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Medicine of the person - The evidence of benefit

Firstly, many thanks to Kathy, Claude, Frederic and other members of the Organising Committee for inviting me to participate in this delightful and rewarding event.

Does the practice of medicine that considers the whole person rather than just a physical or mental pathology bring greater health? Is there reliable evidence to show that it does? Before exploring these questions, it would be helpful to be clear about what we understand by the terms in our title. *Medicine* is straightforward: most commonly, an activity to restore the health of an ailing individual. Of the hundreds of medical students whom I have interviewed most enter the profession with this as their goal. And their training, overwhelmingly, has a similar objective, being focussed intensely on physical illness. More widely, and much less popular with our doctors in training, 'medicine' includes identifying future health risks and implementing strategies to maintain disease-free populations. Of course, all of these activities engage not only doctors, but many other health professionals.

The meaning of *persons* lies at the centre of our collective interest - stimulated by the deeply thoughtful writings of Paul Tournier that began over 70 years ago. Let me a quote from his book with that title which succinctly and helpfully describes the shape of our individual humanity :

> *'Life, then, is characterised not by a material function accessible to science, but by an immaterial, spiritual, purposive function.'*
> [*The Meaning of Persons*, p. 90]

By the time he wrote this, the explosion of scientific enquiry that began in Europe in the 18th century was being applied increasingly to the world of medicine: to studies of the normal and diseased mechanisms of the body and, to a much lesser extent, the mind. Scientifically- based medical diagnosis and treatment was on a sharp, and pleasingly productive ascent. But Tournier, while appreciating this progress, offered caution. In his view, rising scientific fervour, with a cultural shift towards secular rationalism, threatened the holistic approach essential to effective healing. He was at the forefront of a growing cry for 'modern' medicine to maintain its connection with patients, not just as harbingers of physical pathology, but as people formed of far more than physics and chemistry. He emphasised that human life is complex – indeed, in many ways indefinable, elusive and mysterious. Its material component may even play only a relatively modest and dependent part. Many communities across the world, of course, have always held this view. This is not to deny the remarkable design and physical reality of our bodies with which the scientific method can engage extensively. They are a construct of remarkable complexity and interdependence. The many trillions of cells of which we are made, 'know' individually, or are automatically directed in how to establish a co-ordinated whole. The 100 billion neurones of our brains form for themselves some 100 trillion connections

with an extraordinary capacity to store and retrieve data. These are remarkable facts among very many others about the mechanisms of our existence; but not sufficient to explain 'us' as people.

To this physical function Tournier ascribed the term '*personage*', conceiving it as an actor that outwardly expresses our unique character – the 'immaterial and spiritual function', the essence of the *person*. From this intangible entity flows our formative energy and direction, providing the definition of our true selves. He proposes that, by its nature, this foundational reality cannot be accessed by conventional scientific methods; we become acquainted with it subjectively and by intuition. Physical instruments are appropriate for our physical reality; understanding personhood demands the sensitivity, receptivity and the 'mystery' of another person.

Before completing our definitions, may I ask firstly that we use either 'non-material' or 'intangible' in place of the word translated from Tournier's original as 'immaterial'. This is because, in the UK at least, 'immaterial' now commonly carries the sense of 'irrelevant' – the very opposite of the meaning and emphasis we espouse.

Secondly, may I raise the question of how, in Tournier's characterisation of *persons,* are we best to interpret the word, 'spiritual'? Within Christian and other major faiths, this, customarily, has referred to the nature or person of an invisible supreme being. Thus, it has a firm transcendental and religious connotation. In the bible, the word 'spiritual' is used just 18 times, all in the apostolic letters of the New Testament. All refer directly to the person or work of the Holy Spirit. But, the bible also uses 'spirit', with a lower case 's', to refer to an essential, non-material component of man. The *human* spirit that conveys life and drives us is likened to the invisible wind in its force and its unpredictability. It also carries the attributes of personality. Linked with the '*sarx*' – the Greek word for the physical body – it provides a complete definition of a human being. Two other biblical words also refer to our intangible dimension: 'soul', denoting a life-force associated with moral and emotional responses; and 'heart', indicating the governing centre of a person that, above all, makes us unique individuals.

