Introduction

Medical schools educate and acculturate students to the practice of medicine. The ultimate and primary goal is the treatment of the sick. In contemporary society, doctors also become medical scientists, public health physicians, administrators, journalists, teachers, writers and business persons. Despite their differences, all receive the same basic medical education. This has been true since the beginnings of formal medical education. It should remain in the forefront of your thoughts about what medical schools generally teach at present as well as what they should teach—especially when considering the new curriculum that we will be describing in this book: the Physicianship Curriculum.

This book describes what the authors believe should be taught now and in coming years in patient-centered schools of medicine. The curriculum requires new kinds of faculty and changes to the organizational structure of a medical school. It will be described in detail. Some of the new educational modules—particularly in the clinical method—have already been successfully introduced in parts of the undergraduate medical program at McGill University in Montreal, Canada. When this project started, some 10 years before this book, the authors had McGill in mind. It seemed appropriate that a new way of teaching medicine should start at McGill since this was where Sir William Osler began his career and where his novel and inspiring ideas regarding the formation of doctors germinated. As his ideas progressed and began to coalesce into a full-blown detailed program it became clear that major changes in how and what was taught would be necessary. It has also been the case that considerable new resources

have been required whenever transformative changes are initiated. In view of this, the authors believe that the ideas should be moved out into the public space where they can be more widely considered. It is the genesis of this book.

The curriculum of contemporary medical schools in North America was initiated at the Johns Hopkins University School of Medicine when it was founded at the end of the 19th Century. The school's pattern of medical education—two years of medical science followed by two years of clinical training—was considered necessary to promote the newly embraced scientific basis of medicine. It was endorsed by the American Medical Association's Council on Medical Education, created in 1904. The Council asked the Carnegie Foundation to survey medical education in the United States and Canada. The task was given to Abraham Flexner whose report on medical education in the United States and Canada was published in 1910. The *Flexner Report* (Flexner 1910) is widely believed to be the most important event in the history of American and Canadian medical education. Flexner was heavily influenced by what he learned from Johns Hopkins and he championed the centrality of science and its methodology within medicine. His report was an often scathing commentary on the condition of medical education in the early 1900s and by the time the dust had settled many medical schools were gone. The basic model he recommended was two years, (more or less), of medical and laboratory sciences followed by two years, (more or less), of clinical training. This 2+2 structure has remained a recognizable feature of current educational blueprints in spite of various attempts at integrating the two knowledge domains one with the other

and in spite of persistent efforts at fusing them with the humanities and social sciences (Boudreau and Cassell, 2010). These attempts at integration will be described later in the book. Flexner himself, although devoted to the importance of science to medicine, had questions and recurring doubts about a sharp separation between science and medicine's humane functions.

Since the Flexnerian model was adopted by the then existing schools and by every new school as it came into being there have been curriculum review committees formed every several years in most North American medical schools. Invariably, their task is to make changes to the curriculum that reflect desirable responses to new trends in medicine, changes in the student body, or new educational directions that a school might wish to consider triggered by new ideas or interests. Curricular reform is not an easy process because in every school the committees must solve the problems of entrenched interests and the universal stubborn resistance to change by individuals, departments, and institutions. Sometimes the changes reflect new ideas in methods of education. The gradual uptake of problem-based learning and then its slow abandonment is an example of the latter.

The curriculum described in this book is designed to adapt the education of medical students to seven major changes in medicine and society that have occurred over the last 50 years. *First*: the nature of the diseases that engage physicians for the majority of their time has changed from the acute (primarily infectious) diseases to chronic diseases. Many more patients die from chronic than acute disease and that was already true by the 1920s. Chronic conditions

