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Training clinicians in *whole person*-centered healthcare

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Abstract

Since 1987 in New Zealand a form of person-centred healthcare has emerged, which was originally loosely referred to as ‘medicine and story’ and then developed into a University program titled MindBody Healthcare, but more recently has been described in clinical settings and publications as the Whole Person Approach. This paper emphasises the co-emergence of physicality and subjectivity from conception and the harm that comes from keeping mind and body apart in the treatment of physical illness of all kinds. Symbolic physical diseases provide particularly vivid and glaring examples of the need to attend to patient subjectivity as a part of treatment. Clinicians must learn to deal with *whole persons* and the patient’s *story* is a practical doorway into the complexity of this *whole*. Training clinicians over two decades to become whole person-focused and competent has revealed that clinicians need sustained education to move from the typical Western healthcare dualistic view of patients with physical disease to a unitive, non-dualistic, whole person understanding. It takes time, practice, support and supervision for this to be expressed comfortably in clinical settings. The shift from expert clinician-to-disease focus to a more human-to-human dynamic, underlying everything that is done, can be very challenging for some clinicians. Specific attitudes are required and some skills in eliciting relevant *story* can be learned quite easily. There are many sources of resistances to these changes in the health institutions and clinicians are more of a problem than patients. Each clinical discipline within the health sector tends to have unique problems. But the rewards for whole person practice are great for both clinicians and patients.

Keywords

Clinical skills, clinician training, co-morbidity, emotions, life experience, patient narratives, person-centered healthcare, personhood, relationships, subjectivity, symbolic illness, whole person-centered care

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Introduction

Cogent arguments have been presented in the *European Journal for Person Centered Healthcare* [1,2], calling for a turn in healthcare, away from the “vexing failures of medicine, its relentless positivism, its damaging reductionism, its appeal to the sciences and not to the humanities in the Academy and its wholesale refusal to take into account the human dimensions of illness and healing” [3], towards a person-centred healthcare in which “.. disease is part of the person, not person part of the disease..” [1].

The current state of Western medicine means that transforming medicine towards person-centredness is an Herculean venture and Miles and Asbridge have well-described the confluence of necessary conditions and factors needed to facilitate such a movement [2]. Fundamental to any such change is a sound and coherent concept of what a *person* is and, thus, of person-centredness

The development of whole person-centred healthcare in New Zealand

Since 1987, in New Zealand, a form of person-centred healthcare has developed that emphasises *persons* as *wholes*. A clinician is directed to the patient in his or her *entirety*. Moreover, the dimensions of personhood such as physicality and subjectivity, body and mind, are seen as *inseparable*. The arguments for this position have been detailed elsewhere [4]. But, simply put, physicality and subjectivity are developmentally co-emergent from the beginning of life and, therefore, the body and the rich subjective dimensions of being are interwoven, interdependent and need to be considered together in any understanding of health and disease.

My work over the last three decades [4,5-104] exploring the relations between physical disease and a person’s story, life experience, emotions, relationships, trauma and training clinicians to be person-centred [5], has shown that a major source of resistance to the active

consideration of emotional and other subjectivity factors in the healthcare of physical diseases is the implicit dualistic model of persons that pervades most of clinical medicine. Mind and body are typically kept well apart. In reality, there is a systematic legitimisation of neglect of all factors which are subjective in their nature and which are thus outside of the scope of the objective technological assessment of the body seen as a biological machine. Indeed, the whole medical edifice is built on dualistic premises.

The patient's story: a doorway to the whole person

It is reasonable to ask how is it going to be possible to move from pervasively dualistic modes of healthcare to a practicable non-dualistic approach? The *whole person* approach described here provides an example of the processes and challenges involved in such a move. It emerged originally from observations of vivid and multiple instances of physical diseases in which it appeared that the patients' personal 'stories' were crucial to both the appearance and continuation of the diseases [7-11]. These conjunctions of disease and story forced a re-appraisal of the dualistic position and the development of clinically feasible non-dualistic responses to patients.

More importantly, some of these relations between patients' diseases and their individual 'stories' reached such an intensity and manifest meaning that it was obvious to any neutral observer that the physical manifestations of the diseases were *symbolic* representations of those 'stories'. Such an observation raises many questions. I was trained in the orthodox Western biomedical tradition, in the medical specialty of Clinical Immunology, which, in the research area of psychoneuroimmunology (PNI), has a strong interest in brain to body connections. Yet there has been virtually nothing published in the several recent decades of PNI research to encourage the idea that the intimate interactions between mind and body could lead to symbolic physical diseases.

