

A healing curriculum

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CONTEXT The banner of patient-centredness flies over many academic institutions; however, the practice and teaching of medicine remain oriented to disease. This incongruence is the result of an original Flexnerian dichotomy between the basic and clinical sciences and is maintained by a more recent distinction between disease and illness. One mind-set emphasises basic science and pathology pedagogically, whilst clinical medicine becomes a search for disease. The second introduces the patient as the focal point, underlining the personal and social contexts of illness.

RESPONSE AT A CONCEPTUAL LEVEL We must orient ourselves to a single central theme, namely, the well-being of the individual patient. Doing so does not deny the importance of the scientific understanding of biological function. Indeed, recent advances in genetics may permit a richer view of the individual as a unique product of genetic, developmental and experiential forces. The foregoing provide a coherent framework for a scientifically guided and humanistic medicine, which replaces the false dichotomies that have plagued medical school curricula with a congruent and stereoscopic view of medical education.

RESPONSE AT A CURRICULAR LEVEL We describe an undergraduate programme, entitled 'Physicianship', based on the fundamental premise that healing is the doctor's primary obligation. Explicit training in a specific clinical method, whose cardinal features include observation, attentive listening and clinical reasoning, emphasises the knowledge and skills necessary to effect this theoretical framework. The understanding of illnesses emphasises loss of homeostasis, whereas the physical examination highlights

impairments of function. The educational experience is enriched with numerous opportunities for self-reflection.

KEYWORDS education, medical, undergraduate/*methods; curriculum; *professional practice; *physician's role; patient-centred care; physician-patient relations.

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'Although a clinician can be both a healer and a scientist, he cannot be an effective therapist if he merely joins these two roles in tandem by oscillating between them, adding laboratory science to bedside art. A clinician's objective in therapy is not just a conjunction, but a true synthesis of art and science, fusing the parts into a whole that unifies his work and makes his two roles one: a scientific healer... As a healer, the clinician's purpose is to treat the sick person, not merely the manifestation of disease.' Alvan Feinstein¹

INTRODUCTION

This essay describes a new undergraduate medical curriculum that redirects the medical student's gaze away from disease and towards the sick person. We present the conceptual framework, entitled 'Physicianship', and place it in historical context by contrasting it with other patient-centred approaches. We also describe the teaching of a clinical method intended to equip students with the tools required to assess, understand and heal sick persons.

HISTORICAL CONTEXT

A seminal event in medical education in North America was the publication of Abraham Flexner's

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Overview

What is already known on this subject

Traditional curricula, all generally derived from the original Flexner model, are inspired by and nurture classic dichotomies such as disease/illness, and basic science/clinical medicine. These are false and counter-productive to a coherent approach to medical education.

What this study adds

This essay recognises these various dualities but argues that medicine has but a single goal: to improve the well-being of a sick person, particularly in terms of function. It describes medicine's primary mandate as healing and recommends specific modifications to traditional curricular models.

Suggestions for further research

Evidence to support the effectiveness of the conceptual framework and the clinical method associated with it is currently being gathered.

report *'Medical Education in the USA and Canada'*.² Flexner perceived medical education to be bereft of a solid scientific foundation. His response was to propose a 2-phase curriculum, with scientific theory preceding clinical practice. An unintended consequence has been the nurturing of the sentiment, now prevalent, that there are 2 distinct sets of medical knowledge, the first rooted in science and scientific methodology, and the second, at times more difficult to define and delineate, linked to the delivery of clinical care. The recognition that this dichotomy is fundamentally counter-productive has generated the recurring desire to integrate these dual and parallel curricular strands and has guided curricular evolution over the past century. Flexner himself alluded to 2 categories:

'So far we have spoken explicitly of the fundamental sciences only. They furnish indeed, the essential instrumental basis of medical education. But the instrumental minimum can hardly serve as

the permanent professional minimum. It is even instrumentally inadequate. **The practitioner deals with facts of two categories.** Chemistry, physics, biology enable him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience.'² [Emphasis added]

Flexner seems to have acknowledged an inherent limitation of scientific knowledge in fully equipping doctors to understand and take care of sick persons in their social worlds. Despite his cautionary note, the scientific thrust of his report was so dominant that, by mid-century, clinical aspects of the encounter between doctor and patient had virtually completely ceded centre stage to the teaching of the scientific foundations of medicine. The emphasis on science had come to occupy, not simply the foundation of the curricular edifice, but, increasingly, the upper stories as well.

A powerful alternative to the disease model found expression in the biopsychosocial approach proposed by Engel.³ The 'bio-psycho-social' model can be viewed as a systems-based hierarchy where the person (with unique characteristics, experiences and behaviours) is placed at the centre of a social organisation that begins with the individual's internal biochemical milieu and extends outward to encompass the family and community.⁴ This model, coupled with the experience of client-centred counselling,⁵ inspired a reform in the approach to the doctor-patient encounter, described as the patient-centred method.⁶ This has eclipsed the purely biomedical approach, although perhaps more so in teaching than in medical practice.

