Brera GR. & ITFOP Person-centered clinical Method and its teaching Pers Cent Med Int J [Internet]. 2025 Nov 10;XV:ID1. ©2023.
Available from: http://www.personcenteredmedicinejournal.itISSN: 2037-5522

Person -Centered Clinical Method and its Teaching

Giuseppe R. Brera [1 2 3]

&

ITFOP-Italian Task Force for Person-Centered Medicine

Mariangela Porta MD,MA ***. V Galante MD MA, Domenico Francomano MD MA,*** F. Della Croce MD MA,*** ,Paolo Garascia MD MA ***, A.Licari ***, A. Zanon MD.MA,* L. Berti MD,MA,* M.G. Zannoni MD MA+,** P. Pinciaroli MD MA ,** I. P. Pissavini MD MA,** L. Mattaini MD ,*** L. Piazzai MD MA ,*** M. L. Schiavi MD MA,*** M. G. Giuliani MD MA,*** P.Tambaro, MD MA ,*** I.P. Callegaro MD MA,*** M.R. Giovinazzo MD MA,*** G. Ciarelli MD MA*** A. Ciccarelli MD MA,***A. Nicita MD,*** F. Caroli MD MA,***G. Morganti MD MA,*** , A. Pelegatta MD,MA*** ,P. Marchetti MD MA ***, G. de Giorgi MD MA ***, L. Cardi MD MA ***, G. Soliani MD MA, G. Reina MD MA***, A. Battista MD,MA***. [4]

[1] Milan School of Medicine –Università Ambrosiana

[2] Corresponding author : Prof. Giuseppe R. Brera, MD Vle Romagna 51, 20133 Milan gbrera@unambro,it

[3] Brera GR. Education in Person-Centered Clinical Method and perceived quality of Person-Centered Clinical Method. In: Proceedings of the 1st International Symposium on New Perspectives in Medical Education; 2003 Oct 24; Assisi, Italy. Internet

[4] * cooperated in PCCM teaching and application the teaching procedures ** cooperated in evaluating PCCM teaching method quality and experimenting the teaching procedures learning *** cooperated in evaluating PCCM with case reports and clinical discussion and experimenting the learning procedures

Aknowledgements

To Prof. Angelo Bignamini, PhD for statistical analysis

To dr Josie Caruso for the linguistic editing

Abstract

Objective

Clinical method is the basis of medical science, but to our knowledge up to now there have not been investigations regarding its effect on the quality of the medical practice. Person-Centered Medicine is a new inter-actionist and teleonomic paradigm of medical science, structured on the integration of humanities, biologics and clinics. This paradigm has developed a new standard of clinical method: the "Person Centered Clinical Method"

The aim of this study is to investigate the quality of the first application of the Person Centered Clinical Method (PPCM) on a sample of three years by trained physicians.

Method

This is a descriptive pilot study. 20 Physicians (7 medical practitioners, 6 Paediatricians, 3 hospital doctors, 4 private doctors) accepted to fill out a questionnaire on " PCCM Quality in Medical Practice" and e-mail it upon completion. Questionnaire items, positive answer rates on the perception of change in medical practice,

associations with the role of the physicians were studied with descriptive statistics and cross tabulations.

Results

Physicians state that PCCM improves the comprehension of patients (95%) and the health and life quality of patients (75%), avoids useless examinations and drug prescriptions, (70%) spares unnecessary hospitalizations (55%) but requests more time dedication to patients (55%). PCCM effectiveness in saving useless examinations and drug prescription is significantly associated to the medical role (P=0,02). MP (100%) and Paediatricians (85%) declare that PCCM is effective in sparing useless examinations, drug prescription and unnecessary hospitalizations . There is general agreement about the necessity and importance of learning and spreading PCCM.

Conclusion

MCCP leads to enhance the quality of medical practice. Most impressive are the abilities that PCCM has in improving skills in comprehending the problems of patients, in saving unnecessary examination and drug prescriptions, and in enhancing the quality of life and health in general.

Background

Socrates…… Well then, could we ever know what art makes man himself better, if we were ignorant of what we are ourselve
Alcibiades: Impossible ! [5]

Plato first formulated the epistemological basis of knowledge beginning from the lesson by Socrates.
We can know an object only if we know its nature but humans are subjects, not objects. "Who is" this subject is the first question when we need to cope with person-centered sciences like medicine.
"To be" a person is something more than a biological function or structure.
The Roman philosopher Boetius tried to define the person as an "Individual substance of intellectual nature". In epistemological and

[5] Plato. Alcibiades major http://www.ac-nice.fr/philo/textes/Plato-Works/07-Alcibiades.htm

methodological studies, the concept of the person is well-suited to medicine because its applications stresses care of the individual and the prevention of human suffering. Clinical applications are traditionally founded on the synthesis of seven person –centered investigation fields: knowledge of reactions to psycho-biological laws, the structuring of the unrepeatable and unique individuality of human nature from conception to natural death, an ethically based relationship with a suffering person, knowledge of pathogenesis of clinical syndromes and/or pathological behavior, diagnostic methods, treatment, and communication skills. Nevertheless , up to 1999, there has not been an applied theory of clinical method addressed to know

" who is" the person beyond his biology or empirical symptoms and not even teaching procedures.
The paradigm of Person-Centered Medicine (PCM), introduced in 1998,[6] [7]presented in WHO in 2011 [8], is the first formulation of a cohesive explicit ethical, epistemological and educational paradigm in the history of medicine. The paradigm is structured on a theoretical model founded on enunciations corroborated by ethics, humanities ,

[6] Brera G. R, The manifesto of Person-Centred Medicine. Medicine, Mind and Adolescence 1999.XIV, 1-2:7-11

[7] Brera G.R The shift of Medicine to Person-Centered Paradigm . Scientific reports of the Milan School of Medicine. 1-2023 DOI 10.13140/RG.2.2.20291.58405
Internet.
https://www.unambro.it/html/pdf/The%20Medicine%20shift%20to%20the%20Person-centered%20Medicine%20paradigm%20(2).pdf