It was this observation which prompted me to undertake an extended exploration [4,7,8,10] of what kinds of conceptualisation of personhood, of physicality and subjectivity, of mind and body, could allow us to imagine and then explain the expression of manifestly symbolic elements in the body. While many theoretical traditions were drawn upon to explore this, a *co-emergence* model seemed to accommodate the phenomena I and my colleagues were observing, without forcing us prematurely towards more precise and potentially reductive theoretical positions. Simply stated, the idea is that human physicality and subjectivity *co-emerge* [4] from conception and that they are intimately, indivisibly and continuously intertwined over a person's lifetime. Therefore, it makes no fundamental sense to separate or compartmentalise them, nor to imagine that in dealing with human function and dysfunction, including health and disease, clinicians should exclude consideration of one or the other.

Unfortunately, however, this is precisely what is done habitually in Western healthcare.

Embracing the *whole* in the clinic

Beyond re-conceptualising personhood as non-dualistic, a *whole person* clinical approach generic to all disciplines is rapidly developing, which embraces the strengths and benefits of biomedical science and includes the role of subjectivity, the importance of a person's life experiences or 'story', in the development of physical disease. The entire focus, conceptual and practical, is neither the body nor the mind; it is the *person*, the *whole person*, of which body and mind are inseparable dimensions. In practice, this means that an illness or disease remains describable in orthodox diagnostic terms, but is widened to include subjectivity, story, meaning, feelings, relationships and even symbolic elements. This blending of the standard biomedical approach *and* the story approach often leads to unexpected improvements in patients with chronic conditions poorly responsive to biomedical perspectives and treatments to which my own personal experience strongly attests [5,7,9,10].

The problem of nomenclature

Finding a suitable nomenclature for the approach has been difficult. All nomenclature rests on assumptions and all assumptions are limited in scope and reductive. Indeed, ultimately they fail to express or represent the *whole*. This problem is illustrated in the various terms used, in various contexts, over the time of development of the approach I have taken: *medicine and story*, *meaning-full disease*, *mindbody healthcare* (without the dualistic forward slash, /, between mind and body), *co-emergence model*, *somatic metaphor*, *symbolic disease* and, most recently, *whole person healthcare*, which resonates with most people and causes little offence. It is acknowledged that it is pretentious for any clinician to claim that they actually address the *whole person*. But what is meant is that the approach *assumes* a rich, indivisible, multidimensional whole and always *points*, in principle, to the whole. In this way, both physicality (body) and subjectivity (mind) elements are truly free to enter the clinical consultation.

The sociocultural aspects of personhood

Persons exist in relationships, families, social groups, cultural formations, ecological niches and specific physical environments. In this sense personhood has both individual and extra-individual dimensions. The clinical problem is that, once a move is made towards a healthcare based on personhood, just about any element of subjectivity (for example, effects of trauma, relationship difficulties and cultural beliefs), becomes potentially relevant. This creates

issues of clinical manageability, let alone the implications for clinical competence and scopes of practice. A 'story' approach to the subjectivity issues addresses some of these problems.

Developing whole person-centred practice skills

The content of this paper, in respect of skills-development, is a distillation of the my own personal clinical experience since 1987, which includes: a personal fusion of clinical immunology and psychotherapy practices (1987-present); the instigation of a multidisciplinary centre (Arahura Centre, Christchurch, New Zealand) with biomedical clinicians and psychotherapists (1987-2008); extensive individual and group supervision of family doctors and psychotherapists undertaking person-centred work (1990-present); many national and international workshops teaching clinicians a whole person-centred approach; establishing and leading the AUT University (Auckland) postgraduate Masters programme teaching whole person-centred care to experienced clinicians from all disciplines (2006-2013) [5]; introducing and practising whole person-centred care in a tertiary hospital immunology department (Auckland City Hospital, 2008-present); supervising hospital staff undertaking whole person-centred work (2008-present) and consulting in the establishment of the 'story' approach, as the core model of working with pain conditions, in a large Australian Pain Medicine Service (2009).

Three principles of skills training

My experience of training clinicians in *whole person-centred* healthcare has underscored three things that must happen for clinicians to enable them to become competent.

