

OPINION ARTICLE

Patient-Oriented Medicine: a Therapeutic Revolution

L Dubertret

Service de Dermatologie, Hospital Saint Louis, Paris, France

Medical research aims to advance knowledge of disease, and by definition, focuses on broad populations that share certain clinical and biological anomalies.

A new disease is discovered when an original set of clinical and biological symptoms common to a number of patients is identified. Relating the symptoms of a particular patient to the symptoms that identify a particular disease is the basis of diagnosis. The cause of a disease is pinpointed by identifying a common cause–effect relationship in all patients sharing the same symptoms. Treatments are evaluated against placebos or reference treatments by testing efficacy and identifying side effects in large populations of patients.

Therefore, evidence-based medicine must create abstractions of the individuality of patients and of the factors that distinguish them from other patients.

Although scientific medicine is necessary for a diagnosis and unsurpassable in terms of managing acute situations, for patients whose disease is expressed over the long-term, it only proffers a real benefit if complemented by other medical approaches that enable knowledge acquired for populations to be applied to individuals.

Patients—even those with common diseases—differ in terms of their expression of the disease and in terms of response to, and tolerance of, treatments. They also differ in the way a disease affects their daily routines, in the way they perceive treatments, and in their capacity to assume responsibility for treatment.

In Europe, a new approach to medicine is beginning to take hold—under the umbrella of patient-centered medicine—that undoubtedly represents one of the most important therapeutic advances of the beginnings of the 21st century.

New therapeutic approaches tend to develop initially in medical specialties that manage chronic diseases which do not endanger life but whose severity is linked to what are often very significant effects on quality of life. It is impossible,

therefore, to think in terms of quality of life and not to shift the focus from the disease to the patient.

The patient-centered management approach was first applied in the dermatology field to diseases such as psoriasis. Psoriasis does not reduce life expectancy, but often has very significant effects on a patient's socialization—reflecting a disease that could, in fact, be represented as a skin-related disability. A consensus of European psoriasis experts considers the severity of psoriasis to be connected to 3 factors, namely, the degree to which it affects quality of life, the development of treatment resistance, and the body surface area affected. The last item, which is both objective and measurable, has traditionally been considered to be the main severity criterion.

With most acute diseases, it is the doctor who evaluates severity. In diseases whose main impact is on quality of life, however, only the patient can evaluate the day-to-day repercussions and, by extension, the severity of their disease. This evaluation is crucial, given that it will indicate or rule out the administration of potent treatments that may prove effective but at the cost of significant side effects. The most important issue in treatment is clearly the risk–benefit relationship, but given that quality of life is the central issue, only the patient—with the help of their doctor—can really evaluate the benefit of a treatment. The undesirable effects and discomforts associated with the use of a medication (whether administered locally or systemically) are also important, particularly for chronic diseases, due to the negative impact that they will have on a patient's quality of life. It would be pointless to substitute the discomforts associated with the disease for greater discomforts derived from the treatment—something that, in fact, frequently occurs in practice.

A chronic disease cannot, therefore, be properly treated without the informed and responsible cooperation of the patient. Nonetheless, patients who consult a doctor are usually looking for a solution, a remedy, or a prescription and are not prepared to evaluate how their lives are negatively affected by their disease or to cast a critical eye on the treatments offered them. Experiencing their disease as an external aggression, they expect medicine to liberate them in the same way as it provides a cure for an infection or appendicitis.

In the course of a series of visits with a patient, the doctor therefore needs to clear up this misunderstanding, and

Correspondence:
Louis Dubertret
Service de Dermatologie
Hospital Saint Louis
1, Avenue Claude Vellefaux, 75475 Paris Cedex 10, France
louis.dubertret@free.fr

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furthermore, develop a management approach that makes patients responsible for their disease and its treatment. This approach will lay the groundwork for a therapeutic negotiation that culminates in the patient making a therapy choice with the assistance of the doctor, rather than in a prescription.

The 4 stages in this patient management approach are investigation, explanation, negotiation, and prescription.

Investigation

The investigation phase will enable the doctor to understand the family, social, and professional circumstances of the patient, to identify the health context in which any given therapeutic strategy will unfold, to evaluate the severity of the psoriasis together with the patient, and to assess the patient's capacity for self-management, as well as the patient's objective and subjective relationships with both the disease and the various treatments tried in the past. Finally, the doctor will learn what the patient expects of the visit.