In both biblical and non-biblical language, the word 'spirit' also commonly denotes a non-material being, visible or invisible, that has the attributes of persons: autonomy, reason, sentience and communication. Such spirits may interact with people and the world in ways that may be beneficial or malign. These beings and their activity are an important reality to the majority, but, understandably, are dismissed within a rationalistic world-view.

In our post-modern societies, the word 'spiritual' – and even more so its derivative, 'spirituality'– have diffused into a number of different concepts: the notions of existence, morality, purpose, meaning, awe, values, and 'connection'. Thus, 'spiritual' and 'spirituality', while increasingly prevalent in health-related discourse, have no clear or unified definition. In 2005, McCarroll and colleagues published a survey of reviews on the topic of 'spirituality' from which they identified twenty-seven different explicit definitions, among which they noted, *"there was little agreement."*

[McCarroll, P, O'Connor, TS-JJ, Meakes, E (2005), Assessing plurality in Spirituality Definitions. In: Meier et al, "*Spirituality and Health: Multidisciplinary Explorations*", pp. 44-59, Wilfrid Laurier Univ. Press]

Current concepts of whole person medicine – combining the material and the non-material – emphasise the need for healthcare practitioners in any therapeutic encounter to engage with the mind and spirit of a person as well as with their bodies. But how should we view the *mind* in this context? We attribute it to a key role in consciousness, self-awareness, emotion, cognitive processing, and motivation. It has good integration with the physical mechanisms of the brain, as shown increasingly by functional MRI and other advanced scanning techniques. Just one example of these is the demonstration of specific areas of cortical activity that accompany our emotional response of empathy and compassion. On the other hand, it is seen not as physical entity. Perhaps the 'non-material function' of Tournier's *person* equates to the human spirit plus the mind. A useful analogy has been made between our twin 'functions' and a computer. Our physical

'hardware' has the capability of interfacing with the material world and embodies complex biochemical multiprocessing to sustain, inform, manage and repair itself. Our non-material function is then identified as our controlling software designed so that, both autonomously and in response to an external input, it will generate an action involving physical and mental processes.

Thirdly, may I add a final dimension to the body-mind-spirit model of our existence – that of *society*. Our relationships, our social structure and our environment have profound effects on our well-being. In matters of health and healing these factors, of course, cannot be ignored. Medicine of the whole person, thus encompasses attention to all four of these components, with the caveat that in any individual they are all inextricably intertwined. They are indeed a 'whole' that the reductionist approach of modern medical science does not readily address.

So what evidence of benefit do we have of understanding and caring for the material and non-material individual in society; that is, practising whole person medicine? The answer is a great deal! Publications on this topic have grown exponentially over the past 40 years with impressive annual increases from the year 2000. There is currently no shortage of relevant articles identified by two popular electronic search engines, Google Scholar and PubMed: Please would you take a short time to look at the following table either below or on the screen.

Topic	**Google Scholar**	**PubMed**
Benefit of whole person medicine	1,330,000	38,417
Benefit of psychological interventions in health	2,430,000	3,148
Religion, spirituality and health	455,000	3,821
Religion, spirituality and medicine	228,000	2,612
Spirituality and medicine	366,000	5,311
Spirituality and health	696,000	7,749