Firstly, it is crucial that each individual clinician-in-training makes whatever personal conceptual *shifts* are necessary to work from a non-dualistic model of persons. For some, the non-dualistic position is natural or intuitively right and being encouraged to work out of that position is a relief; as if they have 'come home' to what they always knew and wanted. But for others it is difficult, because of the assumed and entrenched separation of mind and body typical of most clinical training and practice in Western healthcare. Leaving the safety of normative concepts can be difficult, at least initially. But it is impossible to practise non-dualistically if one persists in dualistic thinking. A deep change in mind is needed.

The second principle follows from this. The clinicians need not only to embrace conceptual revision and training, but also supportive clinical modelling and supervision over a substantial period. Thinking and behaving dualistically are so habitual in healthcare professions and workplaces that it takes *time* and concentrated *support* for a clinician to develop a coherent 'headspace' in which mind and body are smoothly integrated conceptually, for new clinical

habits to emerge and for the clinician to discover the confidence and skills to move flexibly and rhythmically from a body focus to a mind focus and back again, as needed within the clinical session.

The third principle is that some clinicians need deeper personal change to practise differently. Conceiving of the patient primarily as a *person* calls each clinician to be present and *function* as a person and, it be said, as a person *before* all other roles, even those of diagnostician or prescriber of treatment. All dimensions of personhood, of both patient and clinician, are implicitly or explicitly present in the clinical space together. The clinical encounter becomes a specialised and disciplined enactment of *two persons* meeting. The therapeutic relationship is a crucial and enriched arena of enactment of care. While such a philosophy could be perceived as idealistic and theoretical, it looms large in the practice of whole person healthcare (*vide infra*).

The whole person approach in practice

The following case illustrates many of the features of the whole person approach to physical illness:

A middle-aged female is referred for a second opinion. For five years she has had episodes of sneezing, wheezing, laryngitis and tight forehead about twice per month. These can wake her during the night. Over the last three years the symptoms have worsened to include swelling of throat and tongue and choking, requiring emergency care. Her previous care included elimination diets, avoidance of non-steroidal anti-inflammatory drugs and treatment with various drugs and adrenaline in emergencies. She wonders whether she has pistachio allergy, because one choking episode occurred after eating one of her mother's cakes, which contained pistachio. Pistachio allergy testing proved negative.

From a normative medical perspective she had worrisome and life-threatening airways obstruction. There was no explanation for the beginning of symptoms five years before. Pistachio was suspected (on only one occasion) but there was no biomedical evidence for this. No allergies of any kind could be detected, though she was helped a little by antihistamine tablets. The problem was worsening and she was desperate for answers. She had been managed hitherto in a sound conventional medical manner. What to do?

When asked what was going on five years before the symptoms began, she described a number of pressures. She took on the care of a disabled newborn grandchild. She was struggling to support an elderly mother and two of her adult children (details withheld) and working full-time as an office manager. Her husband had died in a motor vehicle accident soon after a violent family argument concerning one of their children who had got a tattoo.

What was emerging was a very complex story entailing violence, trauma, death, loss, disability and severe relational problems, told willingly by a person keen to be

heard. The responsibility and stress seemed overwhelming. The process of care in the session can be put in simple sequential language:

I asked, she told, and I heard; I supported her in telling her story; I understood and empathised; I made simple educative connections between the explosive symptoms and the traumas and stresses; I suggested she think about these possible connections and come back again to talk about it a bit more; I hoped and believed that she might in some way make use of the insights that had unfolded between us; I was left wondering why she had choking symptoms.

At the second visit three weeks later she seemed open and trusting. She had had a further nocturnal episode of throat symptoms of rasping voice, itchy and feeling 'like something sitting on my upper chest'. Asked about the day before this recent episode, she referred again to how burdened she was and then referred to the trauma of her husband's death. I asked for detail. One of their teenage children came home with a tattoo and in a few 'absolutely terrifying' moments, the enraged father nearly strangles the child. He then rushes out of the house and gets killed falling off a cliff. This had monumental emotional consequences for all parties (details withheld).

At the third visit she reported a minor episode after eating something containing pistachio. She managed to calm herself, went off to bed and was 'still alive in the morning', a triumph it seemed. When asked about the *first* pistachio episode she recalled that on that day she had had a discussion with a sibling about their father's sexual abuse. As a consequence she decided to visit her mother and specifically ask her about possible sexual abuse. But when there she could not bring herself to ask her mother - and at the moment of crisis of choice she was eating the cake containing the pistachio. While an allergist (and the patient) might consider pistachio allergy as cause, a whole person approach also takes into consideration the contextual associations and symbolism of this particular moment of eating the pistachio cake.

