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REVIEW ARTICLE

From Evidence-based Medicine to Human-based Medicine in Psychosomatics

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Human-based medicine (HbM), a form of medicine that focuses not only on fragments and constructs but on the whole person, no longer finds its theoretical basis in the positivism of the modern era, but rather owes its central maxims to the post-modernist ideal that ultimate truths or objectivity in identifying the final cause of illness remain hidden from us for theoretical reasons alone. Evidence-based medicine (EbM) and HbM are thus not mutually exclusive opposites; rather, despite superficial differences in methods of diagnosis and treatment, EbM must be integrated into HbM as an indispensable component of the latter. Probably the most important difference between EbM and HbM lies in the aims and methods of treatment. In HbM the goal is no longer simply to make illnesses disappear but rather to allow the patient to return to a life that is as autonomous and happy as possible. The human being with all his or her potential and limitations once again becomes the measure of all things. This also implies, however, that the multidimensional diagnostics of HbM are oriented not only towards symptoms, pathogenesis, process and understanding but also to a greater degree towards the patient's resources. Treatment options and forms of therapy do not put the disease construct at the centre of the diagnostic and therapeutic interest, but have as their primary aim the reopening of the possibility of a largely autonomous and joyful life for the patient. ***Key words: evidence-based medicine; human-based medicine; humanistic medicine; multidimensional diagnostics; multidimensional treatment; resource-oriented treatment; medical social aesthetics.***

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The introduction of evidence-based medicine (EbM) some 30 years ago marked a milestone in medical history. In contrast to "Eminence-based Medicine" – which had previously dominated the field and in which a small number of recognised experts determined medical standards – EbM used statistical findings from cohort studies as the basis for rational medical practice. From the outset, epidemiological studies, controlled cohort comparisons and biostatistics were the masters of the universe in EbM (1–3). Undoubtedly, the objectification of our medical interventions, which in the final analysis can remain nothing more than an expression of a collective and collectivised form of subjectivity, and which should therefore be perceived as a frustrated attempt to escape from the constraints of this forced subjectivity, has incalculable advantages. In its essence, today's much-praised EbM is still indebted to the positivism of the modern and its maxims, and accordingly asserts (ultimately unverifiable) the objectifiable and objectified correctness of its approaches, which are defined as guidelines in state-of-the-art or consensus conferences and which must then in deference to ultimate medical truths be followed (4).

TRUTH VERSUS PROBABILITY

Today's EbM elevates statistical significance to the sole criterion of truth, i.e. the criterion that decides whether a statement is meaningful or whether it is better left unsaid (5). This was not always the case. Sackett and co-workers (6) from the Department of Clinical Epidemiology and Biostatistics at the MacMaster University in Hamilton/Ontario Canada, one of the birthplaces of contemporary EbM, still define EbM as "the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research" (7). This "integrative" approach advocated by the founders of EbM contrasts sharply with the current clinical practice promoted in strict EbM, in which the physician's clinical expertise counts for far less than controlled statistical studies. Thus, the clinical expertise of an experienced clinician ranks for example only fourth in the German Medical Association's hierarchy of evidence criteria, and as such is the lowest level of acceptable evidence, while the meta-analyses of controlled studies are ranked first and are considered to be the highest level (8).

In contrast to worshiping a strict EbM the analysis of the literature and discussion of EbM raises a host of problems (4). Attention has already been drawn to the central problem, namely the equating or confusing of "truth" and "probability". It is obvious to anyone who has explored the basic principles of mathematics that

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probability calculations can only ever show probabilities and never scientific truths (9), something that is often denied by science-oriented medical research. The results of statistical calculations are in some cases celebrated as scientific proof, although they can at best be indicators of certain factual relationships. In addition, there are a host of methodological problems in strict EbM that have their origins in the modalities with which cohort studies are carried out. These include, for example, problems in relation to the duration of such controlled studies, outcome criteria, selection of study patients, co-morbidities, control groups and exclusion criteria. The resulting limitations of collective case studies mean that the study results can only in exceptional cases, if at all, be considered representative for those patients who in clinical practice are then ultimately to be treated with the treatment modalities derived from the therapy studies (4).

MEDICAL RESEARCH AND CLINICAL PRACTICE

However, the major problem of EbM that overshadows all else lies in the direct transfer of quality assurance measures from medical research to quality assurance in clinical practice. By nature, EbM research projects must be devised as reductionistic; i.e. they aim primarily to simplify the subject or process that is to be studied. Separation, reduction and abstraction are the magic words of positivistic empirical research. In contrast, clinical practice must primarily do justice to the complexity of disease processes and the manifold interactions between disease processes, treatment processes and individualities of those who are to be treated. Individuals do not always behave in the same way as the group (although certain group phenomena cannot be denied). Human beings cannot be reduced to simple machines, their disorders cannot therefore as a rule be remedied with simple measures. For this reason alone, there will never be binding "pilot manuals" for treating sick people. A strict form of medicine based solely on evidence-based data must therefore always fall short; it can only result in effective treatments being withheld from patients, notwithstanding the fact that complex decisions can only sensibly be made by experienced clinicians bearing in mind the potential and limitations of the particular patient, and always taking into account all available proven research results.

