Defining "Patient-Centered Medicine"

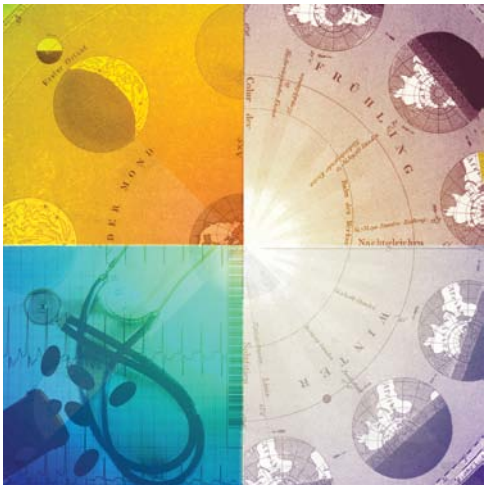
Charles L. Bardes, M.D.

A patient consults an orthopedist because of knee pain. The surgeon determines that no operation is indicated and refers her to a rheumatologist, who finds no systemic inflammatory disease and refers her to a physiatrist, who sends her to a physical therapist, who administers the actual treatment. Each clinician has executed his or her craft with impeccable authority and skill, but the patient has become a shuttlecock. Probably a hassled, frustrated, and maybe bankrupt shuttlecock.

The themes are very old. The Hippocratic Oath itself enjoins physicians to maintain their deportment and privileges while keeping the patient's interests foremost. What is the proper relation between the doctor's and the patient's experiences of illness? Between a scientific understanding of disease, whatever the science of the day may be, and the subjective phenomenon of being sick? Between the subspecialist and the general physician? Between cure and care?

"Patient-centered medicine" is the newest salvo in these ancient debates. As a form of practice, it seeks to focus medical attention on the individual patient's needs and concerns, rather than the doctor's. As a rhetorical slogan, it stakes a position in contrast to which everything else is both doctor-centered and suspect on ethical, economic, organizational, and metaphoric grounds.

The British psychoanalyst Enid Balint appears to have coined the term in 1969. She described a form of mini-psychotherapy that general practitioners could provide for persons who had illnesses that were partially or wholly psychosomatic.[1] Her concept contrasted with "illness-oriented care" and meshed well with other critiques of modern medicine's emphasis on pathophysiology to the exclusion of other means of knowing and treating the patient. Landmarks in this paradigm shift have included Engel's proposal for a biopsychosocial model that would "take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness"[2]; Cassell's transcriptions of clinical encounters, which provided an empirical basis for understanding the doctor–patient relationship[3]; and Kleinman's definitions of "disease" and "illness" as contrasting the doctor's understanding of disordered biomechanics with the patient's subjective experience of feeling sick.[4]



Contemporary forces have bolstered this movement. The growing demands for quality and safety in health care have refocused attention on patient outcomes, even if efforts to ensure more consistently positive outcomes sometimes reduce the physician's prized autonomy. Grave concerns about the exorbitant price of medical care in the United States have led to considerations of whether shifting care from the subspecialist to the primary care physician could reduce its cost. The patient-centered medical home would reinstate the primary care office as the main locus of health care, provided that it can offer such desiderata as longitudinal personal care, access on demand (by visit, telephone, and e-mail), coordination among subspecialists, home-based and social services, open medical records, pay for performance, and a functioning electronic infrastructure. Alas, these services, however admirable, are also expensive and would require that health care dollars be reapportioned from procedurally based subspecialists, whose incomes currently vastly exceed those of generalists.

Supporting these recent trends is a new concept of the patient as consumer. The individual — once the subject of a monarchy whose purpose was to obey, then the citizen of a state whose purpose was to participate in the polity and vote — has now become the consumer in a marketplace whose purpose is to purchase. If the pa-

tient is reconceived as a consumer, new priorities take center stage: customer satisfaction, comparison shopping, broad ranges of alternatives, choice, and unimpeded access to goods and services. Supplementary themes include the provision of information by advertising or other means, the stimulation (and fulfillment) of demand and desire, marketing, branding, and estimations of value. Although some have argued that consumers would make wise, cost-conscious, and informed decisions in a free health care marketplace,[5] the peculiar nature of medical insurance means that patients seldom pay directly for the goods and services they consume and that their incentives for cost restraint are therefore absent. If doctors often make expensive choices, so do patients, and in my practice of general medicine I must often dissuade patients from demanding MRIs for their sore joints, antibiotics for their respiratory infections, and "brand name" medications for their hypertension, hyperlipidemia, and diabetes.

Patient-centered medicine is, above all, a metaphor. "Patient-centered" contrasts with "doctor-centered" and replaces a Ptolemaic universe revolving around the physician with a Copernican galaxy revolving around the patient. The flaw in the metaphor is that the patient and the doctor must coexist in a therapeutic, social, and economic relation of mutual and highly interwoven prerogatives. Neither is the king, and neither is the sun. Health relies on collaboration between the patient and the doctor, with many others serving as interested third parties. Patient and physician must therefore meet as equals, bringing different knowledge, needs, concerns, and gravitational pull but neither claiming a position of centrality. A better metaphor might be a pair of binary stars orbiting a common center of gravity, or perhaps the double helix, whose two strands encircle each other, or — to return to medicine's roots — the caduceus, whose two serpents intertwine forever.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From Weill Cornell Medical College, New York.

1. Balint E. The possibilities of patient-centered medicine. J R Coll Gen Pract 1969;17:269-76.
2. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196:129-36.
3. Cassell E. Talking with patients. Cambridge, MA: MIT Press, 1985.
4. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books, 1989.
5. Berwick DM. What 'patient-centered' should mean: confessions of an extremist. Health Aff (Millwood) 2009;28(4):w555-w565.

What's the Alternative? The Worldwide Web of Integrative Medicine

Ranjana Srivastava, F.R.A.C.P.

Out of curiosity, an impressionable woman in her 30s attends an integrative medicine exhibition; having recently had a child, she's been sleep-deprived and wants to investigate natural remedies. At the seminar, she wins a door prize — a blood test that promises to diagnose cancer. She was considering getting a blood test anyway and seizes this opportunity for a more comprehensive workup. After all, you can't be too careful about avoiding cancer.

Weeks later, she receives a call from an apologetic but alarmed stranger telling her she has advanced cancer.

"How do you know?" she gasps.

"Your blood test is positive for circulating tumor cells."

"What does that mean?" she cries.

He sends her a three-page report and tells her to seek immediate help. She spends a nail-biting week awaiting an appointment with the recommended integrative health expert.

Glancing at the report, the expert declares, "You have advanced non–small-cell lung cancer. You need treatment now." The woman is petrified: Has her teenage smoking habit come back to haunt her?

"Are you sure?" she asks.

"Absolutely. There are circulating tumor cells in your blood."

Tears streaming down her face, the woman asks, "What now?"

The practitioner prescribes a 12-week course of intravenous vitamin C, at a cost of $6,000, paid up front. Without further discussion, an appointment is made.

The woman's head is spinning. Who will look after her baby? How long does she have to live? Why her?