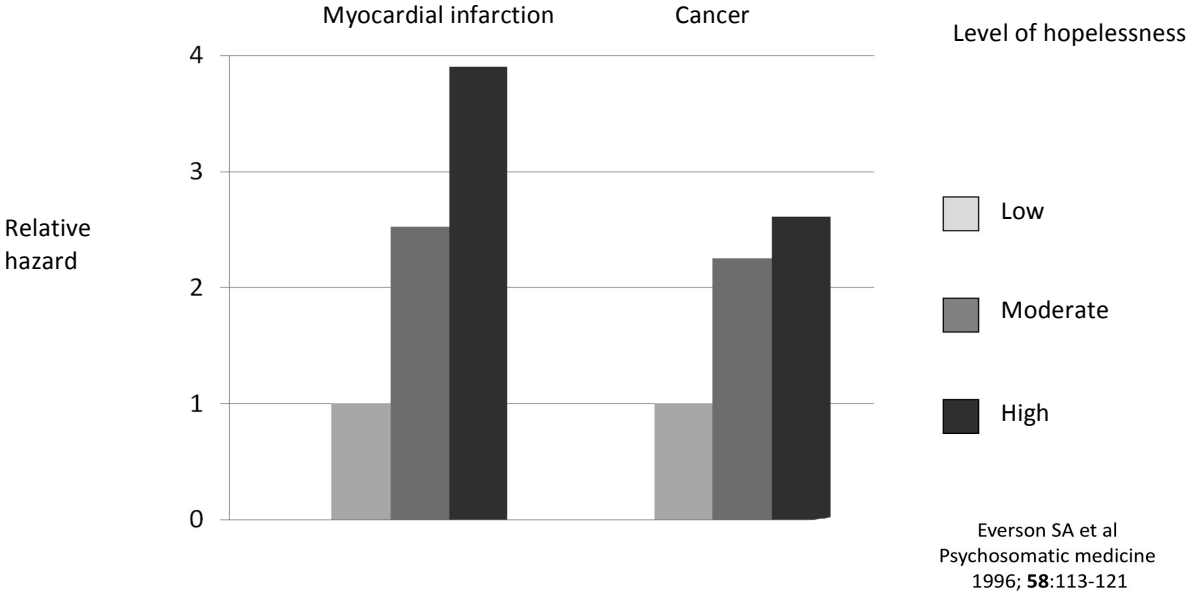
Indexing this work for electronic searches is complex and can lead to widely varying numbers of articles when searched with virtually identical criteria; but the numbers overall are remarkable. Many papers present reflective commentaries rather than rigorous studies, and this partly explains the mismatch between Google Scholar and PubMed. Qualitative studies exceed those using a quantitative approach, but the research methodologies employed in both have included in-depth interviews, focus groups, case studies, case series, cohort or case control studies, uncontrolled and randomized controlled trials, physiological, biochemical and genetic investigations, systematic reviews, and meta-analyses.

May I suggest that there are two categories of data that support the value of recognising and implementing a whole person approach in whatever discipline health-care practitioners are engaged. The first is research that points to the close and powerful interdependence of body, mind, spirit and social connection that are influential collectively on the pathogenesis of dis-ease. From this perspective, a truly accurate diagnosis, the optimal selection of therapy for healing, and effective strategies to maintain health, necessarily require exploring how each and all of these four dimensions contribute to the problem in hand.

The second category of supportive data comprises evidence confirming the benefit in practice of adopting this approach. Predominantly, this concerns either patient recovery through comprehensive diagnosis and treatment, or reducing individuals' susceptibility to disease through primary or secondary prevention. It is good to note, too, that healthcare professionals practising person-centred care often gain psychological benefit themselves that can also influence the systems in which they work. In general, research in this category dwells on the added value of including at least one of the 'psycho–social–spiritual' dimensions of our patients or communities in the assessment and care they receive.

So let us look at typical examples of data from each category :

Firstly, giving evidence of a non-material influence on pathogenesis, the following graph shows the connection of two common and serious physical pathologies to a surprising risk factor, one that must surely reside in the *person* rather than in a biochemical or physical measurement; that is hopelessness.



Hopelessness and the relative risks of death from myocardial infarction and cancer.

A prospective 6 year study of middle-aged Finnish men matched for blood pressure, cholesterol, smoking, drinking,

As you will see, this psycho-spiritual affliction contributes an independent, proportional hazard for both conditions. In fact, it poses a greater threat than the standard risk factors for coronary disease and cancer that receive such prominent publicity.