[8] WHO Person-centered Medicine and Medical Education. (internet) Geneva : WHO Symposium; 4 May 2011. WHO Available from
http://www.unambro.it/html/pdf/All_Symposium_Education_People_Centred_4May2011.pdf

psychobiology and psycho-neuro-endocrine-immunology epigenetics PCM structure is based on:

1. ***Teleonomia*** *of human nature as evidenced by cognitive [9], psychodynamic research [10] and phenomenology. Teleonomy depicts clinics as an ethically founded relationship between two persons finalized to construct new possibilities for the person's reality toward the realization in existence with an harmonic meaning founded on objective values of cognitive (truth), affective (love) and spiritual (meaning) nature [11].*

2. ***Ethical meaning of medical science*** *founded on Hippocratic[12] and anthropological western objective values[13].*

3. ***Interactionism ; Three-dimension interactionist nature of human person:" Body-Mind –Spirit"*** *according to genetics,[14]epigenetics [15]psycho-neuro-immune-*

---

9 Piaget J. The Psychology of intelligence. New York :Harcourt Brace, 1947

10 Fornari F. Genitalità e Cultura, Milano: Feltrinelli, 1973

11 Brera G. R. The kairos of existence. Mystery, Possibility and Reality in Adolescence and Human nature. Milano: CISPM; 1994.

12 Jouanna J. Hyppocrate. Paris: Librairie Artème Fayard,1992

13 Brera G.R Creativity in medicine. Ethos, Pathos and Pietas. Medicine and Mind. 1984; Jan. 2 : 3-10.

14 Strohman Richard. Manoeuvring in the Complex Path from Genotype to Phenotype. Science. 2002; 296: 701-703

endocrinology [16] [17] [18], quantum medicine, research and survival studies.[19] "Spirit" means the quest for a meaning in existence (fig.1).

4. ***Overcoming the deterministic approach to medical science*** *in the light of the theory of relativity of biological reactions to coping possibilities[20] and quality corroborated by genetics[21] [22], psycho-neuro-biology[23] [24] and psycho-neuro-*

---

[15] Blackburn EH, Epel ES, Lin J. Human telomere biology: A contributory and interactive factor in aging, disease risks, and protection. Science. 2015;350(6265):1193-8.

[16] Shavit, Y. . Stress-induced immune modulation in animals: opiates and endogenous opioid peptides. In Ader, R.,Felten, D., & Cohen, N. (eds.).Psychoneuroimmunology. Academic Press; 1991.

[17] Ader R. Felten, D., & Cohen, N. eds. Psychoneuroimmunology.: New York :Academic Press.;1991

[18] Laundeslangers M.L.,Ryan S.M.,Drugan S.F.F et al.. Coping and immune-suppression : inescapable but not escapable shock suppresses lymphocytes proliferation. Science. 1983; 221 :568-570

[19] Field T, Diego M, Hernandez-Reif M, Salman F,et al. D**.** Prenatal anger effects on the fetus and neonate. J Obstet Gynaecol. 2002 ; ;22(3):260-6.

[20] Brera G. R**.** The relativity of biological Reactions and the first Formulation of and interactionist epistemological paradigm for medical science and its application in clinical research and medical education. Medicine, Mind and Adolescence. 1997; Jan. 1-2: 7-15.

[21] Wilet C. Walter. Balancing Life Style and Genomic Research for Disease Prevention. Science. 2002; 296 :695-699

[22] Rees Jonathan . Complex Disease and the New Clinical Sciences. Science. 2002; . 296 : 698-701

immunology [25] *.Health appears relative to quality of interpretation experience possibilities . (fig.2-3-4)*

Since 1987 at the Italian Institute of Adolescence Medicine and Psychology, of the Italian Centre of Medical Psychology and from 1995, at the Department of Adolescentology and Adolescence Medicine at the University Ambrosiana, and then at the Milan School of Medicine (1998) these theoretical enunciations have lead to a person-centered qualitative reformulation of health with the introduction in the PG Medical education curriculum of Medical

Counselling and Person-Centered Clinical Method (PCCM) clinical procedure, a person-centered case sheet and educational objectives[26] along with an experimented teaching method . [27] [28] [29]

---

[23] Rossi E.L . The Psychobiology of mind-body healing. New York: Norton & Co, Inc., 1986

[24] Liu D., Dorio J., Tannembaum J. Maternal care, Hypocampal Glucorticoid Receptors and Hypotalamic-Pituitary-Adrenal Responses to stress. Science. 1997; 277:1659-1662

[25] Fawzy F.L ,N.Y.Fawzy, and al. Short term psychiatric intervention for patients with malignant melanoma: effect on psychological state, coping and the immune system. in C..E. Lewis, C.O'Sullivan, and J. Barraclough eds. The Psychoimmunology of cancer Oxford,.New York, Tokio Oxford University Press; 1994: 291-320

[26] Brera G.R. .Person Centered Medicine and Medical Education in the Third Millennium. Pisa, Roma: : .Edizioni Poligrafici Internazionali , 2001 (It)

[27] Brera G.R. Person-centered Medicine: Theory,Teaching,Research. Int.J.Pers. Cent.Med 2011; 1 \ (1):69-79

[28] Brera G.R Person-Centered Medicine and Person-Centered Clinical Method. Università Ambrosiana ed.; 2021 ISBN: 9798756383423

During these years, progressive improvement of the educational method was such as to reach a definitive, educational procedure in 1999-2000, in a quality system

1.1. Person-centered clinical method learning objectives

Educational training of physicians in Person-Centered Clinical Method (PCCM) comprehends new verbal and non verbal abilities with the introduction of a new first phase of clinical examination called: “Diacrisis”. The final objective is to perceive and organize the qualities of a new person prior to considering him/her as “ a patient”. At the end of their clinical training, physicians are able to carry out the following clinical objectives step by step:

Time 1 “**Empathy” (E)**

Perceiving and interpreting the 1 minute empathic phenomena at the beginning of clinical inter relationships. Problems that are a threat to the life of a person demand an immediate diagnosis and treatment. If this condition is non existent and/or if there are any possibilities for a relationship (the patient does not have the opportunity for a sensorial

and conscious relationship with a physician) , it is then necessary to move on to time 7

Time 2 **“ Build a Personal Relationship**” **(BPR)**

Ask the person : *"In what may I be of help*" or "*Why did you come here"*

Time 3 **Listening to the person's problem (LPB)**

The Physician listens to the reason of the person for requesting his help.

