

■ Artigo

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## Towards a new Philosophy of Medicine<sup>1</sup>

*Para uma nova filosofia da medicina*

Darlei Dall'Agnol 

Universidade Federal de Santa Catarina - UFSC, Programa de Pós-Graduação em Filosofia,  
Florianópolis, SC, Brasil.  
E-mail: ddarlei@yahoo.com

### Editores responsáveis:

Inácio Helfer  
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**ABSTRACT:** In this paper, I argue that Evidence Based Medicine (EBM) and Patient Centred Medicine (PCM) are normally seen as incompatible, but if we avoid the philosophical problems of both sides (e.g., EBM's reductionism and PCM's inflationism), they can then be regarded as complementary. After scrutinizing the main components of EBM and PCM, I proposed a new philosophy of medicine capable of showing that medicine is a tridimensional social practice composed of scientific knowledge (*epistemē*), professional skills (*technē*) and objective values (*ethikē*). I call this approach "Integral Philosophy of Medicine" (IPMed), and I will here sort out some of its tenets.

**Keywords:** philosophy of Medicine, scientific knowledge (*epistemē*), professional skills (*technē*), objective values (*ethikē*).

**RESUMO:** Neste artigo, argumento que a Medicina Baseada em Evidências (EBM) e a Medicina Centrada no Paciente (PCM) são normalmente vistas como incompatíveis, mas se evitarmos os problemas filosóficos de ambos os lados (por exemplo, o reducionismo da EBM e o inflacionismo da PCM), elas podem ser consideradas complementares. Após examinar os principais componentes da EBM e da PCM, propus uma nova filosofia da medicina capaz de demonstrar que a medicina é uma prática social tridimensional composta por conhecimento científico (*epistemē*), habilidades profissionais (*technē*) e valores objetivos (*ethikē*). Denomino essa abordagem de "Integral Philosophy of Medicine" (IPMed) e aqui detalharei alguns de seus princípios.

**Keywords:** filosofia da medicina, conhecimento científico (*epistemē*), habilidades profissionais (*technē*), valores objetivos (*ethikē*).

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## ► 1 Introduction

In “The fiasco of evidence-based medicine exposed by the Covid-19 pandemic,” Couto and Miles (2020) argued that EBM (Evidence-Based Medicine) was not well prepared to deal with the virus SARS-CoV-II and the new disease. The main reason was that, in the absence of RCTs (Randomized Clinical Trials), doctors panicked and this led to inaction. To avoid paralysis, according to them, we should “return to traditional medical reasoning and practice, which remains the basis of an authentic person-centred healthcare.” (Couto & Miles, 2020). Thus, the authors argued for an approach based on the person as a whole, not only on diseases, namely “*Person Centered Medicine*” (PCM; italics added). In this work, I will critically analyse whether Couto and Miles’ claim is true by examining how both EBM and PCM dealt, especially in Brazil, with Covid-19. I will propose a less inflated version of PCM (*Patient Centred Medicine* = PCM\*) to be incorporated into a new approach, namely an Integral Philosophy of Medicine (IPMed). The general problem, then, is this: which is the best medicine for pandemic times?

To give an answer to it, I will compare the main tenets of the EBM and the components of PCM, contrasting them to establish whether they are in principle incompatible or they can be regarded as complementary. After showing, in the first part, that EBM is composed of three main ingredients, namely (i) best evidence; (ii) medical expertise and (iii) patient values, I argue that the biomedical model can be seen as reductionist, but this is philosophically inadequate and can be treated. I also scrutinize the place of patient values showing that it cannot lead to moral preferentialism. In the second part, I examine the main ingredients of PCM, namely (i) health, disease and the illness experience; (ii) the person as a whole; (iii) finding common ground and, finally (iv), enhancing doctor/patient relationship) showing that they also have problems, for instance, a broad concept of ‘health’ and an inflated notion of personhood, but they can also be philosophically treated. In the third more substantial part, I propose to integrate EBM and PCM\* towards a new philosophy of medicine I call “IPMed” capable of overcoming the above-mentioned problems arguing that medicine is a tridimensional social practice composed of scientific knowledge (*epistemē*), professional skills (*technē*), and *objective* values (*ethikē*). Finally, I explore the clinical implications of this new approach, especially for pandemic times.