Secondly, the influence of overall psychological well-being on physical health and mortality has been researched extensively. It is succinctly summarised in a quantitative review of prospective observational studies by Yoichi Chia and Andrew Steptoe. Examining 35 studies in initially healthy populations and a similar number of studies in diseased populations. Their meta-analyses showed that positive psychological well-being was significantly associated with reduced cardiovascular mortality in healthy individuals as well as reduced death rates in patients with existing renal failure or human immunodeficiency virus infection.
[https://journals.lww.com/psychosomaticmedicine/Abstract/2008/09000/Positive_Psychological_Well_Being_and_Mortality__A.1.aspx]

Thirdly, a further illustrative connection of cause and effect, one with wide health and economic importance, lies between cognitive psychology and adherence to prescribed medication. Besides patients foregoing an anticipated therapeutic benefit, the National Health Service in the UK loses about £300 million per year through medicines being dispensed, but unused. Addressing the reasons and remedies for this requires a whole-person approach. Devices to assist memory or ease of administration may help, but an active engagement with how the patient *thinks* is mandatory.

Substantial data exist to show that patients' concepts and interpretation of their illness – which may well differ markedly from that of their attending physicians – has a critical influence in four areas: their mood, their ability to cope, their adherence to medication, and their recovery. Surprisingly, as shown in patients recovering from acute myocardial infarction, even the extent to which husband and wife share or conflict in their beliefs about the illness and its outcome will influence the prognosis of the spouse.

With regard to medication, patients' cognitive judgement of the balance between the benefit and risk of taking a prescribed medicine is the principal driver for their adherence – or not – to therapy. An informed dialogue between the patient and a trusted prescriber that explores these issues is becoming a mandatory objective.

[NHS campaign. http://www.medicinewaste.com]

[Patients' beliefs about prescribed medicines and their role in adherence to treatment in chronic physical illness. DOI: https://doi.org/10.1016/S0022-3999(99)00057-4]

Finally, another contemporary, social risk factor for mental and physical disease that is emerging most rapidly in the 16 – 34 year-old age-group, is the problem of loneliness. Overall, this appears to carry the same risk to physical health as smoking 15 cigarettes per day, or of being obese. This occurs partly because, in itself, loneliness promotes smoking and physical inactivity, with their known adverse effects. Also, it can more than double the likelihood of depression, anxiety, and suicide.

[https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10]

These four illustrations are but a tiny example of reports that demonstrate the widespread, non-material influences on physical disease and its management which, if not addressed, compromise our success in the restoration or maintenance of health in its fullest sense. I am sure you will know of many more.

Concerning data in our second category we will now look at reports of improvement in patient well-being, or a reduction in health risk by addressing their *person* as well as their physical *personage*? The doctor-patient interaction is a good place to start. Firstly, in a study of 800 patient consultations, 26% said that they had not mentioned their greatest concern to the physician because they had no opportunity or were not encouraged to do so. Patients collaborated with the doctor best, and complied better with treatment, when they felt he or she was genuinely concerned. Importantly, measurable health outcomes improved. Also of rather disturbing interest, is that most of the doctors felt they had been friendly while more than half of the patients disagreed.

[Korsch BM and Negrete VF "Doctor–Patient Communication." Scientific American. 1972. 227: 66-74]

Secondly, in another qualitative study of medical consultations, carefully set up to provide 'person-centred care', Axel Wolf and colleagues reported that patients 'value a process of human connectedness above and beyond the formalised aspects of care planning.' Such a relationship enhanced the patient's sense of safety, security and communication that facilitated the therapeutic encounter.

[Wolf A, and Moore L, *et al.* "The realities of partnership in person-centred care: a qualitative interview study with patients and professionals." BMJ Open 217;7:e016491. doi:10.1136/bmjopen-2017-016491]

Thirdly, from a personal perspective, Rosamund Snow in the British Medical Journal pointed out the rewards of collaborative consultation where a true interaction of *persons* was clearly evident. She notes that 'instead of probing my feelings with formulaic questions, the doctor's primary focus was answering the questions I had asked, so l felt she was listening, and that we were working together. That made it much easier for me to share my thoughts and worries with her, too. It didn't take long. I had already started to trust her in the first 15 seconds.' This last comment is worth noting. The time to establish this positive interaction of *persons* required seemingly no great effort or time.