Time 4 **Clinical EPOKE (CEK)**

Upon listening to the problems of the person, the physician must enclose within quotations that which the patient has referred :

" Now, before examining your problems, please tell me about you"

Time **5 Person Diagnosis (Who-Whose-Why) : Giving Space to Word (GSW)**

At this time the physician must ask himself: "*Who is the person I'm speaking with?",* and must ask questions on behavior, relations (affective and family as well as social) , communication, and work, (if the patient is an adult) and on education and other interests, (if a student) .
Particular attention will be given to the ability of the patient to symbolize in both a verbal and non verbal manner, to perceive empathic phenomena, identify incoherencies among them and

interpret them. Of great importance will also be conscious or unconscious choices that give meaning to life such as the religious

beliefs of the patient. Physicians have been prepared to give space and time to the words of the patient ("Giving space to the words") perceiving, identifying and interpreting (if necessary) an empathic phenomena during discourse. *At this time the physician must focus his attention on the person not on the hypothesis for diagnosis*. Physicians must give their maximum attention to gathering information which assesses *points of strength, resources, problems and threats of various degrees, belonging to the three-dimensional world (body-mind and spirit) of the person,* recording them as events and life history and looking for acute and/or chronic stressors and for possibilities, quality of coping styles.

The quality of beliefs and health behavior, more or less satisfying human relationships, the ability of communicating and expressing one's own thoughts and feelings, to symbolize one's own inner and world experiences, his achievements and satisfactions in any field (school, work, hobbies and projects), an open, hopeful and creative attitude toward life, and quality of affective relationships, reliable supports, and along with the existence of positive or negative acute and /or chronic stressors and coping styles, help the physician in depicting the portrait of the persona and trace a history through which he will easily *reach at a clinical comparison between protective and risk factors (health balance*) The first objective of this phase is to create an existential picture of coping styles of the person which contribute in building his life style. This is achieved by re-constructing his/her world, his/her health, his/her resources and problems and consequently, the answers he provides to the questions on the identity of the person. This project, if well carried out, will create hope and trust in the physician and more possibilities for the health of the patient, with a first therapeutic effect. Biological reactions can be modulated at this time yet with a neuro-biological

and endocrinological action. “Hope” and “trust” are the responsible affects which determine the “placebo effect” which is a psycho-neuro.-endocrine-immune reaction determined by subjectivity.
Health problems which have a conscious or unconscious meaning in the life of the person are considered constructs. Life choices and life style, whether conscious or unconscious, are stressful situations or health and resiliency factors or risk factors. *The epistemological assumption of the model is the natural tendency of a human being to an achieved unity where natural demands of a meaningful truth, love, and beauty are fulfilled*. Problems and/or empiric symptoms are part of this dynamic teleonomia toward a personal realization. Sufferance, an expression of an internal conflict on opportunities and limits, has been seen as the emotional -affective pathos in constructing a real awareness of the real meaning of life and can bring important and positive changes in the life of the patient.

Time 6 **Giving word to body (GWB)**

During time 5 and 6, the physician is educated in gathering information about referred problems and their history that must be situated in the lifestyle of the patient, biography and culture. An empiric evaluation of symptoms with a physical examination, can be postponed if not urgently required. This choice must be explained as a method for giving more value in the consideration of the person. At this time, physicians must create an atmosphere of cooperation, and avoid the common approach of treating patients as biological objects.

Time 7 **Clinical Objectives Assessment (COA**)

The physician must build a mental scheme where symptoms are composed of an analogical and hypothetic, clinical picture. The clinical picture must be composed of a *comparison between the*

resource of the person, points of strength related to age and life style and problems in order to create opportunities for recovering, promoting cooperation and action in creating new possibilities for the own health of the patient. (resilience factors). A biological emergency must be immediately treated.

Physicians have to be able to write a portrait of the person in a way in which it contains points of strength, resources, problems, threats and possibilities in creating and implementing, so as to improve the person and his/her life style while it permits him/her to find and find answers. Therapeutic projects must be used specifically for the person and his/her particular life style . Clinical objectives must be assessed and must comprehend finalizations for improving or creating the resources of the person.

The assessment of biological exams and drug treatment must be done only if necessary, and any real possibilities for treatment must be inserted in a qualitative interactionist evaluation of the strong points of the person , resources, problems and menaces for survival.

The unity of the person built in the mind of the physician can address person-oriented clinical choices

Time 8 **Clinical Synthesis (CS)**

The unity of a person built in the mind of the physician addresses clinical choices in assessing a hypothetic thinking about the nature of problems in that person. Hypothetic clinical diagnosis starting from symptoms and physiological data must be placed in analogical evaluation of hypothetic relations with empathic phenomena and person subjective resources and problems evidenced by "person diagnosis". In literary terms, the right result of this phase is a portrait of the person, in which the diagnostic and the therapeutic project is situated.

Time 9 **Therapy (TH)** *Philosophy of therapy is the creation of the best possibilities for improving the life style of the person addressed to build harmony between body, mind and spirit.(kairological paradigm). Enhancing hope and therapeutic alliance , neutralizing threats, improving resilience, buffering risk factors, is the philosophy which must inspire any therapeutic act.* The concept of possibilities for a person must take into account the natural teleonomy of the person and favor self-fulfillment of the person, realization according to age and the own limits and resources of the person. Implementation of possibilities means the implementation of resources and a different approach to limits. This is more evident in apparently desperate cases.
Through its psycho-neuro-immune-endocrinological action, any form of therapy must be accompanied by medical counseling geared towards the enhancement of the resources of the person for a conscious or unconscious therapeutic alliance while recovering.
PCCM has been formulated starting from a medical counseling method of study [30]

[30] Zanon A. Medical counselling teaching in the Prof Giuseppe R. Brera' lectures. Course in medical counseling. Milano : Università Ambrosiana , 1999.