include diabetes, cardiovascular diseases, cancer (which is now often a chronic disease because of treatment success), accident sequela (in part because of the success of the acute treatment of trauma and successful rehabilitation), the chronic impairments of the elderly too often accepted as inevitable, and others. *Second*: the change in the 'status' of patients in the last 40 years so that patient autonomy has much more salience. *Third*: the era of effective treatment of diseases or their effects ushered in after WWII by antibiotics but by now available for countless diseases or impairments of organ function. This development requires a reconsideration of therapeutic thinking and understanding of the goals or reasons for treatment. *Fourth*: the advances of science that have so often revealed the exact mechanisms of pathophysiology. *Fifth*: the revolution in information availability and retrieval and the continuing development and culture-wide spread of new technology in every aspect of life. *Sixth*: the technological revolution that has and will continue to make available new instruments and modalities for diagnosis and treatment. *Seventh:* finally, (and sadly), the deterioration in physicianship that has caused many doctors to perform inadequately in many of the basic skills of the clinical method from history-taking, to physical diagnosis, to communication, to clinical thinking and decision-making.

The authors have all experienced the challenging process of curricular change. For JDB and AF, the issues involved in curricular development have been an important part of their careers in academic medicine.

Medical education, like most social institutions, is strongly influenced by the beliefs of the surrounding society (and the local culture of medicine) about

sickness, disease, health, and the role of doctors. How most people in our culture think about medicine had its origins in the 19th Century with the "invention" of disease in the modern sense. The existence of diseases as unique anatomical alterations (and later biochemical and other abnormalities) provided for the entrance and growth of science in medicine. They also led to something that is more evident in medicine than any other profession—a common language, common interests, methods of investigation, and common purposes among Western medical communities worldwide. Central to all this was the increasing importance and influence of science. This was most striking initially in Europe, first France and finally Germany, where American and Canadian medical graduates went for further training before returning to North America. They included Welch, Osler, Kelly, and Halstead, the "founding four" at Johns Hopkins. These men were strongly influenced by the place of science in medicine and their ideas reflected this. Their influence was far-reaching.

By the middle of the 19th Century in Europe, and to a lesser extent in the United States, the general public became increasingly interested in science and its discoveries. Charles Darwin's book, "On the Origin of Species by Natural Selection," published in 1859, shook the world. Ether anesthesia was first publicly demonstrated in 1846 and antisepsis in the 1870s. It is difficult to over emphasize the revolutionary impact of these two advances. The public paid attention and that further motivated a shift in favor of scientific medicine.

As the influential (usually) younger faculty at important medical schools saw things, their task was to strengthen the influence of science so that it would

displace what some saw as the excessive influence of unlettered experience, social standing, and opinion amongst the clinicians who were the most prominent doctors—physicians and surgeons—in the schools, (and in the surrounding society as well). At Johns Hopkins this meant creating a faculty that was full-time and devoted primarily to the development of its members' special scientific interests, but who were also to be the teachers. William Osler was against the idea of full-time university faculty because he believed it spelled the end of primary interest in the sick patient. An extensive correspondence both before and after he left to become the Regius Professor of Medicine at Oxford in 1905 demonstrates this concern (Osler 1911). As in so many other things, we believe he was correct.

There was continued public interest in medical science before the Second World War. *Arrowsmith*, by Sinclair Lewis published in 1925 lionized the selflessness of the lone scientist and *Microbe Hunters,* the bestseller in 1926 by Paul de Kruif, further excited public interest in medical science. Science seemed to stand not only for its actual content but also for an idealism untainted by monetary interests found perhaps nowhere else. The advances in medicine following WWII elicited more public and professional interest. Penicillin, which cured many common bacterial diseases, often previously fatal, stirred the public and gave meaning to the phrase, "the miracles of modern medicine." New antibiotics followed. Soon the newspapers were filled with stories of never before seen medical and surgical accomplishments. All of the public excitement—actively encouraged by the scientific community—helped further the

already great munificence of the United States government for scientific research, the astounding post WWII growth and increased scope of the National Institutes of Health, and the medical research establishment in the United States and many other countries.