[Snow R. BMJ 2016; 354 doi: https://doi.org/10.1136/bmj.i3729]

In the next example of data in our second category, we will consider a summary of health benefits from a single, entirely 'person'-based intervention – forgiveness. In a reference from one of the 736, 000 listed articles on the topic of forgiveness and health, we are reminded what forgiving or being forgiven has been shown to achieve :

Healthier relationships	Fewer symptoms of depression
Improved mental health	An up-regulated immune system
Less anxiety, stress and hostility	Improved cardiovascular health
Lower blood pressure	Improved self-esteem
Lower cholesterol levels	Improved sleep

Note that these benefits are reflected within physiological, psychological, and societal domains. As a practical example of this, a paper by Waltman reported that a sample of men with coronary artery disease showed reduced anger and improved myocardial perfusion following a period of forgiveness training.
[Waltman, MA (2003) Dissertation Abstracts International: Sect. B: The Sciences & Engineering, 63(8-B), 3971.]

Whole person care may include modalities that, while addressing the person, would be judged at least unusual from a scientific perspective. One of the many studies from the Western literature that reflects this is the work by Smyth and colleagues using writing as a therapy for asthma and rheumatoid arthritis. In one study, patients with one or the other of these conditions were asked to write for an hour on three successive days about their most painful past experience. Controls wrote about a non-traumatic memory or life event. Treatment and control groups were similar in all important respects. The authors found that the treatment group showed a reduced use in medication, and lower symptom scores that lasted throughout the six-month follow-up period.
[See: Kligler B. Lecture Notes: Integrative Approach to Asthma, *Curriculum in Integrative Medicine: A Guide for Medical Educators*, Consortium of Academic Health Centers for Integrative Medicine, 2004.]

It is clear from a wide range of published work – as well as from our own experience – that the mind has a profound effect on the susceptibility to and the recovery from illness, where even taking an inactive placebo rather than nothing can prevent death. But, bearing in mind Tournier's and our own theistic world view, let us look finally at the most thorough, published review of validated research relating health to matters spiritual.

The first edition of the *Handbook of Religion and Health* was published in 2001 by Harold Koenig, Dana King, and Verna Carson from Duke University in the US. They analysed 1200 high-quality papers and 400 systematic reviews from the years 1840 to 2000 that explored the relationship between religion and health behaviours or outcomes. Koenig made clear that his research would focus only on subjects whose 'spirituality' included belief in a transcendent, supreme being and whose behaviour demonstrated at least one attribute that clearly reflected this. He aimed by this in part because of the multiple definitions applied to 'spiritual' bit also to avoid the confounding and the data-contaminating effects of using a term under which psychological profiles could appear as both independent and dependent variables.

The second edition of this extensive work was published in 2012 after exploring a further ten years of relevant, peer-reviewed publications. This brought the total analysed to about 3,300. As may be expected, the research methodologies reviewed varied according to the subject and type of investigation, with a notable difference between those in mental and physical health. May I draw your attention to the following table:

research method	mental health % (N=2508)	physical health % (N=425)
Randomised controlled trial	9	27
Prospective cohort	37	46
Case controlled	1.5	12
Experimental	0	14

The majority of the remaining studies were cross sectional.

Not surprisingly, the use of an experimental design and/or a control group was more frequent in studies of physical health.