Time **10 Clinical Assessment**

Evaluation of remission of empirical symptoms and improvement of physiological parameters must always be joined to an evaluation of the resources of a person at different levels:

Behavior quality and life style, relation, biology, spiritual values and ideals.

The core of PCCM is putting the problem into parenthesis (Clinical epoké) referred by the "person" by *asking him /her " to speak about his person* and *life style* when there is not an emergency case which requests an immediate diagnostic investigation and attention placed only on empirical symptoms and to hypothetic pathogenesis. In these cases, the attention placed on a conscious patient as a person and his cooperation could be determinant in collecting information useful for a diagnosis .

The physical examination, functional and objective evaluation is postponed to a dialogue which aims in creating an opportune time for permitting the person to be aware of his *own points of strength, resources and existential possibilities including spiritual values, relations, emotions, feelings, interests, ideals, styles of coping and behavior.*

In 1993 the Person-Centered Clinical Method teaching received the quality certificate UNI EN ISO 9001. For the first time a clinical procedure teaching was certified for its quality.

In order to create better possibilities for recovery, in a second time only, will the physician give space and time to a semantic and empiric

investigation of symptoms. This has the aim of creating an analogical correspondence among empiric symptoms, the semantics of their definitions, studying the relationship between the subjective and the biologic dimension of the person which must be situated in the life and relationships of the person.
The creation of "Medical Counseling" has been a great contribution to the development of the person-centered clinical method and, it has been for the first time applied in medical education in the program of Masters in Medical Counseling of Adolescents.

2. Objectives

The objective of this study is to evaluate the effects of P.C.C.M teaching on the quality perception of medical practice in a sample of trained physicians.

The research plan has been divided into Five Time Periods

Time 1 (1991-2000) PCCM assessment, the education and development of a learning evaluation system . Foundation of Medical Counselling Teaching theory (1991) and Person-Clinical Method and Medicine (1998)

Time 2 (2000-2002) : Education in using PCCM by a group of MD and evaluation of clinical abilities.

Time 3 (2002) Preparation and administration of the PCCM quality questionnaire to a volunteer sample of medical doctors at the end of their PG course.

Time 4 (2003-2004) Evaluation and analysis of results

3. Method

Research method concerned different objectives in different times and the assessment of different operational tools.

1. Assessment of the person -centered post graduate educational curriculum in medical counselling for MD (1991)
2: Assessment of teaching and evaluation tools (1991-1998)
3 MD Training in PCCM (1999-2002)
4 Idealize, assessing and distributing the PCCM Quality Questionnaire (2002)

5 Analysis of results (2003)

Time 1 (1987-1990)

a. Assessment of a three year post- graduate educational curriculum in Medical Counselling (1991)

At this time, one of us developed a shift in the epistemology of medical science and a three -year post graduate educational curricula in Clinical Adolescentology and in Medical Counselling at the Adolescence Medicine and Psychology Institute of Milan were invented. Prior to and during the same years (1984-1992) the means addressed to perceive and study the empathic phenomena of the patient were invented at the Italian Medical Psychology Research Centre.

Time 2 (1991-1998)

b. Assessment of Teaching and Evaluation of Tools

Concerning the theoretical and experimental formulation of PCCM, starting from the " Medical counseling" method and was concluded in 1998 with the birth of the " Manifesto of Person-Centered Medicine

", [31] the development of a PCM case sheet and an instrument of learning evaluation: The PCCM LEARNING EVALUATION PROTOCOL (PCCM LEP) . (Tab. 1) This procedure received the quality certificate UNI EN in 2003 (the first case for a clinical teaching procedure)

Time 3 (1999-2002)

c. MD Training in PCCM

43 physicians were enrolled in a three-year-master's program for PCCM and Medical Counseling
They received complementary education to apply for PCCM and to join in learning objectives.

Time 4 (2002)

d. Idealization, assessment and distribution of the PCCM quality questionnaire (2002)

A questionnaire on the application of PCCM was developed. This instrument evaluates the effectiveness of PCM in clinical activity.
20 Doctors who arrived at level "Good" of PCCM application, were asked to fill out the questionnaire and to email it upon completion. The total number of patients taken in charge from MP ranged from

[31] Brera G. R, The manifesto of Person-Centred Medicine. Medicine, Mind and Adolescence 1999.XIV, 1-2:7-11

9,000 to 10,000 and from territorial paediatricians from 3,600 to 4,800. The hospital doctor and private doctor patient numbers were not computed .

e.. Analysis of results (2003)

Analysis were made through cross tabulations with the traditional standards for the analysis of data significance.

TAB 1

PCCM LEARNING EVALUATION PROTOCOL (In appendix)

4. Results

20 doctors (7 females and 13 males, aged 33-51 –mean mean±SD 45.2±4.5 ; 1 case omitted) filled out the questionnaire by e-mail : General Practitioners 30% , Paediatricians 35%, hospital paediatricians 15%, private MD 20 %

All the MD believe that PCCM is incident on medical care quality. (tab 2)

TAB 2

“ PCCM and Medical Care Quality ”

	%
Enables a better comprehension of patient and his own problems	95
Improves the finalization of specialty referrals and technical examinations	30
Saves useless examinations and drug prescriptions.	70
Spares unnecessary hospitalizations	55
Reduces hospitalisation times (only if HP)[1]	10
Improves professional realization	40
Is effective on quality of life and health improvement of patients	75
Reduces doctor -dependency	45
Creates new possibilities for research	30
Shortens improvement times	30
Requests more time to dedicate to patient	55

Tab 2 : **PCCM and Medical Care Quality**

All the MD believe that PCCM is incidental on medical care quality. Patients’ comprehension spare of unuseful examination, drug prescriptions, hospitalizations , effectiveness on improvement of life style an health are the best rated.
Considering the possible associations between medical role and answers, PCCM gives evidence to significant differences in the following statements: “ Saves useless examinations and drug prescriptions. : “ Spares unnecessary hospitalizations “, “Improves professional realization “, “Is effective on the quality of life and health improvement of patients, “Creates more possibilities for patients for self-health management “ Creates new possibilities for research”. “Shortens improvement times”

No differences appear in the following: "Improves the finalization of specialty referrals and technical examinations. Requests more time to dedicate to patient. Borderline differences appear in :" Creates more possibilities for patient self-health management (tab 3)

.