Academic hospitals became filled with young recruits doing research and the ideal doctor changed from the clinician to the doctor-doing-science. One of us (EC) graduated from medical school in 1954 and was actively worried that soon there would not be any more diseases to treat. It sounds silly now, because aside from common bacterial diseases, the number of curable diseases has remained much the same. What had changed irrevocably was the *attitude* towards cure. Doctors in the first part of the 20th century, for all the talk of cure, were resigned to the role of attending to the needs of the sick without being able, most often, to definitively change the outcome of the illness. The quote by the famous Oliver Wendell Holmes, "I firmly believe that if the whole Materia medica, as now used, could be sunk to the bottom of the sea, it would be better for mankind-and all the worse for the fishes", was no longer true. The change to an optimistic attitude, however, was of great importance. It was shared by the public which became devoted to the much publicized progress of medicine.

In the last fifty years, science has become a *social force* with its ideas and ideals permeating every aspect of society. The tenets of science about the importance of 'objective evidence' and the lack of merit of 'subjective information' have achieved widespread *social* importance—even dominance. Medical information fills the internet and other sources. It has become a widely held

belief that the facts of medical science are what make patients better, it does not matter who the doctor (or anyone else) is who wields them. Algorithms and the words 'evidence-based' are now found throughout contemporary life. Research modeled on medical science is common in many professional and even commercial domains. With the preeminence of science, its tenets, and its facts, there have been losses. Implicit in the promulgation of algorithms such as clinical practice guidelines is the notion that the medical act can become 'doctor-proof'. Ideas about how the mind works, especially beneath consciousness, were influential from the 1950s to the 1970s but were dropped from professional approval. These understandings decayed, in large part, because of the subjectivity of much of their evidence and the demeaning of subjectivity in our society. Although knowledge of the body and how its parts work has grown exponentially, knowledge about persons and how life can and should be lived has not kept pace.

Another fundamental social change that has been occurring during the same period as the increasing dominance of science is the change in the status of persons. In the years following World War II a world-wide striving for individual freedom burst forth which found expression in the desire of previously marginalized groups to be accepted as 'full persons'. In the United States, the famous '60s' movements, the civil rights movement and the women's movement are examples, as is the rise of bioethics at the end of the 1960s. Bioethics emphasized patients' rights and the importance of autonomy. As its influence spread so too did the importance of the idea of the patient as a person who is the

central figure in medical care. In the 1950s the slogan was treat the patient as a person but a decade later the patient *had become* a person. Over the next several decades these ideas culminated in patient-centered or person-centered medicine. By now, probably every medical center, medical school, or medical institution defines itself as person-centered. Definitions vary. The definition of the National Academy of Medicine is representative of many: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." The AARP (American Association of Retired Persons) hopes there will be a cultural shift in medical schools such that doctors will preferentially 'engage the client' rather than 'treat the patient'. (English 2016) The definition of Donald Berwick, a well-known expert on health-care policy, is: "The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care." (Berwick 2009) Some definitions resemble a statement of necessary respectful behavior of one person for another; others, such as Berwick's have a forceful political overtone. By any definition, the concept is widely accepted. Nonetheless, the medicine generally practiced remains disease-centered. There is no question that this concept and the belief in patient autonomy, primarily understood as freedom of choice, has resulted in the common practice of providing the patient with a full description of alternative choices and then inviting the patient to make the final decision.

We believe that many current conceptions of person-centeredness are inadequate. There are three important reasons. First, they do not take account of a central truth of medical care; that it is relationship-based. The picture of the autonomous agent who must make the final decision is not true of patients in a relationship with their physicians nor is it true of personal decision-making in general. In studies of decision-making in everyday life, help is almost always sought from other knowledgeable persons. (Hutchins, 1996) Second, they are predicated on the assumption that a person's ability to exercise full autonomy is unfettered by sickness. That is vastly misguided. Illness transforms persons and impedes their abilities to evaluate and select amongst various options. Therefore, to equate patient-centeredness with a radical self-determining agency, as is often done, is highly problematic. The third reason is that medicine is and has always been centered on the person in the important sense that the nature of the person who is the patient plays a major part in which illness develops, its onset, presentation, diagnosis, treatment, course, and outcome. Sickness occupies the whole person—persons are of a piece. It cannot be otherwise.