In Koenig's analysis, the data were grouped into three main areas: mental health outcomes, general health behaviours, and physical health outcomes. As expected by his team, about 80% of research involved studies in mental health. They argued that this proportion was likely on the basis that spirituality is, as they described it, more 'proximally related' to our thinking than our physical processes. They did not expect spirituality to have any direct or immediate effects on physical health; rather they proposed that its influence, in quotes, *'worked indirectly through intermediary psychosocial and behavioural pathways'.*

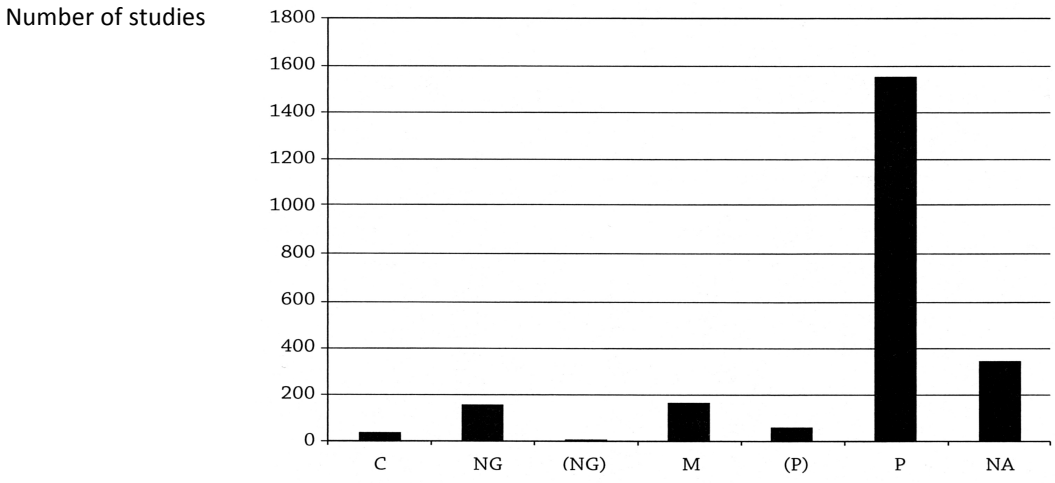
The studies in mental health included :

- coping with adversity (454 studies)
- positive emotions (620 studies over eight different dimensions)
- depression (444 studies)
- psychotic and bipolar disorders (studies)
- personality traits (209 studies)
- substance-abuse (463 studies)
- social problems (271 studies)

Although the results were inevitably mixed, they showed an overwhelmingly positive benefit in measured outcomes in patients demonstrating their interest and activity in transcendental, religious beliefs.

The results in the 326 general health behaviour studies addressing smoking, exercise, diet, weight, and sexual behaviour, similarly showed a strong positive correlation between a spirituality and benefit. And the same number of studies in physical health, covering cardiovascular disease and surgery, Alzheimer's disease, immune function, endocrine function, cancer, overall physical function, self-related health, pain and mortality also showed a similar pattern.

A grand summary of their data was presented as a single graph :



Religion – health related relationships
Key: C=complex, NG=negative, (NG)=negative trend,
M=mixed, (P)=positive trend, P=positive, NA=no association

[From *Handbook of Religion and Health*. Koenig *et al*. 2nd ed Oxford University press, p 602]

Herein, this industrious group presents a strongly positive association between religious beliefs and practices and a very broad range of favourable health outcomes. The Negative [NG] and No-association [NA] columns are dwarfed by the large number of positive results [P] that represent 84% of the studies. Mixed results [M] and trends [NG & P in brackets] are small by comparison. Adverse effects were infrequent – at

about 4%. This research seems impressive in spite of the defined independent variable in these studies allowing the inclusion of a wide range of persons and social contexts. Also, religious attachments were not a therapeutic intervention, rather an established world-view that was predominantly beneficial for maintaining health and recovering from illness.
[A readable version of the work by Koenig *et al*. can be found at: ISRN Psychiatry, Volume 2012, Article ID 278730; doi:10.5402/2012/27830]

I wonder what you think. Does this seem plausible? Is it, in fact, concerned too much with the behavioural or mechanistic? How does this 'scientific' enquiry fit into Tournier's essence of the *person* being psychological and spiritual (at least in the sense of the human spirit) and therefore 'inaccessible to scientific observation'? Perhaps the sheer scale of these data eclipses our view of the details wherein his expansive, multifaceted view of the *person* would gain more prominence?