TAB 3

N	Answers categories	MP	P	HP	PD	p
1	Permits a better comprehension of patient and his own problems	5 83,3 %	7 100 %	3 100%	4 100%	
2	Improves the finalization of specialty referrals and technical examinations	2 (33.3%)	2 (28.6%)	1 (33.3%)	1 (25.0%)	0.992
3	Saves useless examinations and drug prescriptions.	6 (100.0%)	6 (85.7%)	1 (33.3%)	1 (25.0%)	0.027*
4	Spares unnecessary hospitalizations	5 (83%)	4 (57.1%)	1 (33.3%)	1 (25.0%)	0.263**
5	Reduces hospitalisation times (only hospital MD))					
6	Improves professional realization	2 (33.3%)	4 (57.1%)	2 (66.7%)	0 (0%)	0.210**
7	Is effective on patient quality of life and health improvement	4 (66.7%)	6 (85.7%)	1 (33.3%)	4 (100.0%)	0.190**
8	Creates more patient possibilities for self-health management	2 (33.3%)	3 (42.9%)	1 (33.3%)	3 (75.0%)	0.580
9	Creates new possibilities for research	3 (50.%)	2 (28.6%)	1 (33.3%)	0 (0%)	0.411**
10	Shortens improvement times	0 (0%)	4 (57.1%)	1 (33.3%)	1 (25.0%)	0.165**
11	Requests more time to dedicate to	4 (66.7%)	4	1	2	0.813

	patient		(57.1%)	(33.3%)	(50.0%)	

Tab. 3 **Medical Role and PCCM Quality**

Associations between medical role and answers. PCCM gives evidence to significant differences in the following statements: " Saves useless examinations and drug prescriptions. : " Spares unnecessary hospitalizations ", "Improves professional realization ", "Is effective on the quality of life and health improvement of patients, "Creates new possibilities for research". "Shortens improvement times"
* P< 0.005 ** P<0,5

Moreover, MD believe that PCCM is necessary (60%) and important (40%) for the development of medical science, without significant differences among roles and 90% of them state that learning PCCM changed quality of their medical skills. Private +Hospital MD (71,4%) state that PCCM learning permitted them to comprehend the interaction between quality of life, individuality and biological variables (Odd Ratio : Territorial MD/ H+PD= 0,25) .

Cases rates of positive answers have been computed . Answer mean of 5.35 by individual. (tab 4)
.

Table 4

Rate of positive answers

ITEMS	N	% of answers	% of cases
Enables a better comprehension of patient and his own problems	19	17.8	95.0
Is effective on patients' quality of life and health improvement	15	14.0	75.0
Saves useless examinations and drug prescriptions	14	13.1	70.0
Spares unnecessary hospitalizations	11	10.3	55.0
Requests more time to dedicate to patient	11	10.3	55.0
Creates more patient possibilities for self-health management	9	8.4	45.0
Improves professional realization	8	7.5	40.0
Improves the finalization of specialty referrals and technical examinations	6	5.6	30.0
Creates new possibilities for research	6	5.6	30.0
Shortens recovery times	6	5.6	30.0
Reduces hospitalisation times (only hospital MD))	2	1.9	10.0
Overall	107	100.0	535.0

Tab. 4 **Rate of positive answers**

Comprehension of patient, effectiveness on life style and health, spare of unuseful examinations and drug prescription and hospitalization are the first four hits of MD trained in PCCM.

5.Discussion

PCCM teaching is based on the new epistemological principles of Person-Centered medicine founded on interactionism and teleonomy. A necessary attribute for physicians is to be knowledgeable.[32] To date it seems that medical culture is addressed to censor the impact of basic sciences like psycho-neuro-immunology on clinical method and research.

This pilot study, makes evident the positive results of PCCM teaching method and its effectiveness in changing clinical practice.

Nevertheless, the physicians' general statement that PCCM changes medical practice must take in account the clinical activity in different contexts.

Almost all the physicians state that PCCM permits a better comprehension of patients and his/her own problems and there is a general agreement that PCCM is effective in promoting a better quality of life but requests more time to dedicate to patients.

[32] The Medical Schools Objective Writing Group. Learning Objectives for Medical School Education-Guidelines for Medical Schools:Report I of the Medical School Objectives Project.Acad Med.1999;74:13-8

Nevertheless, there is an evident difference between MD working in a territorial context compared with hospital and private MD about "Saving useless examinations and drug prescription" .

These results are considerable and could offer many reasons to consider the PCCM effectiveness to carry out these objectives and encourage further studies in the method.

To the date medical science is extremely addressed to bio-technology, evidence Based Medicine (EBM) and Problem-Centered Medical Education.

Person-Centered Medicine and its clinical method, presented in 1998, is well supported by a solid interactionist epistemology and represents a new way in pioneering and conceiving medicine and in going back to the original Hippocratic qualitative paradigm, based on the quality of life style and finalized for the well-being of the person . Human nature is a body-mind-spirit construct, where spirit means a human quest for a sense. Consequently physicians like investigators demand a preparation to work with biological, psychological and spiritual variables. To the date health appears

the result of a three-dimensional teleonomic interaction of humans. PCCM breaks the Cartesian dualism giving unity to the three-dimensional concept of the person..