Only a few years after the development of EbM, without actually mentioning it specifically, Gadamer (10) wrote an essay entitled "Über die verborgene Gesundheit" ("On Hidden Health"), in which he expressed the desire to see greater awareness of the differences between medical research and the actual art of healing – a difference that automatically existed between knowledge of things in general and the specific application of knowledge in the individual case, between theoretical treatises or hypotheses and the practical application of knowledge. As important and indispensable the achievements of EbM are, it nevertheless needs to be expanded by a medicine, which focuses not just on disorders and their treatment but which places the person with all his or her potential and limitations at the centre of its diagnosis and therapy interests, and which therefore can be truly called human-based medicine (HbM) (11, 12). This HbM has its roots in patient-centred approaches that go far back in medical history to Hippocrates (13). However, it also broadens these approaches in as much as it focuses on the living individuum (the indivisible human being) whereas the majority are patient-oriented approaches (person-centred approaches) (14, 15).

Whereas the main job of the researcher is to provide an analysis that is easy to follow and can be checked by others – in other words an analysis that correctly reduces, separates and abstracts data – the task of the clinician is to help alleviate the patient's suffering as far as possible and to induce and support a process of healing. The basis for a medicine understood not only as a scientific discipline but also fundamentally as an art of healing applied in clinical practice, is not simply the analysis of pathologically determined factors, but rather the synthesis of all the individual pieces of information to which clinicians have access on account of their academic knowledge, their experience and their observations and assessments and which enable them to formulate a multidimensional treatment plan that reflects the complex nature of human beings. Adhering to the findings of individual studies without seeking to synthesize them in any way not only fails to improve the possibilities for treatment (which is said to be the supreme objective of EbM), but inevitably leads to a restriction and hence a deterioration of the treatment situation. People suffering from disorders are not clones of study groups; they are always originals. Not to mention the fact that – contrary to what the prevailing symptom-based EbM would have us believe – in everyday clinical practice what we encounter is not the disorders themselves but rather whole human beings suffering from particular pathological states and features.

Considerations like these formed the starting point for evolving a form of "psychosomatics" that focuses not only on fragments and constructs but on the whole person. This approach, which we call HbM, no longer finds its theoretical basis in the positivism of the modern era, but rather owes its central maxims to the post-modernist ideal that ultimate truths or objectivity in identifying the cause of illness remain hidden from us for theoretical reasons alone: all being is always dependent on context and thus subject to change; language as the basis of our thinking has multiple meanings, and it changes in and through its use; the observer always remains part of the system, so that he himself becomes an important part of the input leading to the results that he then describes as "objective" (4). A medicine built on such foundations

must not necessarily culminate in an "anything goes" situation (16) without truths or reference points. On the contrary: HbM as envisaged here, focuses on the whole individuum. The absence of ultimate truths opens up the possibility of simultaneously recognising different, even apparently contradictory truths, which may emerge in the course of a multidimensional diagnosis.

HUMAN-BASED AND EVIDENCE-BASED MEDICINE ARE NOT MUTUALLY EXCLUSIVE

The main theoretical premise of HbM, the dependence of being on context, enables the simultaneous coexistence of several apparently contradictory "truths". EbM and HbM are thus not mutually exclusive opposites; rather, despite superficial differences in methods of diagnosis and treatment, EbM must be integrated into HbM as an indispensable component of the latter. The risk of a "pure HbM" with absolutely no evidence-based foundation is that medical decisions in diagnostics and treatment will be based solely on the subjective experience of individuals, with which the earlier problem of an "eminence-based medicine", i.e. medicine based on the subjective clinical experience of more or less highly respected clinicians, would reappear in everyday medical practice. Subjective experience alone is too little, pure evidence based only on HbM-based medicine that builds upon the principles of EbM and which focuses on the individual will make it possible to provide treatment that is designed for people. Since the chief focus of HbM is no longer a pathological construct but rather a human being suffering from an illness, the multidimensional diagnostics of HbM as an extension of traditional categorical diagnostics (the domain of EbM) must be primarily oriented towards individual phenomena. The aim is to analyse the phenomenon itself and above all the underlying mechanisms from different perspectives (e.g. psychological, biological, interactional, economic and social etc.) in order to create a basis for a pathogenesis-oriented therapy (4).