It is crucial to understand that both EBM and PCM are attempts, from the 1990’s onwards, to transform *conventional* medicine (Hippocratic) guided by the doctor’s pathophysiological knowledge and daily experience as represented by the acronym SOAP: Subjective (the patient’s chief complaint (symptoms)); Objective (information about the patient (signs)); history of present illness, and social history; physical examination; lab exams etc.; Assessment (the clinician’s evaluation of the patient: diagnosis & prognosis); and Plan (the clinician’s plan for therapeutics). There are, obviously, other alternative philosophical movements such as Darwinian Evolutionary Medicine (DEM), Precision/Personalised Medicine (PPM) etc. (see Thompson & Upshur, 2018), but EBM and PCM are the main attempts to transform Hippocratic medicine. Both philosophical approaches regarded conventional medicine (not to be conflated with traditional medicine) as paternalistic, disease-centred, non-updated etc. Soon, however, they looked incompatible, but I will argue that if we avoid mainly the reductionist tendency of the EBM as well as an inflationist version of the PCM, they can be regarded as complementary. To visualize this, I will propose a new model, the IPMed.

## ► 2 Avoiding the reductionist tendency of EBM

Evidence Based Medicine was initially proposed as a reaction against the problems faced by the Hippocratic tradition, frequently seen as paternalistic and not up to the latest scientific developments.

It was a self-proclaimed new paradigm led by doctors at McMaster University (Canada) in the 1990's, against medical professionals who guided their clinical practices by manuals and daily experience only, and not by cutting-edged knowledge as published by scientific journals. It was, back in 1992, presented as a revolution by the "Evidence-Based Medicine Working Group," composed by more than thirty authors, in a paper published by *JAMA* (Journal of the American Medical Association) led by David Sackett and Gordon Guyatt considered the founders of the movement. The books *Evidence-Based Medicine: how to practice and teach EBM* (first edition, 1997, organized by Sackett *et al.*) and *Users' Guides to the Medical Literature: a manual for evidence-based clinical practice* (Gordon, *et al.*, [2002]) soon became the main bibliographical sources of the movement despite of the fact that they are variations of the same approach. In Brazil, José Paulo Drummond organized a book, namely *Fundamentos da Medicina Baseada em Evidências*, first published in 1997, with the expression in the subtitle "new paradigm," substituted in the second by "theory and practice." Today, we have many manuals teaching how to practice EBM including how to interpret scientific papers (Alencar, 2021).

Having presented this brief historical remark, I would like to scrutinize the main tenets of EBM. Normally, they are presented (Straus *et al.*, 2019, p.1; Guyatt *et al.*, 2015, p.50) in terms of three main principles:

- i. best research evidence;
- ii. clinical expertise;
- iii. patient values.

By 'best research evidence,' Sackett and his team meant not only clinically relevant research from the basic sciences of medicine, but especially knowledge from patient-centred clinical research including clinical examination. The aim is to reach a high accuracy and precision of diagnostic tests leading to good prognostics, and the efficacy and safety of therapeutic, rehabilitative, and preventive strategies. Gordon Guyatt and collaborators developed many epistemic questions around this first tenet of EBM such as: what is evidence?; which are its main sources?; how to establish a hierarchy of evidence?; are RCTs more trustful than observational studies?; should doctors rely only on empirical evidence or be also led by theory? There is no space in this work to answer all these questions, but it is worth pointing out that one of the major contributions of EBM was arguably to propose ways of hierarchizing evidence, leading, for example, to the GRADE (Gordon, 2008) as proposed by the Cochrane Collaboration and made available by The Centre for Evidence-Based Medicine of the Oxford University.

By 'clinical expertise,' they meet the ability to use clinical skills and past experience to identify the unique patient's health state (diagnosis), his or her individual risks and benefits of potential interventions. Moreover, according to the proponents, clinical expertise is required to integrate evidence with patient's values and circumstances (Straus *et al.*, 2019, p.1). There is a growing area of studies, namely translational medicine, making a bridge between bench (lab *in vitro* and *in vivo* research) to scientific trials (e.g., RCTs) and to daily clinics helping doctors to deliver the best possible care.