Questions on age, work, working conditions, the duration of the psoriasis, a family history of psoriasis, etc, will allow an initial picture to be obtained.

Age is an important factor and, above all, physiological age. For example, with older patients, a nurse may be needed to apply local treatments, retinoids should be administered in small doses, methotrexate doses should be adapted to take into account the fact that kidney function diminishes with age, and account should be taken of the fact that older patients experience greater side effects with cyclosporine.

It is also important to be aware of the patient's weight, and in particular, whether the patient has gained weight recently, given that adult psoriasis often worsens in line with weight increase. Obesity reduces the efficacy of local and systemic treatments and increases the risk of side effects. Blood pressure affects whether or not cyclosporine can be used. High cholesterol is an indication for close monitoring of patients being treated with retinoids, which are contraindicated in patients with significantly increased triglyceride levels.

Liver disease (eg, hepatic steatosis, incipient cirrhosis, or chronic hepatitis) is almost always a contraindication for the use of methotrexate and would necessitate consultation with a hepatologist.

Although smoking generally aggravates inflammatory skin reactions, the stress associated with giving up smoking—occasionally associated with a significant weight increase—may lead to an outbreak of psoriasis.

Work—and above all, working conditions—will render some treatments impossible. Local treatments or phototherapy are practically impossible for patients

working long hours or patients who travel frequently, respectively. A combination of frequent business lunches, reduced physical activity, and increased professional responsibility is particularly propitious to the development of psoriasis.

Questions about work also provide an insight into the impact both of work on the patient's quality of life and of psoriasis on the patient's working life.

It is also important to know what medication the patient is taking, as this will enable the doctor to better identify associated diseases, as well as treatments that may aggravate the psoriasis, such as suspending the use of systemic corticosteroids, lithium, β -blockers, interferon, and—according to more recent information—calcium antagonists.

Certain drugs may contraindicate the use of particular psoriasis treatments; for example, co-trimoxazole is contraindicated in patients taking methotrexate, and many drugs interfere with the metabolism of cyclosporine.

Questions about previous treatments provide very valuable information, not just about the kind of treatment, but also about the strategies used. This information enables the doctor to assess previous patient compliance with different treatments and to establish why compliance may not have been optimal.

Allowing patients to give their opinion on previous treatments will ensure a better understanding of what they expect and the inconveniences they are capable of tolerating. A treatment may have been disappointing because the strategy used was inappropriate or because the treatment was stopped as soon as the skin lesions disappeared. Consequently, it is particularly important to know whether a relapse was perceived to occur during or after a treatment, as this will enable the doctor to evaluate whether there is resistance to a previous treatment (one of the severity factors mentioned above).

Throughout the investigation, the doctor needs both to assess the patient's degree of demoralization regarding the psoriasis and to identify the therapeutic discomforts that the patient is willing to accept.

By this stage, the investigation can focus on an issue that is central to therapeutic management, namely the severity of the psoriasis and the context in which it develops.

If the psoriasis commenced recently, a crisis situation may need to be confronted. Patients do not spontaneously view themselves as implicated in their psoriasis. Their perspective on therapy is often that of the antibiotic that cures by exterminating an external invader or the scalpel that separates the bad from the good. The investigation phase will, in this case, be particularly important, because the nature of the questions themselves will invariably modify the reasoning processes of the patient. Patients will gradually discover that their psoriasis goes beyond its physical expression and has repercussions on many aspects of daily

life. They will become aware that they must assume responsibility for improving their own image with the help of their doctor, that they must improve their quality of life, and that, as a consequence, their participation in the choice of treatment is essential. Hence, questions will move onto issues of stress, possible sources of conflict, the quality of a patient's relationship with him/herself and others, and the essential elements that define the patient's quality of life.

If the psoriasis is an old acquaintance that the patient has progressively adapted to, for better or for worse, over the years, the doctor will need to evaluate how the disease has affected the patient's relationships with him/herself, with a partner and children, and with others. Other related questions will explore whether the psoriasis has caused a patient to miss out on opportunities, has had negative repercussions on their professional career, or has affected their possibilities for choosing a sport, their way of dressing, or their choice of holidays.

Did the appearance of the psoriasis coincide with some major life event? Are the circumstances that led to the expression of the disease still present? What plans does the patient have to modify these circumstances and thus assume control of his or her disease (or at least of what it expresses)?

Is the patient capable of accepting a relapse after a period during which the disease was absent without feeling more demoralized than before? Is the patient willing to undergo intermittent treatment?