Is Koenig's report relevant to patients who own no 'religious' faith? In that regard, and to a degree puzzling, is his proposal that other belief systems such as secular humanism – defined as a meta-narrative of human virtues and ethics based on reason and empathy – could generate similar healthy behaviours and therefore similar benefits. To me, this seems to negate his key requirement for patient inclusion, that of their evident belief in the transcendental. Individuals and institutions with no declared ownership of a 'religious' faith have published frequently on the necessity of regarding patients as persons. As one example, a prominent report from the King's Fund, an independent national 'think tank' in the UK, made clear the need for health professionals and institutions '*urgently to focus on caring for the person in the patient*'. It supported the view that a patient *'is a unique person with diverse needs, an individual to be cared for not a medical condition to be treated'*.

In our Christian perspective on religion and 'spirituality' in health-care, we gain from including the Spirit of God, the Holy Spirit: One who helps us in our weakness [1 Romans 8 v26-27], who conveys and amplifies our prayers to heaven [Romans 8, v26-27], who makes God's wisdom accessible to us [James 1 v5], who, even in these days, may heal in a way that defies our scientific expectations. And perhaps this also alerts us to the mystery and indefinable nature of persons that are by no means irrelevant to our relationships, our well-being and our interaction with health care.
[http://undergroundhealthreporter.com/medical-miracles-in-hospitals/ *is of interest*]

The array of evidence from many studies that endorse the benefit of whole person medicine seems irrefutable. But are these helpful, sufficient or even necessary for promoting it? Most healthcare professionals at the start of their training have measurable empathy, a characteristic central to whole person medicine. And we know that this is associated with more effective consultations, improved patient satisfaction and adherence, and favourable health outcomes. The compassion that many students and practitioners intrinsically wish to incorporate into their work is similarly beneficial, not only to their patients, but to themselves, as Paul Gilbert reports : '*Research has found that developing kindness and compassion for ourselves and others builds our confidence, helps us create meaningful, caring relationships and promotes physical and mental health.' 'Practical exercises focusing on developing compassion have been found to subdue our anger and increase our courage and resilience to depression and anxiety.'*

That said, several studies have also shown that empathy and compassion wanes as students advance in clinical training, particularly among those entering technology-oriented specialties. Fortunately, medical schools are rapidly becoming alert to this challenge, adjusting their curricula to emphasise these qualities as well as teaching an expanded bio-psycho-social approach within the healing relation between clinician and patient.
[Chen DC. Med Teach. 2012;34(4):305-11. doi: 10.3109/0142159X.2012.644600;
Toward person-centered medicine: from disease to patients to person. Mezzich J, Snaedal J, van Weel C, and Heath I. doi.org/10.1002/msj.20187]
[Gilbert P. The Compassionate Mind, Constable & Robinson UK, 2009]

In my work across the world with a Christian charity whose main purpose is to teach whole-person clinical care, I have been surprised at the sudden recognition that many attendees have shown of its dramatic and understandable value. Two indicative quotes provide an illustration : *'Here will be the change in health care by teaching people around the world whole person medicine.'* And, *'All my life I felt I should consult like this. Now I have permission.'*
[http://www.prime-international.org/home.htm]

In a short time we have reviewed a little of the published data supporting Tournier's pioneering observations and reflections of persons in health care. But perhaps the most persuasive evidence of benefit, and the most readily acquired, comes from our own interaction with patients, especially when there is a true moulding together of our *persons*. This seems chiefly achieved by our careful – should I say prayerful? – listening and empathic imagination. The reward *will* be a new level of health in those for whom we care, even if no physical investigations or treatments are involved. Even if their physical diagnosis is resistant to physical therapy.

Returning to spirituality let me quote the words of Chris Levison writing in *'Spiritual Care Matters'*, from National Health Service Education for Scotland :

> *'Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires. The provision of spiritual care by NHS staff is not yet another demand on their hard-pressed time. It is the very essence of their work and it enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care.'*

The accumulated data, particularly over the last 10 years, provide good evidence to this effect.