Points arising from this clinical example

From a whole person-centred perspective, many points can be made from such stories. Illness is meaning-*full* and can be powerfully symbolic [4,7,8,10,11]. Patients can suffer for years (and die) without such whole person data ever ascertained or responded to. Story data can be as crucial as the biomedical data. The patient's story may include predisposing elements (in the above case, the earlier tattoo-related violence), precipitating elements (the advent of the disabled child five years before) and perpetuating elements (the multiple and ongoing stresses).

The stories addressed are not merely artefacts of *posthoc* narrative-making, but reflect the reality that physicality and subjectivity are co-emergent, woven together from conception and thus both inevitably contribute, at least in principle and potentially, to the emergence and perpetuation of illness. Clinicians of many

backgrounds find addressing the emotional meanings of these stories adds a powerful dimension to treatment [5].

A non-dualistic attitude that allows inclusion of both mind and body in clinical work is crucial [7]. Physical and subjective dimensions can be addressed in the same clinical 'time/space' if the clinician has achieved an 'integral aperspectival' [12] capacity; that is, the capacity to move fluidly and flexibly from a focus on the biomedical elements to a focus on the story and back again. With training this can be achieved [5].

Reducing clinical attention to the mere diagnosis of anxiety, depression or some other psychiatric category, is just not adequate in physical illness. It should be normal practice to ask questions that uncover the neglected 'mind', life experiences and stresses. The clinician needs to listen very carefully and hear the 'stories' within and behind the 'little' that is provided in the material that emerges from simple and generous asking and listening [10]. The relational way a clinician goes about this is crucial [10]. Stories *emerge* in the generous, compassionate, willing, I-to-I, person-to-person relational space between the patient and the clinician. In being open to the 'story' the clinician is 'calling forth'[13] the whole person into the clinical session.

Teaching clinicians to attend to the person

The clinician's gaze

To a significant degree, the conventions of medical diagnosis and clinical management constitute and indeed require a restriction of clinical gaze [14]. Breaking out of these restraints, while maintaining biomedical rigour, by opening up to the 'story', poses problems of feasibility and manageability, well-described by clinicians from widely differing disciplines, who have gone down this pathway [5]. What should clinicians gaze at in these stories? It is inevitable that there will always be some restriction of gaze because it is impossible to gaze at everything. But any attempt to solve this problem, by systematising the rules of story taking, risks building yet another formidable edifice of norms and conventions, with reiterative potential to suck the life out of clinical encounters.

The story as portal and the *smorgasbord* question

What we have learned is that ultimately the patient knows what is important. If the right questions are asked and the right environment is created then the right 'stuff' will emerge. When dealing with the person-as-subject, the 'materials' of interest include feelings, emotions, meanings, life events, relationships, home, work, trauma, spiritual and existential issues and cultural issues. The 'story' is that *tapestry* of elements relating to the person's past, present and future *experience* as a subject.

To access this we often use the *smorgasbord* question, which is essentially an invitation to the patient to tell the clinician what she regards as important. It may sound like this: ‘What was the most important, memorable, interesting, difficult, troublesome, worrying, frustrating, stressful (*etc.*) thing or things happening around the time you first got ill? Or when you got your symptoms again last Thursday?’

Uniqueness and story taking

In medicine clinicians are taught ‘top-down’ listening. The clinician has theories and taxonomies of disease and diagnosis. The patient is ‘interrogated’ for certain kinds of symptoms and examined for certain bodily signs. Diagnoses are patterns of symptoms and signs agreed upon and recognized by physicians exercising this way of functioning.

But when it comes to listening to stories the approach must be ‘bottom-up’. While stories often have elements in common, every story is unique. The best way to establish rapport, to hear the story properly, to respond accurately, is to empty oneself of all assumptions and listen very intently and carefully and to treat the material emerging as emotionally unique. What is more, the clinician (as a person, as a listener) is unique as well, so that what emerges between them will be unique by its nature. In this way the relational space between clinician and patient is indeed unique, open, expectant, engendering of trust and has powerful potential for discovery and hope.

The confident clinician

The clinician becomes increasingly confident that, by taking this posture, those elements of story that are indeed important will frequently and naturally emerge. This develops out of the conviction that a person is a whole and that body and mind are deeply integrated and that the story that is being heard is a truthful portal, in some way, to the whole, including the body. And with time the clinician finds he or she can move backwards and forwards, smoothly and competently, from the traditional top-down medical function to the bottom-up story taking function.