At present, clinical teaching is addressed in order to introduce communication skills, but this approach does not take into account the revolution of epistemology in medicine similar to the revolution in physics in 1920-30. In medical science, determinism and mechanism are an obsolete and dangerous use of biological knowledge whose results, in opposition, state a relativity of biological reactions, to subjectivity and behavior.[33] *Any research which does not take in*

account variables belonging to the subjectivity and behavior of the person is not correct in an epistemological perspective and cannot give reliable results..

The PCCM approach, which one of us has created and formulated in the last 15 years, is meant to *postpone attention from empiric symptoms and before focusing on hypothetic-deductive investigation on pathogenesis and physical examination (provided there is no urgent need for the solution of survival problems), considers the person independently from his problems giving importance to empathy, subjective and affective resources and to life style. A person-centered symbolic and interpersonal space and time is created before so that person, reveals him self to the physician who must to be prepared to a" maieutical" relationship.*

The sentence : "Now that you've spoken about your problems, please tell me about yourself and your life" suggesting a fictitious division between life and problems, is the "clinical epoké " base of the method, remembering the Husserlin phenomenological lesson. Before this interlocutory phase, physicians are prepared to perceive and assess empathic phenomena, whose importance is determinant in knowing the person, because their close relation with emotions and unconscious phenomena.

"Diacrisis" is a new concept which comprehends the traditional "anamnesis". Prior to considering the problems of the patient, it is necessary to comprehend his/her own person.

This gives value to the world of the person and locate the origin of the problem in the life of the person. Viktor Von Weizsacker already

[33] Laundeslangers M.L.,Ryan S.M.,Drugan S.F.F et al.. Coping and immune-suppression : inescapable but not escapable shock suppresses lymphocytes proliferation. Science. 1983; 221 :568-570

founded the patho-bioghaphic method inspired by psychoanalysis. [34] In the bio-psychosocial model of George Liebmann Engel, humans are seen like hierarchically interdependent ordered systems. [35]

Nevertheless, only during last 20 years neurobiology and psycho-neuro-immunology have changed the epistemological basis of medical science to an

indeterministic paradigm.[36] With PCCM, the person, prior being considered a patient, has the opportunity of speaking about himself , (eg values, affects, hopes, emotions, beliefs, relationships, job and or school, interests, hobbies and behavior).This subjective world, is linked to the endocrine-immunitary system via neuro-mediators and hormones in a bi-directional way. *The individual is person before to be patient*. This irrefutable axiomatic truth determines a starting point of a therapeutic effect at the precise moment of the clinical encounter because of the neurobiological –immune interaction activated by the doctor-patient relationship. [37] [38]

The well-known interaction between hormones neuro-mediators, the immune system through the expression of genetic receptors, which

---

[34] Viktor Von Weizsacker . Filosofia della Medicina.. Milano: Guerini , 1995

[35] G.L.Engels. The need of a new medical model: a challenge for bio-medicine ? Science. 1977; 129-137

[36] Brera GR. Epistemology and medical science: change of the paradigm. Paper presented at: Return to Hippocrates: Quality and Quantity in Medical Education; 2005 May 27-28; Milan, Italy.

[37] De La Fuente-Fernandez R, Stoessl AJ. The biochemical bases for reward. Implications for the placebo effect. Eval Health Prof. 2002 Dec;25(4):387-98.

[38] Ciompi, L. Affects as central organizing and integrating factors. A new psychological-biological model of psyche. British Journal of Psychiatry. 1991; 159: 97-105.

gives a biologic correspondence to positive affects like hope and trust in doctors, the basis of the therapeutic alliance , gives this clinical method phase a psycho neuro-endocrine therapeutic meaning with probable effects on the patterns of neuro-mediators, the variability of which has already been noticed in relation to a subjective change of state.
The method of medical counseling (1991)[39] has been the principal contributor to the formulation of MCCP.

Basic biological research has been the true responsible agent for overcoming the Selye deterministic concept of "General adjustment syndrome" [40] and the birth of the theory of relativity of biological reactions to possibility and quality of coping.[41]
Medical science must measure itself in the light of qualitative nature knowledge and probabilistic quantitative measures. The *qualitative study of the person is not an option but a clinical necessity. Its omission is an attack on scientific truth*. We irrefutably are in a new phase of medical science and physicians , comforted by basic research have the chance of being considered as persons who face other persons, not bio-technicians in an extreme and sometimes deviant ratio indifferently addressed to life and death. The first great revolution of education in PCCM is the due space given to perception of empathic phenomena, their eventual connotation and use in communication *and the attention placed on points of strength, and*

[39] Brera G.R. Medical Counselling teaching method . Milano: Università Ambrosiana., 1991

[40] Selye H. The stress of life. New York :Mc Graw Hill ;1956

[41] Brera G.R A revolution fo medical science and biomedical research: the determinate and the quality indeterminate relativity of biological reactions, Milan :Università Ambrosiana pub. ; 1996

resources before problems if there is not survival emergency. This is a must for constructing new possibilities (enclosing examinations and drugs prescriptions) for person and request for a physicians' particular training in analogical perceiving.

The great error of contemporary general practice is to consider person clinical problems as entities, completely independent of the *conscious and unconscious subjec's action concerning values, affects, relations, beliefs* which are requested in playing in life his own resource. We have to go back to the original philosophy of Hippocrates who asked: " How do you live" ?

PCCM antagonizes the reductionist epistemology of Evidence -Based Medicine (EBM) and Problem -Centered Medicine and Problem Based Learning (PBL)[42] [43]

The first introduces knowledge of the person as a corollary of scientific evidence of diagnostic and therapeutic effectiveness, because considers " Medical science" only a result of empirical, probabilistic clinical trials, where only biological variables are evidenced.

