Conceptual aspects of integration

Presentation at the symposium

Person-centered care – its potential for integrating religious and spiritual issues within the practice of mental healthcare

Professor Gerrit Glas MD PhD
Faculty of Humanities
Vrije Universiteit, Amsterdam (NL)

g.glas@vu.nl

Overview

- Person-centered care: roots, focus, variants
- How does PCC help ‘integration’?
- What does it require, conceptually and practically?

Person-centered care

Core idea:

The patient is not the carrier of disease but the central focus of medical/therapeutic attention

Mezzich (2011)

PCM is:

"… medicine *of* the person (of the totality of the person's health, including its ill and positive aspects), *for* the person (promoting the fulfilment of the person's life project), *by* the person (with clinicians extending themselves as full human beings, well-grounded on science and with high ethical aspirations) and *with* the person (working respectfully, in collaboration and in an empowering manner through a partnership of patient, family and clinicians). The person here is conceptualized in a fully contextualized manner, consistent with the words of philosopher Ortega y Gasset, I am I and my circumstances"

(Mezzich 2007; 2011; Mezzich et al. 2016; Miles & Mezzich 2011).

Influences from….

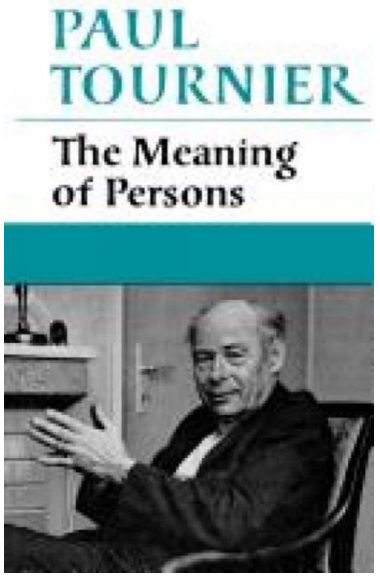
…..Carl Rogers (‘non-possessive warmth’, genuineness)

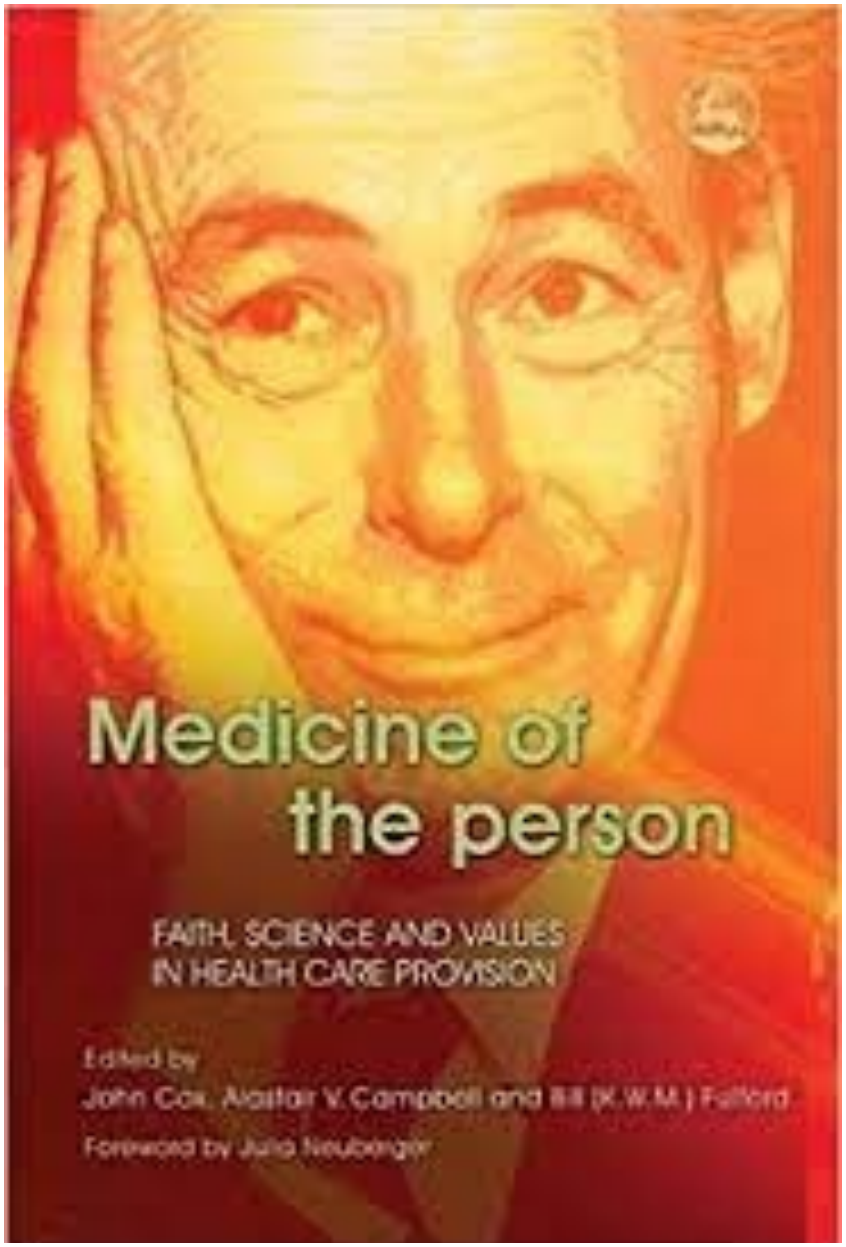
…..Paul Tournier (medicine of the person)