Is the anguish provoked by the psoriasis constant or does it occur only at specific times of the year as a result of affecting certain specific sites? Is this anguish proportional to the actual visibility of the lesions? (In this case, the doctor should test for a personality disorder that affects body image and should probably consider arranging for psychological support.)

Given that patients with a chronic disease tend to organize their lives around their disease in order to minimize their anguish, it is important to assess the extent of this restructuring so as to discuss both the best way of administering a particular treatment and strategies for its use.

In this way, a doctor begins to build a holistic picture of a possible therapeutic scenario for a patient.

Can emergency treatment of the lesions produce an improvement that can be taken advantage of to help the patient reassert control over his/her life and to shift the focus to maintenance treatment (with all that this entails for the patient, the doctor, and the treatments)?

Alternatively, will it be necessary to choose a longer-term strategy that ensures gradual improvement in the patient's quality of life?

This stage of the investigation does not end here, as the disease and treatment explanation phase (described below) will pose new questions, highlight the importance of certain

questions, and enhance the quality of responses, given that the explanations will help the patient understand the problem and, in turn, enable him/her to make an informed choice about treatment.

Explanation

Explanations need to be given in regard to both the psoriasis and the possible treatments available so that the patient can actively participate in choosing their therapy.

Psoriasis should be explained as a polygenic disease that responds to, but is not directly caused by, environmental factors, infections, seasonal changes, stress, drugs, skin irritations, etc—anything, in fact, that accelerates skin renewal. It is also important to determine which of these factors are relevant to the patient. Plaque psoriasis occurs as a consequence of a rapid renewal of the skin, resulting in flaking and an aggressive inflammatory reaction that perpetuates the condition. The mere act of scratching or removing flakes accelerates the skin renewal process (just 5 minutes of scratching is sufficient to reactivate the psoriasis for 2 weeks), which is why treating pruritus is a key issue in treating the underlying psoriasis.

The patient also needs to understand that psoriasis is neither contagious nor life threatening, and that its severity depends on how it affects quality of life. Only the patient, therefore, will be able to assess the severity of the psoriasis and whether major treatment—potentially risky treatment requiring close monitoring—will be absolutely necessary.

Different treatments rely on different mechanisms to slow down skin renewal. If a treatment is suspended once plaques disappear, then relapse is likely to occur almost immediately. For this reason, it is crucial to continue treatment after the lesions have disappeared. The skin continues to appear completely abnormal under the microscope 6 months after the disappearance of psoriasis plaques; consequently, treatment is usually continued for a year after their disappearance.

It cannot be emphasized enough that the ultimate aim of psoriasis treatment is to improve quality of life; thus, only the patient can really evaluate treatment efficacy. Patients are not necessarily condemned to continuous treatment; treatment can be based on specific times of the year or body sites, depending on a personal formula for balancing the discomfort caused by the disease and that caused by the treatment.

This second phase therefore refers to explanations in relation to the individual local or systemic treatments available, their method of use, how they will affect a patient's daily life, their side effects, and the monitoring strategies used.

Negotiation

From the perspective of patient-centered medicine, negotiation is the most important phase in terms of taking responsibility for the patient's treatment. This phase unfolds from one visit to the next as the patient becomes more informed via questions, answers, and explanations. The patient thus develops a capacity for dialoguing with the dermatologist as an equal with a distinct but complementary point of view. The aim of the negotiation is to achieve the best possible compromise between discomforts associated with the disease and those associated with the treatment. As with all successful negotiations, the doctor and patient should feel that they have reached agreement on the best possible compromise for a particular moment and a given situation. This approach ensures vigilance and therapeutic efficacy.

Prescription

Under no circumstances do we refer to prescription in the sense of imposing a treatment, given that negotiation, by implication, forms the basis for a doctor–patient agreement that is underwritten by both. Although this new approach to therapy may unfold in different ways in different medical specialties, the ultimate aim is to release patients from the relative imprisonment (to which doctors sometimes contribute) implied by their disease. This represents a revolution in the doctor–patient relationship.

Skin diseases, by affecting self-image, often severely affect the social relationships of a patient, whose sensation of being imprisoned within an impaired image is felt very intensely. This is an issue that goes beyond dermatological disorders (or any disease), as the knock-on effect from the organ itself can completely destabilize the individual's social functioning.