By 'patient values,' the authors refer to the unique preferences, concerns, and expectations that *each* patient brings to the clinical encounter. They must be integrated into a shared decision making process because, as Guyatt points out (2015, p.58), evidence is necessary but not sufficient for good decisions. By 'patient circumstances,' they meant the patient's individual clinical state and the clinical settings. As can be seen, there is a close connection between these three components since clinical expertise is required to integrate evidence with patient values.

Having reconstructed the main tenets of EBM, I would like now to assess them. Critics say EBM is not a complete clinical method (Stewart *et al.*, 2024, p.26,) since it is too concerned with the production of scientific knowledge and not with caring for the patient as a whole. Even though there is a grain of truth in it, EBM's evolution over the years is sufficient to show that this criticism is unfair. Guyatt's book (2014, p.59) includes substantial work on clinical *practice*, not just guidelines for reading medical papers, and insists on humanist elements such as sensitivity and listening, communication skills, compassion etc. There are two other criticisms, however, that seem justified: first, EBM tend to be reductionist, that is, it looks at the patient in naturalist terms only as one can realize in some applications of the biomedical model; second, by introducing patient's values, it runs the danger of preferentialism, that is, relying too much on subjective values.

The biomedical model assumed by EBM is reductionistic because it uses a special ontology, namely metaphysic naturalism. In their introductory book *Philosophy of Medicine*, Thompson & Upshur (2018, p. 44) argue that all scientists must adopt a materialist stance and, therefore, should work as if all that exists in the world is matter or reducible to it. Ontological reductionism, then, tries to explain diseases in causal terms only (e.g., of its molecular composition) not appealing to something supranatural. Human beings, however, are not only organism reducible to physicochemical terms. They have culture, that is, they attribute symbolic value to things and, for instance, have different religious beliefs. By trying to eliminate these cultural factors reducing them to natural terms, a substantial loss is produced: the ethical dimension is eliminated. One might then say that the biomedical model commits a *mereological fallacy* taking a part as if it were the whole. Thus, a human being cannot be reduced to its body and must be considered as a whole being with different beliefs. A physician needs to respect the patient's values. Therefore, medicine can assume a scientific approach, but only in terms of *methodological* naturalism, not a metaphysical view of the world. As I will argue in the third part, there is a plausible variety of EBM that is not reductionist.

Another criticism relates to preferentialism. EBM seemed to accept patient's values just as an ethical add-on. However, as argued by Darwall (2004) and care ethicists, a person's well-being is not *necessarily* constituted by what she desires, prefers or has interests in, but by what the one caring, perhaps she herself, would consider constitutive of her welfare. Furthermore, medical ethics is composed of objective and universal principles, for instance, at least, do no harm. There are also many objective values in the shared decision making, for instance, respect for persons. Even scientific research is guided by objective values such as true information etc., so preferentialism is not suitable in healthcare. Here, it is crucial to realize that the relationship is very complex: a patient can be a participant in research and a professional can also be a scientist. Both have *dual roles* with specific rights and responsibilities. Again, in the third section, I will argue that care and respect are two basic attitudes in bioethics.

Finally, how was EBM practiced in Brazil during the Covid-19 pandemic? In the first half of 2020, the country was coping, as the rest of the world, using available knowledge on SARS-CoV-II and trying to adopt restrictive social and economic measures not always supported by all. In this sense, there was no significant differences between following EBM or PCM to save more lives. However, after July 2020, when observational studies first, and RCTs afterwards, proved some treatments such as Hydroxychloroquine were unsafe and ineffective, a clear division took place among those who follow EBM and those who did not. Some medical associations such as the one represented by intensivists (AMIB) clearly followed science and were against the so-called "early treatment" (a composition of several drugs including Chloroquine, Ivermectin etc. known also as "Kit Covid,") while others, led by the Federal Council of Medicine, supported ineffective practices propagated by the Bolsonaro's government up to January 2022 (see Senado's CPI da Pandemia). This negationist approach took half a million of Brazilians lives

that could be saved by following a more plausible EBM approach (see Dall’Agnol, 2023, for further reflections of the way Brazilians dealt with the last pandemics).