Paul Tournier (1898-1986)

Medical doctor, counselor, with much emphasis on spiritual values

Médecine de la personne (1940): “Medicine of the person is not just another branch of medicine. It is an attitude towards contact, an approach to patient-care, applicable in all areas. It puts the emphasis on awareness of patients as whole persons, with places in their community and society. Both the organic and the psychological approach are integral parts of Medicine of the Person, as is consideration of the connection between state of health, life events, social insertion and spirituality.”





Recent revival…

….esp. in the UK

J. Cox, AV Campbell, KWM Fulford (2007), *Medicine of the Person: Faith, Science and Values in Healthcare Provision*. Jessica Kingsley Publ.

Miles and McLoughlin (editors of *Journal of Evaluation in Clinical Practice*) recognize the ‘resonant voice’ of Paul Tournier in the rise of person-centered medicine

Miles and McLoughlin (2011)

“. . . it seems incontrovertibly clear from raised voices worldwide, that patients are no longer prepared to be ‘dealt with’ or ‘processed’ by technicians in applied bioscience, but wish rather to be attended by scientifically trained advocates who recognize their problems not only at an organic, but also at an emotional and spiritual level and who, in addition, then proceed through shared decision making to tailor treatment for the patient through a medicine of, for, by and with the patient” (idem, p. 534).

PCC is familiar to ‘positive health’ approaches

Huber et al. (2011): there is need for a positive and dynamic concept of health that is based on “the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of well-being.”

Health is, then, “the ability to adapt and to self-manage, in the face of social, physical, and emotional challenges”.

Explicit attention to the spiritual and existential dimension (‘meaning’)

PCC is something different than…

…..personalized medicine (or: precision medicine; stratified medicine; individualized care)

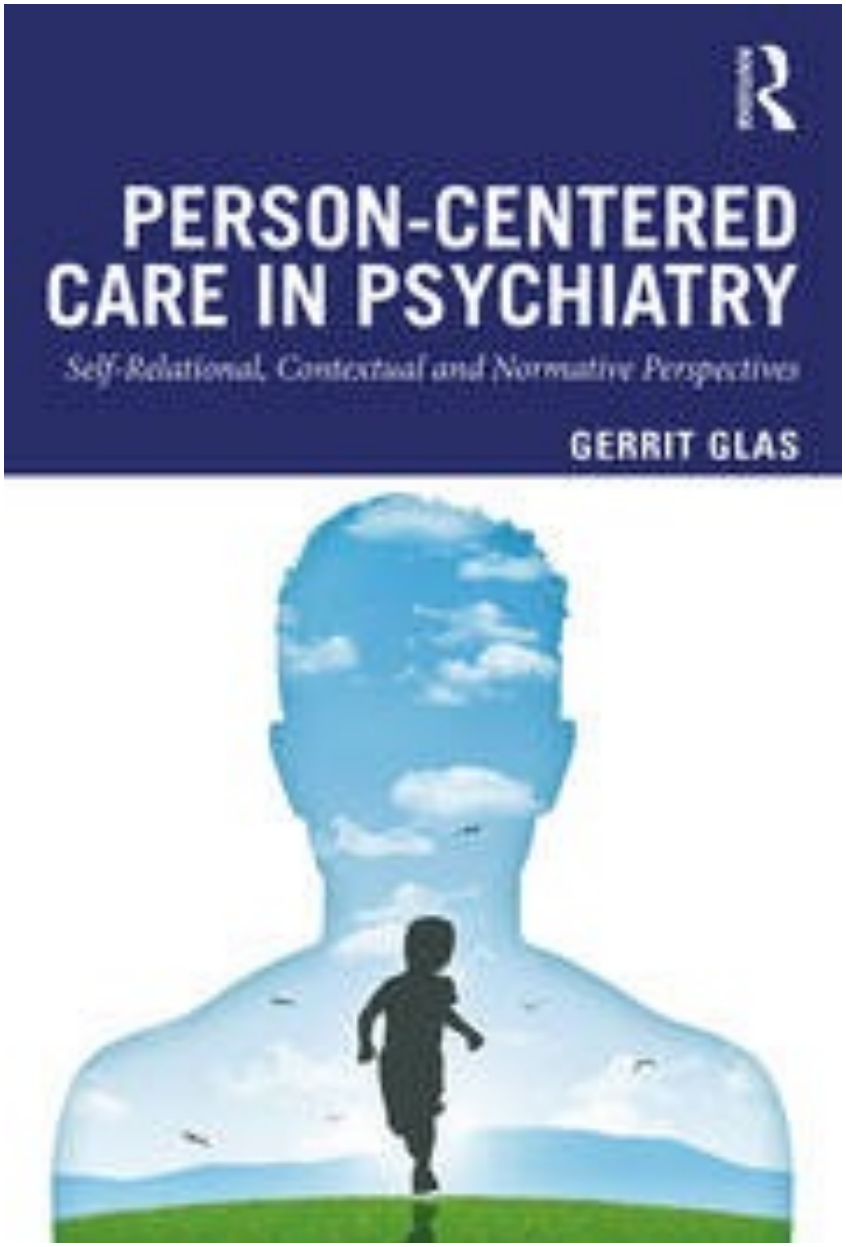
It aims at treatments targeted to the needs of individual patients based on genetic, biomarker, phenotypic, or psychosocial characteristics that distinguish a given patient from other patients with similar clinical presentations (Jameson & Longo 2015)