Physical and mental disorders are not concrete constructs, which simply emerge and then continue to exist merely because they have been emerged. Rather they are dynamic processes subject to a certain patho-plasticity whose course is determined by disease-preserving factors. Hence multidimensional diagnostics of this kind must likewise always be process-oriented. Illnesses arise not only as natural phenomena but also in the narratives associated with them (17). These narratives not only provide meaning that is intertwined with the pathological process but actually interfere in the pathological process as disease-preserving factors and thus themselves become elements determining the illness. Understanding pathological events and the narratives connected with them thus has a special role to play in a differential process of diagnosis.

Probably the most important difference between EbM and HbM is in the treatment aims. In HbM the goal is no longer simply to make illnesses disappear but rather to allow the patient to return to a life that is as autonomous and happy as possible. In other words: the human being with all his or her potential and limitations once again becomes the measure of all things. This also implies, however, that the multidimensional diagnostics of HbM are oriented not only towards symptoms, pathogenesis, process and understanding but also to a greater degree towards the patient's resources. HbM treatment above all involves a completely different therapist–patient relationship. The former diagnostic and therapeutic monologue (18) directed at medical analysis should be replaced by a warm-hearted dialogue; where "psychoeducation" used to play a primary role, a more profound understanding must now evolve based on the principle of reciprocity. The patient is no longer viewed as a person on the opposite side of the table who simply has to be treated according to the latest therapeutic guidelines, but as an Other who is met in the diagnostic and therapeutic process on an equal footing in a genuine dialogue. A psychosomatic treatment unit can thus become a meeting place that is characterised by lived reciprocal hospitality (19).

The treatment of the individual is not now focused exclusively on his or her deficiencies but instead on resource-oriented strategies. The idea is to create the space and the atmosphere in which all that can be done for the individuum afflicted by mental illness becomes possible. In contrast to earlier moralising approaches to therapy, in which the therapist, like a kind of coloniser or missionary, told the patient, what was right or wrong with his life, HbM therapy focuses on patients' wishes and potential for development, which the therapist strives to discover in the course of real dialogue.

SOCIAL AESTHETICS

Such a human-centred treatment also requires the development of a new aesthetic in psychiatry to create an appropriate basis for this kind of therapeutic process. Berleant (20), one of the fathers of social aesthetics, defines social aesthetics as "… an aesthetic of the situation…". Like every aesthetic order, social aesthetics is contextual. It is also highly perceptual, for intense perceptual awareness is the foundation of aesthetics. Furthermore factors similar to those in every aesthetic field are at work in social aesthetics, although their specific identity may be different … creative processes are at work in its participants, who emphasize and shape the perceptual features." The main components of social aesthetics are full acceptance of others (esteem), heightened perception (perception of all sensuous qualities), freshness and excitement of discovery (fascination), recognition of the uniqueness (person/situation), full personal involvement (engagement/opening), relinquishment of restrictions

and exclusivity, abandonment of separateness (places/atmospheres), and mutual responsiveness.

A social aesthetic for psychosomatics, which has already begun to take shape but must be further developed (21). It has the task of cultivating interaction between the patient and the therapist – in particular the initial contact, which is so important for the further progress of treatment – to fill empty rituals and modes of behaviour in the therapeutic setting with humanity, to create a fruitful atmosphere in the treatment room and to incorporate genuine friendliness in the day-to-day hospital environment, to deconstruct barriers and to open up boundaries and to facilitate enjoyable situations and relationships despite the suffering caused by illness in order to open to the patient aesthetically agreeable perspectives for the future (21). Treatment options and forms of therapy that have been and can continue to be developed from such a social aesthetic do not, as in EbM, put the disease construct at the centre of the diagnostic and therapeutic interest, but aim primarily to reopen possibilities for the patient. The goal of such a HbM that is based on the premise of social-aesthetics and, which on account of its pretension to totality, must always be human-based psychosomatic medicine, cannot just be to restore physical function, it must always include psychological health. However, mental health, as defined in the WHO-criteria of 1949 as not just the absence of mental disorders or disabilities but as a state of complete mental well-being (22, 23), is only achieved when the patient is once more able to live an autonomous and largely happy life (15, 24). The main task of HbM, (also within the meaning of comprehensive psychosomatics, as formulated by Emiliano Panconesi (25, 26) at the beginning of the 21st century), is therefore to open up possibilities for individuals suffering from any kind of illness to exercise personal autonomy and live a happy and thus healthy life (27). This kind of humanistic approach to therapy, in which the human being once again becomes the measure of all things, can only be realised in clinical practice via multidimensional diagnosis methods and treatment within the scope of inter-disciplinary cooperation.

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