Includes what is understood about the patient's particular clinical predicament and life situation, including their unique biology, psychology, and sociology; what is understood about both the burdens of illness and the burdens of proposed treatments; what is known of their individual resilience and sources of support; and what they have previously expressed about their beliefs, values, and preferences.

Population perspectives
Includes knowledge of how health systems function, how public and population health considerations affect decisions for individuals, and how current events and societal context could also affect decisions for individuals.

Professionalism
Includes understanding the individual clinician's values, professional ethics and the moral responsibilities of clinicians, and also developing and maintaining key characteristics such as integrity, respect, compassion, and sustained curiosity, as well as robust lifelong learning skills.
(This list is not meant to be jointly exhaustive or mutually exclusive.)