Descriptions of patient-centred programmes routinely identify a need to integrate the science of medicine with a focus on the patient. Many models have been adduced. One description shows a weaving, back and forth, between 2 strands: that of science and its pathophysiologic perspective of disease, and that of patients in all their human complexities⁷ (Fig. 1a). This approach is grounded in the distinction between illness and disease, as introduced by Cassell⁸ and illustrated by Reading⁹ (Fig. 1b). We believe, however, that, as important as the biopsychosocial approach has been in the evolution of our thinking, a medical pedagogy that considers its main task to be the integration of science with concern for the patient is left with a fundamental error. The

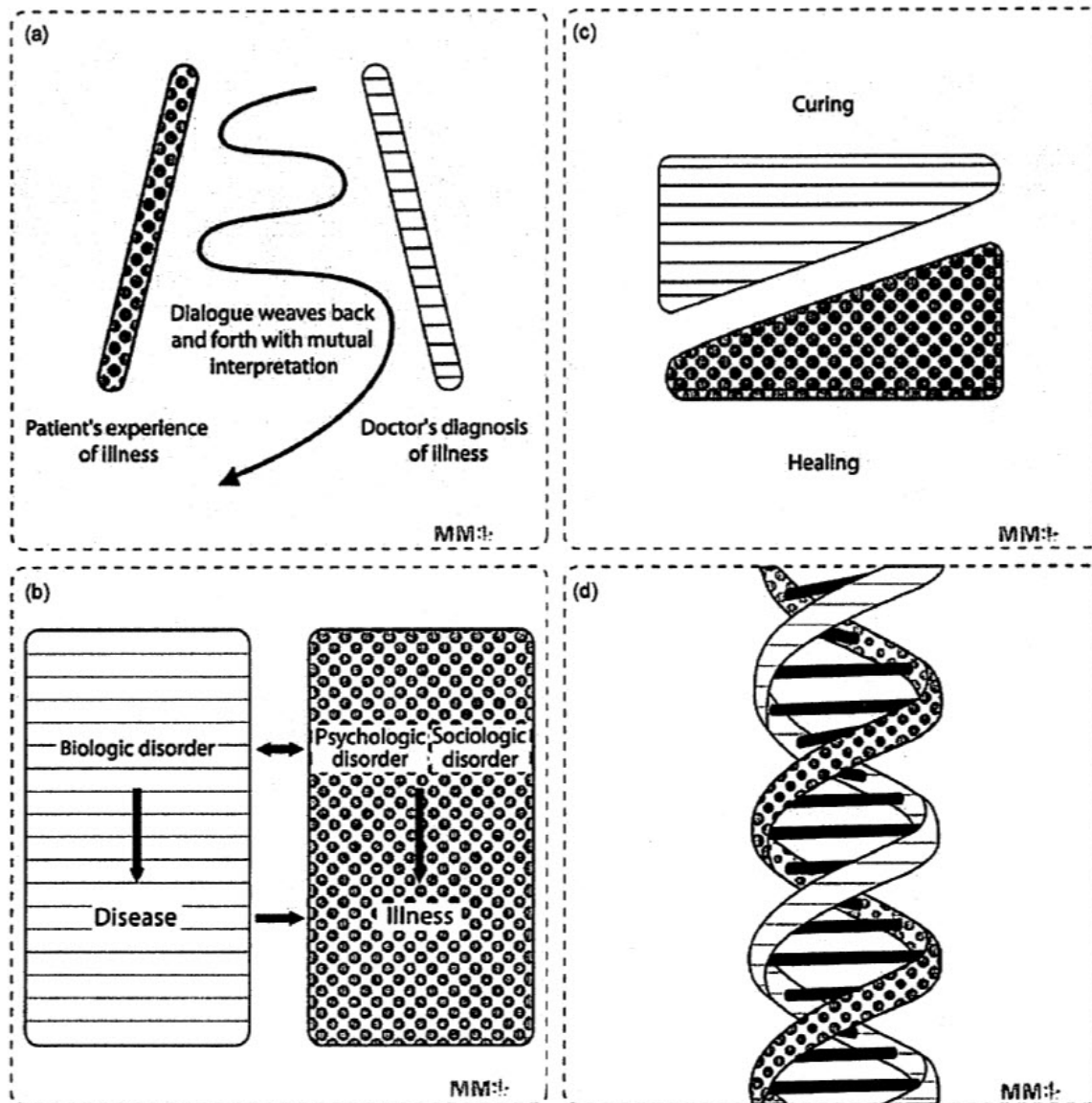


Figure 1 (a) Model showing dialogue between science and its pathophysiological perspective of disease and patients (after McWhinney⁷). (b) Model showing the distinction between illness and disease (after Reading⁹). (c) Model showing the tension between curing and healing (after Milstein¹⁰). (d) Model using the structure of DNA to illustrate 2 strands of a curriculum, representing basic science and clinical medicine (after the University of Rochester School of Medicine and Dentistry¹¹).

problem does not lie in the fact that this construct recognises 2 kinds of knowledge – medical science and knowledge of patients – but, rather, in the fact that it suggests 2 separate goals. Indeed, it makes explicit the duality it seeks to eliminate. The first goal, the prevalent perspective of the last century, is focused on the scientific problem of disease and its pathophysiology. The second goal is focused on the human problem(s) of the patient. Many clinicians, particularly in the context of palliative care, have grappled with this tension by making a distinction between curing and healing – between abnormalities

of the body and those difficulties that arise from the patient's experience of those abnormalities (Fig. 1c). In this latter model, the 2 strands are attributed varying degrees of priority depending on the clinical situation – for example, healing is seen to predominate in end-of-life care.¹⁰ A final example of a patient-centred curriculum, again with split fields, has been described using a contemporary image, the structure of DNA (Fig. 1d). In the 'Double Helix Curriculum',¹¹ the 2 strands represent basic science and clinical medicine, although it is not clear what the 'rungs' represent.