There are other reasons the idea of patient-centeredness has difficulty entering practice. From their earliest education, physicians are focused on disease. Their textbooks, teaching aids, learning shortcuts, the extensive literature about sickness was and is about disease. Their everyday professional language, rules of thumb (often referred to as heuristics) and linguistic shortcuts are about disease. Their technology is a disease finding or disease treating

technology. The information on which they rely for their care of patients—the accurate, valid, and reliable information from omnipresent tests and measurements—is mostly about disease. This focus is sharpened by the demands of insurance companies, government reimbursement methods (Medicare, Medicaid, Ontario Health Insurance Plan, etc.), electronic health records, and hospital management (with Diagnosis-related groups or DRGs). These all request disease related information. More, the habits of years of practice, short or long, are about disease.

The focus on disease is, importantly and unfortunately, reductionist when the object of medicine should rather be the patient and the patient-doctor relationship. Discussions of medical actions generally revolve on actions in relationship to specific diseases or classes of disease, rather than on what is good and right for the patient in his or her lived-world and the patient over time. This point is sharpened by two recent publications. In the *Annals of Internal Medicine,* of October 6th 2015 (volume 163 number 7) in a section called "Beyond the Guidelines," the question is raised whether routine annual bimanual pelvic examinations should be done. The discussant (an internist) who believes annual examination should not be done points to the paucity of evidence for the procedure's ability to find unknown pathology (which, incidentally, is a limitation equally applicable to screening ultrasounds). The guidelines of the American College of Physicians do not recommend routine annual bimanual pelvic examinations. In a rebuttal, a gynecologist notes the importance of continuing to do examinations in order to maintain proficiency (Burns et al, 2015). The

guidelines of the American College of Obstetrics and Gynecology continue to recommend the procedure.

In the same issue of the same journal, in a Section called "On Being a Doctor," a physician recounts the story of a bachelor farmer in his 80s with mild hypertension and diabetes who came under the care of an organization dedicated to assiduously following established guidelines for the treatment of his diseases. Neither his hypertension nor his diabetes responded and his medication doses were increased (following the guidelines). Three weeks later he got up to urinate and fell, fracturing his hip. (It is implied that the fall resulted from the new medical regimen.) The story is recounted by the physician who admitted him to the hospital for an arthroplasty. He had a number of complications and ultimately was unable to return home. The necessary medical care exhausted his savings and he required Medicaid. A lien was placed on his home because of Medicaid. His brother, with dementia, whom he had been caring for, was placed in a nursing home. The piece was called "The Tyranny of Guidelines." (Sarosi, 2015)

The general internist who does not do routine pelvic examinations has a significant probability of misdiagnosing (for example) the woman with an acute abdomen and a twisted ovarian cyst because proficiency in pelvic examinations is poor due to lack of experience. The focus of the discussion was diseases to be or not to be found rather than the place or issues related to pelvic examinations in general and on the competence of physicians; the latter is in question because of lack of experience arising from a predominant disease-

focus. The second case reveals potential problems with the routine application of guidelines and on the questionable competence of physicians in judging when or when not to apply guidelines.

The Physicianship Curriculum is devoted to preparing medical students to take care of sick patients—its focus is the patient, the student, the physician-as-clinician, the physician-as-teacher, and their inter-relationships. If disease is the reason for the sickness, it must be treated, but the critical point is *attending to* what is best for the patient and what is required of physicians so that their judgments and skills are best able to meet that responsibility. In parallel, if the transmission of knowledge and skills to novices is an obligation of teachers, this must take place, but a reverberating imperative is *attending to* the character development of the student so that they come to think, perceive, judge and act like physicians. The notion of *attending to* is as important to a pedagogic as it is to a clinical relationship. A defining feature of this curriculum is a triangle of relationships. We have termed it the “Educational Triangle.”