More than confidence

Some clinicians do not have the stamina or emotional resourcefulness or generosity to do what is needed. Listening to stories effectively requires a determination to listen deeply and safely facilitate the emergence of that which is or maybe hidden or has been too dark to reveal. There must be a preparedness and ability to accompany and ‘hold’ the person through this process. The bottom-up listening needs to be, in some measure, self-emptying and committed to listening to exactly what the patient says, rather than listening partially and then being triggered prematurely into offering one’s favourite way of seeing or interpreting the world (*aka* top-down listening). There needs to be a belief in the deeper ‘truth’ of the story and an ability to imagine and see beneath the little that is offered.

Or, put another way, an ability to imagine empathically. This is linked to the idea that when people are really heard there begins a healing journey.

Discussion and General Comments

As discussed above, the training of clinicians in a whole person approach has been enacted in a variety of professional and institutional settings and with clinicians of diverse kinds and motivations. This gives rise to some useful observations and comments which I now proceed to make below.

Firstly, it needs to be said that there is in this approach no objection to biomedical interventions, unless of course there is something better. In chronic illness the whole person approach is often better than a body-only approach. But novices in whole person work may become so enthusiastic about the new clinical scenarios that are uncovered and their growing skills, that they swing too far away from their biomedical responsibilities; in other words, swing towards another version of reductionist dualism. Initially, clinicians do tend to struggle with the required ‘integral-aperspectival’ element [12], that is, including body and mind together and this struggle leads some to be too focused on story. But the training is geared to encouraging retention of normative skills, which are at the same time widened to a whole person level. This is in line with our preference for influencing clinicians in their current workplaces rather than creating new whole person-approach ‘silos’. The disadvantage of this is that it does not lead to the formation of conspicuous *exemplary* whole person treatment ‘centres’ or critical masses of like-minded clinicians.

Secondly, person-centred care is based on *generic* attitudes and principles (see chapter one in [5]) with respect to the nature of people, the world, the nature of stories and the power of relationships. Training clinicians in a multi-disciplinary environment tends to reinforce these crucial generic elements. Nevertheless, it is more efficient and comfortable training people who all come from the same discipline.

Thirdly, most people, especially patients, believe in the value of being person-centred. Clinicians do too, in principle if not in practice. Clinicians will buy into whole person approaches, especially if it makes their lives easier. But if it gets too challenging they may turn away, rationalise and avoid. Clinical dualism is endemic and it takes a lot of training time and modelling to shift old default ways of thinking and working. Changing to a person-centred approach engenders temporary clinician incoherence, a sense of incompetence and destabilisation. Like most humans, clinicians will typically go with the crowd and most will not change without warm ongoing social support. Confidence and resilience is necessary in the face of difference (and indifference) from one’s colleagues.

Fourthly, for a clinician to be person-centred requires authenticity, self-knowledge and courage. Many clinicians do not have the interpersonal or ‘intimacy’ skills to

manage themselves in the face of painful stories and emotional distress. There is a constant risk of incoherence in a strategy that is not based so much on prior expertise, diagnostic taxonomies and treatment algorithms, but tipped more towards intimacy, openness, curiosity, uniqueness, not knowing and risks of dissonance and conflict. No one likes to feel clumsy. There are risks in sailing into the unknown. For some clinicians the fear this generates is projected as a disdain of the 'warm fuzzy' elements of the clinical encounter. The three main answers to these problems are: (a) a rigorous and well-argued conceptual basis and training; (b) modelling of person-centredness linked with on-going supervision (groups work well); (c) a growing experience of patients experiencing radical change in the trajectories of their diseases when a person-centred approach is taken. Everyone wobbles initially - the first few 'successes' are important.

Fifthly, clinicians will not necessarily heed evidence of person-centred clinical effectiveness, whatever its quality. In general, doctors are the most resistant of the clinical professionals to change. Typically, they have a heavy investment in the biomedical model and the authority hierarchies built around this model and workplace dynamics and funding structures are often inimical to change. Turning to a whole person approach threatens the sense of hard-won biomedical expertise, stimulating the discomforts of not knowing and feeling incompetent. Some will resort to '*this is not what I trained for*' or '*it is not my role*'. Some clinicians have personality tendencies towards mechanistic activities and practical interventions and some a tendency to avoid relational complexity and emotional suffering. The health professions and disciplines are built around dualistic assumptions and activities and thus story taking is not '*core business*' and is outside a '*scope of practice*'. For 'body workers' (for example, physicians, surgeons and physiotherapists) this constitutes a disavowal of the mind (story) as having a place in their professional activities. For 'mind workers' (psychologists, psychotherapists, psychiatrists) it can be an opposite disavowal of the body.