### ► 3 Avoiding the inflationist tendencies of PCM

Another reaction against conventional medicine also started in the last quarter of XX Century, but this time denouncing the paternalistic assumptions of the Hippocratic tradition as well as its excessive emphasis on disease. It is known as the Person Centred Medicine (PCM) or Patient-Centred Medicine (PCM\*). The main objection was directed at the predominant biomedical model, which was substituted by the so-called “biopsychosocial model” proposed for the first time by George L. Engel. In his seminal paper “The need for a new medical model,” he argues (1977), based on a systems ontology (the world is composed of subsystems), that the patient cannot be seen from the lens of the reductionist biomedical model only, but instead must be regarded as a whole *person* including social and psychological components. The new model metaphysically placed the person at the centre of the universe and “above” exhibited the connections with family, community, environment etc. and “below” the organism, cell, molecule, atoms and so on. Moreover, Engel insisted that not only disease matters, but the experience of illness is paramount to take care properly of the person (see Rosen & Hoang, 2017). This reaction developed in the United Kingdom, United States, Canada etc. and reached Brazil in the *fin de siècle* mainly through the creation of a movement called “HumanizaSUS.”

As for the EBM, there are varieties of the PCM. For instance, Rosen & Hoang (2017) present four principles, namely acceptance, empathy, conceptualization, competence. However, the most complete presentation of the main tenants of the PCM is today found in the book that Moira Stewart and collaborators organized, which is now in its fourth edition (2024). Note that in Brazil, in the case of Stewart’s book, “patient” was translated by “person”. According to the proponents of the *Patient-Centered Medicine: Transforming the Clinical Method*, PCM’s main components are:

- i. exploring health, disease, and the illness experience;
- ii. understanding the whole person;
- iii. finding common ground;
- iv. enhancing the patient-clinician relationship.

By introducing the first component, the authors focus not only on disease as conventional medicine did, but they wanted to consider health in the first place. Medicine must be preventive, not curative only. Now, PCM uses the WHO’s definition of ‘health,’ namely a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Moreover, it must proceed not only using the doctor’s knowledge and expertise, but also the way the patient experiences illness. In this sense, the acronym FIEFE (Feelings, Ideas, Effects on Function and Expectations) guides the way health professionals must understand the patient as a whole person using the biopsychosocial model. As we will, however, see below this very broad definition of ‘health’ is not without problems.

The second component involves several complex elements, not only the patient as an individual, but also the family and its wide context. For instance, each person has his own individual development, so it is crucial to identify the life cycle in biological terms, but also to understand the patient’s own narrative (or his rationalization and/or sublimation of what is going on), his stories about the way he is experiencing the disease etc. According to both Stewart’s book as well as Rosen & Hoang approach, the whole context is also paramount. Thus, the patient’s family connections and history are crucial

since some diseases are genetic and others involve cultural dimensions, for instance the way social relationships such as education, employment etc. impact welfare. Moreover, the environment also plays an important role since the ecosystem has a clear relationship with a patient's well-being as we noticed during the Covid-19 pandemic.

By 'finding the common ground,' the proponents mean, basically, the need to reach a diagnosis and prognosis through a shared decision-making process. Thus, the goals of medicine are no longer established by the doctor autocratically. The paternalistic model of the Hippocratic tradition must be overpassed in the direction of a more egalitarian view. Not only Stewart' and Rosen & Hoang's books underlie this point, but also the phenomenological approach to PCM proposed by Mitchell and Loghlin (2023) emphasize it. The roles of patient and clinician changed over time and while the first is looking for assistance the latter needs to know the person as a whole to better provide it. Thus, the process of finding common ground needs to be clear about the problem, the goals and the roles each participant performs to reach a shared decision.