PCC also differs from the P4 approach

P4: predictive, preventive, personalized, and participatory

Impetus comes from the recognition of the increasing blending of science and practice as a result of patient empowerment and the establishment of new, interdisciplinary networks of researchers, patients, and other stakeholders.

Core goal of personalization is “to acknowledge the position of patients and citizens at the centre of the endeavour, not merely as receivers of care but as active contributors of data and as participants in the process of decision-making” (ESF 2012, 14; cf. Hood & Friend 2011; Weston & Hood 2004).

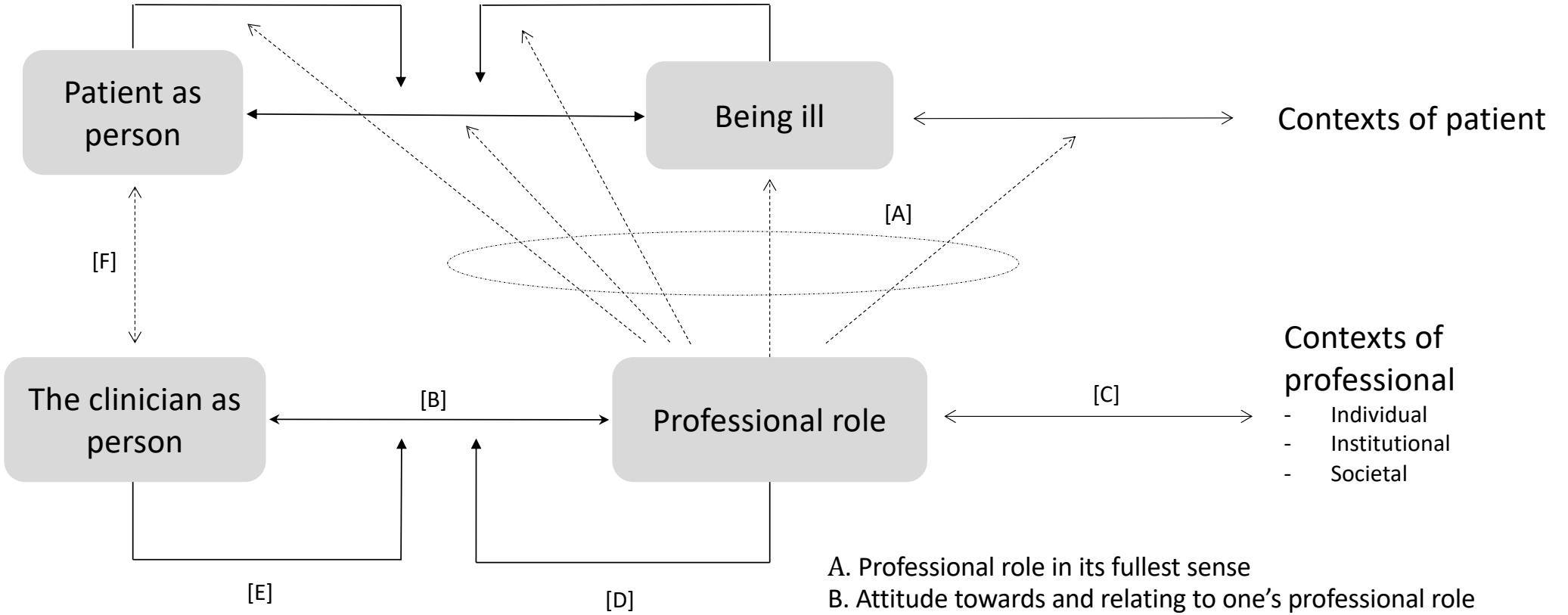


My own approach (Glas 2019)