A major barrier to physicians becoming person-centered in their day-to-day practice is that what they know or learn about persons is not *logically* related to disease or the language that we use to speak in disease terms. The following quotation emphasizes the place of logical coherence in our thought and actions:

"For more than a century, diseases have had *logical*—conceptual—status as a biological entity within the system of medical science. It is, in fact, the logical focus of the system. This means that in thinking about medicine one always ultimately gravitates to the concept of disease. A system in the sense of the system of medical science is a group of related ideas and beliefs that circumscribe and contain within them all the pertinent aspects of the system being considered. The word *model*, as in *medical model,* is commonly used to express the same idea. In a coherent system, all statements about its parts

should *necessarily—logically*—follow from one another. Whatever else one might say about illness, pointing out possible psychological or social elements will remain peripheral to medical thinking because those concepts lie outside the system of medical science.

Working within the scientific model of medicine, the social, psychological, and personal elements found in *all* illnesses do not logically follow from considerations of disease because of a fundamental assumption of the medical system: since diseases are biological entities they are part of nature. From this assumption it follows that they can be understood and investigated as material things—matter—just like the rest of nature.″ (Italics in the original.) (Cassell 1997p 48)

Previous curricular innovations have attempted to solve the problem of introducing patient centrality within the educational experience by emphasizing two side-by-side goals. For example, the University of Rochester developed what it calls the "double helix curriculum." One strand followed the traditional biomedical model and the other strand was devoted to person-centered concerns. The University of Western Ontario curriculum, described so well in the excellent book, *Patient Centered Medicine: Transforming the clinical method,* with Moira Stewart as the lead author has the biomedical diagnosis and the person-centered diagnosis coming together at the end. (Stewart 2003). However, we maintain that there are not two separate goals—a person related and a disease-centered conclusion. Our book proposes a synthetic principle, one based on a unique definition of sickness.

As long as disease remained the almost single minded concern of physicians' education and thought, technology, therapeutic thinking, therapeutic modalities, and underlying research, we, in common with others who have tried, could see no solution to the problem of ensuring that the non-disease elements which bear on sickness were part of the thinking of physicians or of ensuring that the functional needs of particular patients were part of the therapeutic equation.

Attempting to teach that which lies outside logical coherence invariably leads to failure.

We believe that the solution in logic lies in redefining illness so that the sick person is central rather than the disease. We reasoned as follows: All persons have a body. All human activities, relationships, involvement in the world occur through the body. A medicine of persons, however, cannot stop at the edge of the body. A definition of illness must recognize this fact. The definition must reflect the actual phenomena of the illness *process* (events occurring through time) throughout the person, true to the *individual* sick person, and rooted in the biological basis of human life. We believe that the definition described herein meets these requirements. The Physicianship Curriculum is based on this definition: *A person is sick who cannot pursue his or her goals and purposes because of impairments in functioning. Functional impairment may occur anywhere from the molecular to the spiritual.*

Many, but not all, impairments of function and functioning are related to disease. Patients are not better, even if the disease is eradicated. Patients are sick if they are not functioning well enough for them to do or accomplish what is important to them. This state can be seen wherever the aged can be observed in the activities of daily living. With this definition the primary object of diagnosis is impairments of function and the secondary object is the source of the impairment. Problems of functioning can be secondary to physical, psychological, or social impairments. Since the object of medical care is not only

to discover the dysfunction and its origin, but to restore functioning, pride of place does not go to the physical sources of the problem.

Medical care based on that definition becomes inescapably person-centered because only persons know what goals or purposes are important to them. Persons know how goals and purposes evolve in the face of changes in the arc of sickness, for example, the dying patient continues to have goals and purposes if only to continue to be the person he or she is. A focus on function provides a basis for medical action. It takes into account many features of everyday life and is responsive to context as well as social, psychological, and environmental factors.