Finally, enhancing patient-clinician relationship is paramount since to be *patient-centred* means exactly not to be *doctor-centred* as it was in conventional medicine. The physician and the patient are morally equal and morality, not power, must guide the relationship. Thus, phenomena such as transference must be dealt with and the ethical dimensions of empathy, caring, trust etc. are then essential to enhancing the relationship and the healing process. Hope must always be in place, so that medicine's nature becomes clear as a caring enterprise, and not a curative task only. Cure is not always possible, caring is. For this reason, many other ethical requirements must be part of the package, for instance, self-awareness and even virtues such as practical wisdom.

Having presented the main components of the PCM, I would like now to critically assess this approach to medicine. Many criticisms were addressed to it, for instance some authors say it has to do with soft sciences (Humanities) only, not with the hard, basic sciences of medicine (chemistry, biology etc.). This objection, however, does not hold since medicine is a social practice as it will become clear in the next section. Sociology, psychology etc. are *sciences* after all and, even though they do not use quantitative methods of research only, the qualitative ones are also essential, for instance to find out a patient's satisfaction regarding the health services provided. Now, other objections seem more consistent. For instance, some critics say PCM is in danger of inflating concepts such as 'health' and 'person' and that this has negative implications for medicine. As we saw above, the proponents used the WHO's definition of 'health,' which is in danger of being too subjective. Actually, some varieties of PCM are extremely relativist regarding the concept of 'health,' for instance "as being unique to each patient and encompassing not only absence of disease but also the meaning of health *to the patient*" (Stewart *et al.*, p.49; italics added). This, however, may lead to overdiagnosis and, consequently, overmedication. For this reason, we need a better definition of 'health' not too subjective, but also not too strict as the one used by the biomedical model, namely absence of disease. I will return to this point in the next section.

This problem relates also to the inflated use of the concept 'person.' The biopsychosocial model is a step forward regarding the reductionist assumptions of the biomedical one, but some varieties of PCM introduce new dimensions to the patient that seem to make medicine impracticable. The biopsychosocial model cannot be overstated with "n" dimensions, for instance an energetic one calling for a holistic therapy as represented by Complementary and Alternative Medicine (CAM). Clearly, some traditional practices can be seen as *complementary* to conventional medicine (acupuncture etc.), but some products sold as *alternative* are ineffective and make the line between a scientific led medicine and folk healing, as represented by shamanism or witchcraft, blurred. A spiritual dimension may be part of considering the person as a whole, but this only means that we are no longer talking of medicine

as a practice guided by science, but religion. There is no need to consider ‘personhood’ just an illusion as some neuroscientists did (Farah & Heberlein, 2010), but inflating it does not help either. This can be clearly seen in the Heideggerian notion of *Dasein* as proposed by the phenomenological approach to PCM, which uses a strange definition of ‘illness’ as ‘being-not-at-home’ (Mitchell & Loughin, 2023, p.69). The model proposed by Engel, leaving the metaphysical assumptions aside, is a more realistic account to be adopted by an IPMed.

As I did for the EBM, I would now like to consider how PCM dealt with Covid-19 in Brazil to finish assessing it. Clearly, during the first semester of 2020, even professionals trying to treat not only the disease, but listening to the patient’s experience of illness, considering the person as a whole etc. could not save all lives. At the beginning, Covid-19 was identified as a pulmonary problem, but soon scientific research showed that it is a systematic disease impacting the whole body including the brain. Thus, it was the kind of studies EBM proposed that helped PCM reach its goals. This means they can be made complementary. Now, balancing the positive and negative aspects of both EBM and PCM, it seems clear that we need a new philosophical approach to medicine. The reductionist tendency of the EBM distorts medicine neglecting the ethical dimension and EBM uses an inflated conception of ‘health’ and ‘personhood.’ Besides, both support an untenable preferentialist account of patient’s values in the healthcare system that needs to be replaced by a more realistic account on the nature of care and respect.