Sixthly, the listening challenges are many [10]. When all prior training has been towards 'top-down' listening, which is largely based on theory, normative disciplinary narratives, cultural patterns and jumping to conclusions, it is difficult to become a really accurate *bottom-up* listener. In this information age there is a tendency to gather more and more superficial information. But fastidious and accurate bottom-up listening is geared to the depth and implications of simple statements and then carefully checking out whether the discerned depth is accurate.

Seventhly, scopes of practice are a major issue. Some clinicians fear the opprobrium of colleagues if they are seen as stepping outside of the normative and ordinary. This occurs more in public institutions where there are often more colleagues around to be concerned about and more bureaucratic control of work allocation. Some clinicians fear disapproval of professional bodies and '*getting into trouble*.' The reality is that the combination of rigorous normative practice and a widening of focus towards the whole person so vastly improves the quality of

care that complaints are rare, reputations grow and the scepticism of colleagues drops away.

Eighthly, it is true though that all clinicians function in both a personal and professional cultural context. Good sense has to govern how far one can go in this work with any particular patient on any one day. Clinicians have a responsibility to care for each patient to the best of their ability and resources and in the patient's best interest. But, clearly, if one is a family doctor seeing thirty people in a day, it is not possible to offer a whole person approach to everyone, nor may it be needed. Enthusiasm needs to be tintured with realism. There is a constant process of triage, based on the type of condition being presented, the chronicity of the illness and effectiveness and acceptability of normative treatments for that illness, the openness of the patient, the funding resources of the service, the limitations imposed by current health system policies and the skills and self-care needs of the clinician.

Some of the potential stresses can be mitigated by understanding these elements and by some simple procedural skills. For instance, pre-emptive explanation can be very helpful. When first introducing myself to a patient I will explain that I am a physician and a psychotherapist and am interested in the whole person, that I do not believe in treating the mind and body as separate and that I will be asking them about both physical and non-physical things and are they alright with this? They always are, thus bypassing the problems that occur if one starts asking about psychological things unexpectedly in the consultation, which often triggers concerns and mistrust around whether the doctor thinks '*I am a hypochondriac*', or '*it's all in my head*', or '*my symptoms are not real*.'

Ninthly, idealism and over-responsibility need to be avoided. A clinician can be very effective even in a limited whole person-centred role. For instance, much of my own work as a clinician is as an educator. Just drawing attention to the possible relations between illness and the patient's life circumstances, feelings and unresolved issues can be helpful in enabling people to recover. In this way a clinician can 'midwife' a person to health. This may just be a matter of information, or it may be a process of education and growth of trust over several sessions at which point the patient might then engage with a whole person-oriented psychotherapist.

Tenthly, and finally, there are discipline-specific challenges. Doctors tend to have the most problems with clinical dualism, with a default orientation to diagnosis, a 'fix-it' mentality, the expert role and time limitation. Psychotherapists are generally open in principle to mind and body connections, but tend to steer well clear of the diseased body. Their listening is often rather theory-based and there is a discomfort with the 'education' role. Physiotherapists, with their permission to touch the body, are in a very good position to do whole person work, but the extension from touching to listening and talking can be challenging, particularly around boundary issues. Nurses are often inclined to whole person approaches, but can be constrained by clinical dualism residues similar to doctors and hierarchical constraints.

Conclusion

Patients greatly appreciate a whole person approach, though at times the emergence of stories relevant

to their diseases and care is a painful experience and difficult to face. This requires the clinician to develop excellent intimacy skills. Over time, clinicians can and do develop the 'integral aperspectival' clinical competencies and report very satisfying clinical results and enjoyment of their work. But this is generally only achieved through revision of old dualistic concepts of disease, adequate support in skills acquisition and, for some, an emerging ability to be an authentic person in the clinical relationship, with emotional intelligence and a capacity to reflect dispassionately on the process and content of the consultation while remaining thoroughly present as a person.

Acknowledgements and Conflicts of Interest

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