Taking care of the sick (or even the well) person requires a huge body of knowledge. It is universally expected that medical school will teach that knowledge to the students. This Physicianship Curriculum will do the same. We believe, however, that it will go beyond many curricula in several important respects. First, since it is person-centered it will specifically teach about persons from the first day of the first year—the first year will have a course that teaches in detail what a person is. In the beginning it will teach about normal persons and in the second year it will teach about sick persons. The curriculum will teach about the body and its function in health and sickness and in relationship to the function of persons in their lives. For example, kinesiology, the study of the physiological, mechanical, and psychological mechanisms involved in human movement will be in taught in conjunction with surface anatomy.

We believe that William Osler was correct in stressing the importance of students learning medicine with actual patients. Circumstances have changed drastically since the days when the rooms of the hospital provided sick patients with whom students could be taught and from whom students could learn. In the modern hospital, patients are hospitalized for such short periods that students cannot establish relationships nor learn about the trajectory of illness. In addition, diagnostic studies previously done on patients in the hospital are now often accomplished outside the hospital. So the teaching with actual patients must be approached in other ways. Our students will start seeing patients at home from their earliest days at medical school and will follow them at home and in clinics. When they are in their final year they will gain experience in hospital medicine. Some things previously taught with patients as the subjects can now be taught in simulation centers which are common to most schools. The details of our approach are in the chapters that follow.

As a didactic method the parade of lectures to whole classes day after day (and often hour after hour) are a thing of the past. The lecture format has its place but other teaching methods have largely supplanted it and will be employed here. Learning is universally acknowledged as important and all physicians can recall teachers who had an outsize influence on their development. Despite this, teaching does not generally receive the same status as, for example, medical research. In the Physicianship Curriculum students are in the same small groups throughout their medical school career and these

groups have ‘Attending Teachers’ who receive appropriate recognition and rewards by the medical school.

Finally, every year of the 4-year curriculum is occupied by active teaching. Through all the years, the problems of technology—its use and control—are part of the curriculum. Not only how technologic devices work and are employed, their diagnostic or therapeutic utility, their continued development, but also their contributions and limitations in decision-making. Another technology—information retrieval and processing—has completely upended an aspect of medicine that previously played an important part in medical education. Factual information used to be part of the daily commerce of the student. Facts, their acquisition and access, are now easily accessible. This is a result of the omnipresence of information whose display is part of the everyday activity of a large body of the population. They are as simply discovered by patients as by doctors and their availability will only get easier and faster. The *knowledge, cognizance, or understanding* that physicians have of the body, persons, function, and disease must be distinguished from the factual information at their fingertips. Understanding human life, patients, function, pathophysiology, disease, sickness and its impact, and treatment is the focus of medical education. The development of information technology, the availability of learning aids can only help physicians maintain their knowledge of medicine, writ large. By what means this knowledge is continually gained and by what means it is maintained is emphasized throughout the curriculum.

The practice of medicine takes place through time. The doctor of tomorrow is the doctor of today plus the experience gained through on-going clinical work. This explains, in part, the prominence of the time-honored method of the apprenticeship in medical education. The learning of medicine as a practice is a life-long temporal object. Ideally, doctors are always learning and becoming more proficient at what they do. Every working day is distinct and occupied by patients who are different than on previous days (even if they are the same patients). So much time and so much writing about medicine is currently occupied by administrative, social, political, and monetary details that the actual 'being' of a practicing doctor, his or her lived experience and relation to medicine can get lost. Further, the habit of mind, illustrated above by the example of the question of periodic examinations has made every doctor-patient interaction into an event that seems not to have a relationship with other similar interactions. Many descriptions of what person-centered medicine is or the ethical consequences of the concept are written as though there is no past or future or as if a doctor-patient interaction is an event of an isolated moment.

Think again of the pelvic examination, as a screening test for ovarian cancer, or the digital rectal examination in relationship to prostate cancer, and also think of the person-centered defining phrase, "nothing about me without me." Should the doctor say to a patient: "I would like to do this examination but my chances of finding disease are very small. If I don't examine you my skill will diminish so it is important that I do this to remain skillful. The risks to you are negligible. May I do the examination?" Were the question posed in this manner, we expect that

most patients would refuse—understandably so. But, we ask the reader to consider the roots and the implications of this. It is an illustration of the single-minded focus on disease and also evokes the idea that every interaction is an event without a past or a future. This perspective may have obscured the actuality of the working doctor. We are not certain how to mitigate its influences but it may require a revitalized commitment to an on-going, inter-subjective relationship over time.