#### ► 4 The IPMed

In this part, I will argue that, if we avoid misrepresentations of both EBM and PCM\*, for example the reductionist tendency of the biomedical model and the inflationist propensity of the biopsychosocial model when using concepts such as ‘person’ and ‘health,’ there is no incompatibility between these two approaches, and they can be regarded as complementary. But this integration cannot, *pace* Stewart *et al.* (2024, p.14), be done in simplistic terms, as if PCM “incorporates and subsumes” EBM. I will propose a new philosophy of medicine (IPMed) not only synthesizing them, but also enhancing some elements showing that medicine is a social practice composed of epistemic elements (*epistemē*), professional skills (*technē*) and objective values (*ethikē*).

Why do we need a new model? Because the previous approaches have the above-mentioned philosophical problems, and also because the ethical dimension of medicine is not well developed. There is, then, another problem: both EBM and PCM subscribe to preferentialism regarding patient’s values, but this is misleading. There are objective values all the way down: (i) in research ethics, one cannot fabricate *data* both in the preclinical (*in vitro* and *in vivo*) phase as well as in the clinical trial stages where, for instance, the participants must have their autonomy respected by giving informed consent; (ii) in the publication process, there are objective ethical guidelines, for instance the recognition of the authorship; (iii) in the clinical settings, medical ethics is guided by universal rules such *primum non nocere* while taking care of the patient and, obviously, patient’s values must be respected, but not *any* of his preferences, for instance, demanding ineffective treatment; (iv) in trying to reach a shared decision, both parts must respect each other. That is why we cannot just accept a patient’s preferences at face value. To avoid confusion, I will use Darwall’s critique of preferentialism (2024) to show that a person’s welfare is best understood as what someone who cares for her (perhaps the patient herself) should rationally desire for her. Finally, I will propose the concept of respectful care and introduce it into the IPMed.

Another reason to propose a new philosophy of medicine is that most current philosophies are partial. They emphasize epistemic/ontological features of medicine only, neglecting moral aspects

or relegating them to other disciplines such as bioethics (see: Reiss & Ankeny (2016); Thompson & Upshur (2018); Karhausen (2023) etc.). Now, I believe that medicine is a social practice composed of three dimensions: the epistemological aspects of the basic sciences that constitute it (*epistemē*); the necessary skills to best practice the art of caring (*technē*); and the values involved in the relationship between health professionals and patients (*ethiquē*). Thus, we need an *integral* philosophy of medicine, that is, one that can show the interconnections among these three dimensions, for instance, that a professional needs several abilities to translate scientific knowledge into clinical practices providing respectful care to patients.

I will now propose a way of integrating EBM & PCM\* into a better philosophy of medicine capable of dealing with the challenges of pandemic as well as non-pandemic times. Three basic questions, then, must be answered to build up an IPMed overcoming the problems of the previous approaches: (i) what are the scientific bases of medicine?; (ii) which skills are necessary to be an excellent physician?; (iii) and what are the values underlying good medical practices? Of course, I cannot provide full answers to all these questions in this paper, but I will try to present an overview of the main issues at stake. The idea is just to give a preliminary account on what IPMed is all about.

First, we need to embrace the Hippocratic revolution and proceed scientifically, leaving aside *traditional* healing practices based on myths. This cognitive change was deepened during the renaissance leading to modern experimental sciences (e.g., anatomy) and in the XIX century by the lab turn in medicine. In this sense, the emergence of the EBM in the late XX Century can be seen simply as a step forward in the long process of guaranteeing the scientific basis of medicine. Now, to avoid the partiality of both EBM relying too much on the quantitative methods mirrored by natural sciences such as physics and chemistry and the relativistic tendency of PCM depending on subjectivity, we must assume methodological *pluralism*: probabilistic inductions; hypothetical deduction; inferences to the best explanation; practical syllogisms translating general knowledge into particular applications etc. are all acceptable ways of providing cutting-edge scientific knowledge to basic medical sciences including the so-called “Humanities,” for instance psychology. In this sense, it is important to keep an open mind to the constant evolution of scientific knowledge. Thus, we must acknowledge EBM’s relevant contributions to base medicine on evidence and the attempt to create hierarchies establishing different degrees of trust. A high degree of trust as provided, for instance, by meta-analyses is paramount both in doing science and in clinical practices as well. Again, there is no space here to examine in detail all the criteria for considering a belief or a theory, scientific or not, but, according to the current philosophical discussion on the nature of human knowledge, we can assume that it must be testable in the direction of refutability, that is, a hypothesis can be accepted true when *corroborated*, that is, it has survived tests, but not permanently. This means that science can always revise its beliefs, that it is fallible, and we must keep an open mind so, philosophically speaking, one cannot be a foundationist in epistemology. That is to say, the construction of the scientific basis of medicine is an ongoing process. Therefore, medical training must be part of permanent education too.