PCCM considers scientific evidence only at the end of the clinical procedure, when doctors must integrate choices related to the health of the person with his own individual possibilities, resulting in a balance among the points of strength , resources, problems and threats to the person.

PBL and Patient-Centered Medicine develop an educatonal approach which firstly transform *person* into *patient* without any consideration

[42] Tonelli M R. The limits of evidence-based medicine**.** Respir. Care. 2001; 46(12):1435-40

[43] Towle A, Brian J. Case studies: recent curriculum designs. In Brian J& Rees L.(ed.)"Medical Education in the Millennium" Oxford: Oxford Un. Press, 1998

of the resources of the person and the role of physicians for building them beyond the prescription of drugs or behavior.

EBM [44] links clinical reasoning to scientific results of clinical trials, but its experimental approach to medicine created a dangerous underrating of the traditional Medicine DNA: empirical - qualitative observations of clinical nature. EBM application in Finance – Centered Health Systems caused the call for standardized applications of therapeutic protocols which physicians are invited to execute. This is an erroneous triumph of a mechanistic determinism in clinics founded on a linear causality between stimulus (S) and biological reaction (R) (S-R Paradigm),[45] without any consideration of the interactionist paradigm posed by the epistemological evidence of a psycho-neuro-endocrine-immunological network. EBM maintains the Cartesian dualistic paradigm and consequently it is epistemologically incorrect. PBL is more a teaching method than a paradigm. In this case medicine is reduced to a problem-solving approach and its teaching only to a problem-centered hypothetical-deductive training. One of the problems of Evidence Base Medicine and PBL is *the person's complete objectification* . This is a great error for his detrimental effects to annul person resources for the psycho-neuro-immune induction of the recovery process.

According to PCM , health concept is considered a teleological balance among resources, problems and possible limits which determine quality of life style, enclosing coping. Human nature is seen

[44] Evidence Based Medicine Working Group, JAMA**,** 268, 2420 (1992)

[45] Brera G. R Person-Centered Medicine and Person-Centered Clinical Method Teaching. Paper presented in the Conference: Return to Hippocrates: Quality and Quantity in Medical Education II° International Symposium on New Perspectives in Medical Education, Milano, 27-28 May 2005

as revealing in time a teleonomia which request an answering and to which belongs any personal actions. Health and disease belong to this mysterious dichotomy . This new epistemological conception [46] of health opens doors to research on "protective factors" and "resilience", posing the person and his own world between any environmental stimulus and answer.

Bacteria, viruses, neoplastic cells, physical agents, always finds person's resources to cope with and to react to. There is a variability in biological reactions relatively to possibilities and quality of the ways of being of the person and his coping. Human biology is not a mechanism independent from the person.

The main new physician's question to the person facing him and asking for his help according to PCCM is " Who's the person in front of me ? " This "who's who" has a common existential denominator :" To Be" Only a person "is". According to PCM, the PCCM second fundamental question is : "Which resources does this person have and which possibilities could help him resolve his own problems realizing his fundamental existence question, given the fact that we cannot be substitutes to his personal responsibilities." All the doctor's work could be conceptualized in giving a contribution for a better expression for such possibilities. Any clinical act generates possibilities for persons to be aware of their dignity and realize themselves

Any definition, like clinical descriptions and definitions are an attribute to his/her being and no measure of these can build his/her being . Consequently, any clinical act, which axiomatically is

[46] Brera G. R, The manifesto of Person-Centred Medicine. Medicine, Mind and Adolescence 1999.XIV, Jan. 1-2:7-11

addressed to person and derives from an other person, is a contribute to the being or not-being of the person . This main fact concerns both the health and life of the patient and doctor.

This theoretical relation between the "to be" and the "to have" represents the pathos and the core of PCCM and its teaching and require physicians' new analogical skills in order to perceive empathic phenomena and construct a human portrait where the clinical picture is inserted. Person -quality and his/her own clinical phenomena are based on body-mind –spirit relation addressed to build human person reality which consists in his/her own realization answering fundamental questions of existence. A teleological conception of human nature is the base of PCM. [47] [48] Asking for a doctor's help while in a suffering state, is to be aware of the necessity of interest and/or care of "a someone" who is competent and affectively available to give attention, affection, hope.

This is an awareness of truth and love as necessary objective values for a person's own life.

Medicine has the cultural mission to reveal the existence of truth and love as objective values for person and culture and to allow patients to perceive their non reducible dignity.

Hippocrates stated that Medicine was founded on *truth* (scientific knowledge) and *well*ness of patients. The Christian culture introduced a new ethical person –centered concept : " taking care of a person" . From the parable of the "Good Samaritain" we owe the founding of hospitals meant to taking care of the suffering leading up to their

[47] Brera G.R. Epistemological aspects of medical science . Medicine and Mind. 1992 VII, Jan **.** 1-2 :5-12,

[48] Brera G. R. The kairos of existence. Mystery, Possibility and Reality in Adolescence and Human nature. Milano:CISPM,1994.

recovery, and a new form of a person-centered religious anthropology based on a unconditional love for the weak , abandoned and rejected persons which revolutionized culture and medicine. "To care for" means considering person as subject losing his own health and autonomy not an object of diagnostic and therapeutic actions. It implies the concept of creating the possibility of going back *to be* a "person". Any clinical act generates possibilities for persons to be aware of their dignity and fulfill themselves. We must accept that there is something transcendent and mysterious meaning in our lives as doctors and patients and in each of these human encounters. The work of a doctor cannot be interpreted as a " technique" but as a "mission" which is an answer to a call for an answer to the existence meaning. Patients often unconsciously ask something more than a pill but want experience an objective meaning in their existence: "Is there someone who accepts myself and my suffering without any kind of moral judgment?"

The principal PCCM teaching objectives[49] are to teach the empathic phenomena assessment and to use this ability in any and the interlocutory work, the"clinical epoké", the life style (and its history) analysis with a biographical, maieutical work addressed to reveal person's resources and problems (here traditional anamnesis and the physical examination are comprehended), the clinical objectives assessment with an interactionis structure and the person's "portrait".