- Patients relate to their problems: a *relational* view on illness and illness behavior
- The patient's problems are *contextually* co-determined
- Professional practice is norm-responsive: a *normative practice* approach

Person-centeredness: focus on the relation to the patient, which includes the patient's relationship with the illness and the professional's relationship with respect to his/her (expert) role

In his/er professional role the clinician relates in different ways to his/er own professional role [A-E]



A. Professional role in its fullest sense
B. Attitude towards and relating to one's professional role
C. Interaction professional role – context
D. Influence professional role on attitude toward professional role
E. Influence of person on attitude toward professional role
F. Person–to–person relationship

How does PCC help ‘integration’?

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- The easy part of the answer: as ‘whole-person approach’ does it encourage clinicians to pay attention to r/s aspects of the patient’s problem and allow them to play a role in the treatment process

- The more difficult part: to integrate one’s own ‘whole-personhood’ in one’s professional’s attitude (Tournier: “attitude towards contact”)

The existential core of professionalism…

….comes to expression in

- ….awareness of and openness towards one's own most fundamental motives and concerns
- ….ability to experience them and willingness to let them play a role, implicitly or explicitly

The communication about these aspects starts often in moments of unease, lack of control, or uncertainty (of the therapist)

Role of ‘indirect communication’

- Plain denial of r/s/e issues or refusal to talk about them is also a form of communication
- “We are no experts on these issues”?
  - Answer:
    - Indeed, but that does not imply silence about these topics; silence is also a form of communicating: and/or
    - OK, but, let’s then become experts; and/or
    - The least one can do is to help patients to verbalize their r/s/e concerns and to develop sensitivity for the kind of r/s/e appeal the patient exerts; and to one’s own reaction to that appeal

What is ‘new’ in this approach

- More emphasis on the receptivity and sensitivity of the professional than in other (‘activistic’) integration attempts

- No neglect of the expert role; integration of this role within one’s personhood as professional

- Focus on the inherent norm-responsiveness of the clinician – patient relationship

What does it require – conceptually and practically?

What does it require?

Sensitivity to the needs of the patient…..

….given one's role;

….given the nature of healthcare as a practice

Flexibility and sensitivity to the norm-responsiveness of professional practices, which implies …

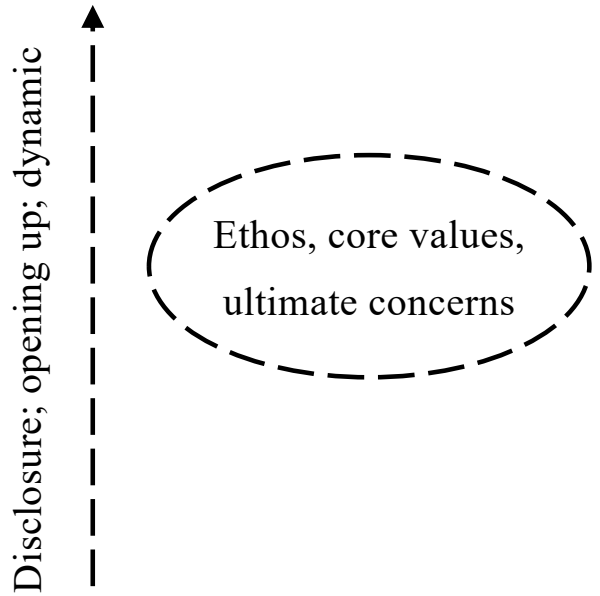
….second-order professionalism: the ability to navigate properly among different roles and interests given the core values of the patient and the professional

Medicine as normative practice

Constitutive norms and normative principles (structure)

Qualifying norms:	moral
Conditioning norms:	jural/legal
	economic
	social (institutional; societal)
Foundational norms:	scientific knowledge
	technology
	expertise, skills

Regulative direction (dynamic)



At the heart of our professions….

….is the encounter with the patient, whose needs, longings, and illness-related experiences have often an existential dimension

….this encounter is norm-responsive in the sense that the patient's suffering appeals to core values of the profession, its 'ethos' (solidarity, trust, altruism, honesty)

….these norms/values are not external, but intrinsic; to see this we should start with what is at the heart of the profession, the personal encounter and its appeal on us

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