The discussion whether medicine is art or science is misleading, since it is a practice composed of both elements. I do not intend to make a complete enumeration of the skills needed to be a good general practitioner or for all kinds of medical specialization, but I would like to illustrate how the development of abilities is essential to reach medicine’s goals. Knowing-how is constitutive of our practices as it is theoretical knowledge. There is no doubt that the ability to listen, and communicative skills are central to any successful anamnesis to diagnose a health problem. Imagination and creativity are required to propose hypothetical causes of diseases and ways of testing them, even if by rejecting the wrong ones, and are constitutive of the art of medicine as a scientific practice. Moreover, the capacity to translate knowledge into a treatment or with a good prognosis to restore health to the patient is also crucial. In

this sense, any doctor must be a scientist in spirit even though many platforms nowadays, using AI, already help the whole process. Apt feelings and emotions such as empathy are essential too. Some virtues such as practical wisdom, not to speak of veracity, privacy, confidentiality and fidelity, help to provide cure and, if it is not possible, care of the patient always respectfully.

Finally, there is no doubt that medicine is a value-laden social practice. Not to consider its ethical dimension leads to a simplistic philosophy of medicine. I already mentioned above several objective values in the ethics of research, especially clinical trials, on the ethics of publication of medical journals, virtues such as practical wisdom to translate knowledge into treatment for a particular patient, even feelings required by health professionals and, most importantly, respectful care. I have proposed this fundamental bioethical attitude to counter both the dilemmatic cases of the application of *prima facie* principles (Beauchamp & Childress, 2019) and the danger of paternalism of the Hippocratic tradition or even of the beneficence-in-trust model (Pellegrino & Thomasma, 1988) as well as the negative implications of Engelhardt's autonomism (1996), namely indifference and individualism. As I understand it (see Dall'Agnol, 2016 for more details), respectful care requires being concerned with a patient's well-being *for her own sake*.

Having made some brief clarifications of the tridimensional features of medicine, I am in a position now to present a panoramic view of an integral philosophy of medicine. To see it at glance, this is how an IPMed looks like:

1. **Medicine as a social practice:** social and political legitimation (*ethikē*) of medicine as a scientific (*epistemē*) and professional (*technē*) enterprise.
  - 1.1 – **Public Health:** epidemiological guidelines *to prevent diseases* and *to promote health* according to EBM's main principles and (bio)ethical norms for scientific activities to implement good professional practices as established by PCM\* leading to a solid scientific, ethical and professional education of the medical staff;
  - 1.2 – **From Bench to Bed:** basic research and clinical trials (e.g., RCTs, meta-analyses etc. as established by EBM) in physiology, genetics etc. adopting *methodological* naturalism and investigative pluralism guided by the objective values of sciences and medical ethics (PCM\*) in order to be transposed to unique patients respecting them as persons.
  
2. **Medicine as clinical practice:** clinic/hospital interventions guided by scientific knowledge (*epistemē*), medical expertise (*technē*) and moral knowing-how to reach shared decisions with patients aiming to provide respectful care (*ethiquē*):
  - 2.1 – **Clinical encounter:** anamnesis led by an empathic and respectful interview following PCM\*'s standards considering not only the symptoms, but also patient's history, her family, social and environmental contexts as preconized by the biopsychosocial model;
  - 2.2 – **Accurate diagnosis:** physical examination, lab tests (if necessary) guided by the precepts of EBM trying to identify the causes of the disease's signs aiming to obtain patient's informed consent to the diagnosis and treatment;
  - 2.3 – **Shared decision** on the best therapy with good prognosis for alleviating suffering or curing the patient's problems including, if necessary, prescription of drugs, surgery, prothesis etc. for treatment or rehabilitation of her wellbeing;
  - 2.4 – **Continuous caring** for preserving or increasing not only health, but the patient's quality of life, for instance, alleviating suffering looking for preserving a respectful clinician/patient relationship;
  - 2.5 – **Empathetic communication** enhancing doctor/patient's relationship and *palliative care* if treatment is futile in the therapeutic sense and, if demanded, assistance in dying.