The organ must be cured, of course, but a patient's social life must also be reestablished, and this is impossible without the active, informed, and responsible participation of the patient, given that it is very difficult to free anyone against their will.

For thousands of years, medicine has had the patient as its focus, empathy as a treatment, and death as a constant companion. The development of medicine based both on evidence and on increasingly inspired therapeutic tools has focused attention on the disease and on highly effective treatments.

This progress has enabled a better understanding of the role played by the nervous system (and, consequently, by the emotions) in controlling immune reactions, inflammatory responses, and cellular proliferation in a wide range of organs.

It is natural that organ-focused medicine—mobilized in the battle against disease—has begun to uncover the individuality of the patient. This awareness forms the ideal basis for a much more effective and beneficial sharing of tasks between specialists and general practitioners in a way that facilitates holistic management that has the patient at its center.

Medical advances in general, including those in evidence-based medicine, demonstrate the urgency of implementing approaches that ensure the best possible application of generalized knowledge to specific individuals, and consequently, the importance of developing what we refer to as patient-centered medicine.

Is this new approach merely a return to humanistic medicine? Quite the contrary; this approach is crucial to the effective management of long-term disease, and does not necessarily have any bearing on the nature of the doctor, his/her capacity to display empathy, or the patient's desire for independence.

The artificial distinction drawn between the technical medical specialist and humanistic doctor as 2 entities in opposition must disappear. Doctors today need to use all available scientific knowledge in the light of their own experiences and the individual circumstances of the patient, in order to be able to help patients choose the means for reestablishing physical and psychological equilibrium. It is noteworthy that there is an increasing tendency for patients to bring doctors documentation on their illness downloaded from the Internet. The stance adopted by the patient is unequivocal: "I found this on my disease and its treatment, doctor, and I want to talk to you about it." Today's patient, therefore, has already typically entered the third phase—negotiation. However, this does not preclude the need to return to the 2 preliminary phases (investigation and explanation); quite the contrary—the investigation and explanation phases will be enriched as a consequence.

The question is, however, whether this new approach to managing a patient is genuinely feasible. Unfortunately, in the current climate in which medicine is practiced, the answer can only be negative. This approach needs time to be developed, and time is a scarce resource for doctors nowadays. If the management of chronic patients is to be improved, it is essential to allow doctors to invoice not for a visit but for their time (if only for a half or full day a week). This would not increase healthcare expenditure, as there would be no change in the prescriptions for this day or half day.

As for the issue of adapting medical training, some courses are already incorporating this new approach. Rheumatology has witnessed an early attempt—referred to in terms of "the patient-as-colleague"—consisting of organizing small work groups involving medical students and patients willing to collaborate with special training. These meetings are aimed at making students sensitive

not just to issues concerning a disease but also those affecting the patient as a whole.

That said, this revolutionary care strategy will undoubtedly have greatest impact in the area of ongoing medical training. It will require the development of completely different training techniques, which will enhance traditional training methods based on the expert imparting knowledge to learners. In ongoing training seminars, facilitators will present case studies that will take account of all the elements of an individual patient, and participants will propose different ways of managing these cases. Such seminars will conclude with an explanation of the management approach adopted (and why) and the outcome. This kind of ongoing training will enable patient management to develop not just from the point of view of the disease but also from that of the patient.

The development of drugs would also be affected by this new perspective: a drug would not only be required to be efficacious, but would also have to improve quality of life. Patients would also need to be provided with all the information necessary to enable them to participate in choosing a therapy. In this context, health education becomes a priority that requires close collaboration between doctors, the pharmaceutical industry, and public authorities.

In this new approach to management, patients assume control of their disease and, in turn, of their medical history. They become responsible for their own health, and in turn,

for healthcare expenditure—since society cannot assume absolute responsibility for all healthcare costs—and so will rapidly begin to participate in the financial management of healthcare spending. They can do this, for example, by voting at the local level (in local authority elections), provided they first have all the information necessary to inform their decision in a context of budgetary ceilings. If healthcare continues to be managed on the basis of a pyramid system (even if power is delegated to the regions, which represents a mere displacement of the object of dissatisfaction), individuals will become increasingly dissatisfied and the healthcare system will collapse.

Patient-centered medicine is not likely to reduce the power of doctors. By enhancing patient knowledge and freedom, in fact, medicine reveals its true function, which is to cure an equal. Doctors become indispensable as human beings as they render their medicine superfluous by liberating their patient from disease.

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Conflicts of Interest

The author declares no conflicts of interest.