Since 1991 we work to assess the teaching method and to the date we have standardized the teaching method and the learning evaluation in our PG School.

The perception of trained doctors of PCCM quality documents a general enthusiasm and awareness of a general necessity to learn

[49] Brera G. R. PCCM and Medical Counseling Teaching Objectives. Clinical Method Teaching Quality System , Milano: Università Ambrosiana, 1998.

about it. (100%) During their learning stage, doctors discover a general improvement in their ability in taking care of patients and having a great effect on their lives. Drug prescriptions, examinations

and hospitalization number lessen. Surprisingly, only 45 % believe in the necessity of more time for PCCM application. All doctors believe that in medical education teaching PCM is necessary.
These amazing results derived from trained doctors in a three year course, document that PCCM could be extended to medical schools and faculties and to the entire medical community and in such a way that could produce the right change of medical science education, application and research.

Appendix

PCCM LEARNING EVALUATION PROTOCOL

- **Empathic description**

Is the doctor able to emphatically describe the person at the first colloquium and during the clinical work ?

Y N if Yes I S

- **Giving space to word**

Is the doctor able to create space and time to listen to the person's life story?

Y N if Yes I S G O

- **Problem evidence and communication**

Is the doctor able to make the communication of the person's problem possible or to postpone it if necessary ?

Y N if Yes I S G O

- **Putting problem in parenthesis**

Is the doctor able to put the referred problem in parenthesis (if there isn't a life emergency) controlling diagnosis anxiety and stimulating the person to speak about his own life style: behavior, and styles of coping, relationships, affective bonds, work, interests, values, religion faith if present ?

Y N if Yes I S G O

- **Giving space to word**

Is the doctor able to create space listening to the person 's life story ?

Y N if Yes I S G O

- **Person centered anamnesis**

Is the doctor able to perceive and analyze the personal relationships in and out of the family , in cultural context, life events, stressors , negative and/or positive peak experiences to date and insert problems, symptoms and diagnosed diseases (if present) in life history building a biography ?
Is doctor able to answer the question: Who's this person I'm facing?

Y N if Yes I S G O

- **Evidence of strength points and resources**

Is the doctor able to evidence points of strength and resources in the person's different life dimensions and to permit the person to be aware of these ?

Y N if Yes I S G O

- **Evidence of menaces and problems**

Is the doctor able to evidence menaces and/or problems ?

Y N if Yes I S G O

- **Portrait**

Is the doctor able to describe the person in literary terms (portrait) ?

.

Y N if Yes I S G O

- **Empirical Examination**

Is the doctor able to describe the examination method and its results and to communicate the results to the patient or their omission if opportune?

Y N if Yes I S G O

- **Balance**

Is the doctor able to make a health balance with a comparison between resources and problems ?

Y N if Yes I S G O

- **Empirical Diagnosis and analogical subjective meanings**

Diagnostic hypothesis about person, problems and symptoms
Hypothesis about empirical diagnosis and research of analogies with conscious/unconscious subjective meanings studying possible

interactions among affections, emotions, spirituality in the light of theoretical knowledge to date and information of anamnesis and clinical objectivity.

Y N if Yes I S G O

- **Possibilities for new resources**

Is the doctor able to construct possibilities for new points of strength and existential resources neutralizing menaces and promoting active coping for problem resolutions

Y N if Yes I S G O

- **Strategy and therapeutic project**

Is the doctor able to construct a therapeutic project taking into account resources and objectives to be implemented step by step?

Y N if Yes I S G O

Brera GR. & ITFOP Person-centered clinical Method and its teaching Pers Cent Med Int J [Internet]. 2025 Nov 10;XV:ID1. ©2023.
Available from: http://www.personcenteredmedicinejournal.itISSN: 2037-5522

Summario

Obiettivo

Il metodo clinico costituisce la base della scienza medica, ma, a nostra conoscenza, fino al 2025 non sono state condotte indagini riguardo al suo effetto sulla qualità della pratica medica. La Medicina Centrata sulla Persona rappresenta un nuovo paradigma interazionista e teleonomico della scienza medica, strutturato sull'integrazione delle scienze umane, biologiche e cliniche. Questo paradigma ha sviluppato un nuovo standard di metodo clinico: il "Metodo Clinico Centrato sulla Persona" (PCCM).
Lo scopo di questo studio è indagare la qualità della prima applicazione del PCCM su un campione di tre anni da parte di medici formati.

Metodo

Si tratta di uno studio pilota descrittivo. Venti medici (7 medici di base, 6 pediatri, 3 medici ospedalieri, 4 medici privati) hanno accettato di compilare un questionario sulla "Qualità del PCCM nella pratica medica" e di inviarlo via e-mail una volta completato. Gli item del questionario, i tassi di risposta positiva sulla percezione del cambiamento nella pratica medica e le associazioni con il ruolo dei medici sono stati analizzati mediante statistiche descrittive e tabelle di contingenza.

Risultati

I medici dichiarano che il PCCM migliora la comprensione dei pazienti (95%) e la qualità della salute e della vita dei pazienti (75%), evita esami e prescrizioni farmacologiche inutili (70%), riduce ricoveri non necessari (55%), ma richiede una maggiore dedizione di tempo ai pazienti (55%). L'efficacia del PCCM nel ridurre esami e prescrizioni inutili è significativamente associata al ruolo del medico (P=0,02). I medici di base (100%) e i pediatri (85%) affermano che il PCCM è efficace nel ridurre esami, prescrizioni e ricoveri non necessari. Vi è un consenso generale sulla necessità e sull'importanza di apprendere e diffondere il PCCM.

Conclusione

Il PCCM contribuisce a migliorare la qualità della pratica medica. Particolarmente rilevanti risultano le capacità del PCCM di potenziare le competenze nella comprensione dei problemi dei pazienti, di ridurre esami e prescrizioni farmacologiche non necessari e di migliorare la qualità della vita e della salute in generale.