This integral philosophy of medicine (IPMed) has the potential of overcoming the problems of previous single-minded approaches such as reductionism and inflationism discussed in the previous sections. Moreover, it contains a central ethical element, namely respectful care not always clear in simplistic approximations between EBM and PCM. It means basically that health professionals must respect the patient as a person, that is, as an agent with rights and responsibilities, by practicing care as a way of intrinsically valuing her. That is why the concept of respectful care is pivotal to IPMed.

Before finishing this work, there is one more issue I must deal with. One of the central problems of any philosophy of medicine is how best to define 'health' in order to provide a plausible account of public policies to healthcare systems. As we saw in the first section of this work, neither a too strict nor a too broad definition of 'health' seems suitable for clinical practice. Thus, I will provide below a conceptual analysis making explicit some assumptions of the IPMed exposed above.

Considering 'health' a thick concept, that is, involving descriptive as well as normative elements, I would now like to ask under which necessary and sufficient conditions one can attribute to a person the qualification 'healthy'. It seems the case that P seems healthy iff:

- i. P does not reveal *symptoms* and, after being examined by doctors, presents no *signs* of pathologies;
- ii. pathologies (diseases, injuries, and severe disabilities) impair P's *active* living;
- iii. P *feels well* and can potentially lead an active life.

I can now stipulate: health =<sub>def.</sub> state of feeling well, with no pathologies, and being active.

To go now back to the problem we started, I believe Couto and Miles are *partially* right in complaining about the way we dealt with Covid-19, but also that they were too critical of EBM overestimating PCM. In fact, during March and April of 2020 *no one knew* how to effectively treat Covid-19. Since it proved to be a systematic disease affecting not only lungs, a PCM approach sounded more adequate, but it was not without any problems, for instance, using ineffective treatments. Soon, however, in May/20, the first observational studies showed, for instance, that Hydroxychloroquine made no difference. Afterwards, in July/20, the first RCTs proved the CLQ was ineffective and, more importantly, unsafe. Thus, EBM made a substantial contribution. After that, it was unethical not to use the best science available, but in Brazil the federal government was still supporting early treatment (Kit Covid) till 22/01/22 as can be realized in the (in)famous "technical" note written by a director of the Health Ministry. This is the reason why Brazil has one of the highest mortality rates in the last pandemics: with less than 3% of the world's population, we have more than 10% of total deaths. An IPMed integrating the best science available, high medical expertise and more objective values such as respectful care could have avoided our "tragic" performance, and half a million Brazilians would still be alive. IPMed is, anyway, a proposal to face the new pandemics ahead and perhaps the best approach to non-pandemic times also.

## ► 5 Concluding remarks

In this work, I tried to answer the following question: which is the best medicine for pandemic times? Reconstructing and assessing both EBM and PCM, I concluded that we need an *integral* philosophy of medicine. I proposed, then, a new approach, IPMed, which overcomes the reductionist assumptions of the biomedical model underlying EBM as well as the inflationist tendencies of PCM when using concepts such as 'person' and 'health'. I also made the substitution of the preferentialist account of value subscribed by both for a more objective view, synthesizing care and respect into the concept of respectful care as expressing an intrinsic valuation of the PCM\*.

Last, but not least, I would like to present a definition of ‘medicine,’ arguably the main goal of any philosophy of medicine. It seems clear that, according to the IPMed, medicine is a care practice based on the ability (*technē*) to apply scientific knowledge (*epistemē*) diagnosing and prescribing therapeutics for the patient’s benefit, respecting her as a person (*ethikē*).

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### **Declaração de Disponibilidade de Dados:**

Todo o conjunto de dados que dá suporte aos resultados deste estudo foi publicado no próprio artigo.

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