For the moment, think of the physician's life as a necklace of beads. The concern of many medical teachers seems to be the individual beads, not with the necklace. A life is an aesthetic object in part because it is a temporal object. As the American philosopher John Dewey (1928) expressed, in his inimitable fashion: "human behavior is longitudinal, not just cross-sectional." Each bead counts as one among many – on a trajectory. The Physicianship Curriculum accepts the challenge of having an influence on the life, the being and the identity, in addition to the knowledge of the graduating doctor. The life of the doctor practicing medicine is lived through days, weeks, months, and years, not just done day to day. Any other view is not true to doctors who care for sick persons….or to physicianship.

William Carlos William was one of the best known poets and men of letters in the 20th Century. For forty years, all his working life, he was also a small town doctor. At age 68 he wrote his autobiography one chapter of which is called, "The Practice." Here he is on the working doctor in the practice of medicine:

"It's the humdrum, day in, day out, everyday work that is the real satisfaction of the practice of medicine; the million and a half patients a man has seen on... visits over a forty-year period of [working] days...that make up his life...But the actual [seeing] people at all times under all conditions, the coming to grips with intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get better when they were ill, has always absorbed me……

"Time after time I have gone into my office ...feeling as if I couldn't keep my eyes open a moment longer...Once I saw the patient all that would disappear. In a flash the details of the case would begin to formulate themselves into a recognizable outline, the diagnosis would unravel itself, or it would refuse to make itself plain and the hunt was on. Along with that the patient himself would shape up into something that called for attention, his peculiarities, her reticences or candors. And though I might be attracted or repelled, the professional attitude which every physician must call on would steady me, dictate the terms on which I was to proceed. Many a time a [doctor] must watch the patient's mind as it watches him, distrusting him, ready to fly off at a tangent at the first opportunity..."(Williams 1948)

Practicing doctor after practicing doctor has said the same thing (although not so well).

The new educational modules that were introduced in 2005 at McGill University were grounded in the notion that a physician fulfills two roles: that of the professional and the healer. This idea was captured using the term, 'physicianship'. Physicianship became one of the program's important and distinctive features and one of five curricular components. Its main focus of attention was the teaching of a new clinical method, one adapted to the exigencies of contemporary medicine. The revised clinical method incorporated teaching towards the obligations of the healer role (e.g. the relief of suffering through presence and accompaniment) and emphasized time-honored traditions such as clinical observation and attentive listening.

The experiences of McGill's undergraduate medical program, over the course of a decade, in developing, implementing and evaluating physicianship as

a curricular sub-component inspired the three authors to imagine its continued development, enhancement, and expansion. The transition from a program that has physicianship as one of its conceptual pillars and representing one set of courses amongst several others to one where physicianship represents the core defining vision as well as the armature of the entire educational blueprint is the focus of this book. The new curriculum is therefore a blend of the 'already outlined and previously implemented' with the 'envisaged and yet-to-be-delivered'. We have tried to make this clear in our writing. For example, wherever we speak of the new imagined curriculum we use upper case for the first letters. This new curriculum is therefore the 'Physicianship Curriculum'. This is in contrast to a program (such as existed previously at McGill and other schools) where specific and isolated aspects of physicianship, physicianhood, doctoring, professionalism, and/or healing were addressed.

The book presents the theoretical basis and educational blueprint of the Physicianship Curriculum. The logic of its organization is straight forward. It has four sections:

Section I lays out the rationale for a new conception of the medical mandate. It discusses various understandings of health, illness and disease. It proposes a new definition of sickness and based on that a new strategy for diagnosis and treatment. It presents the two main concepts foundational to the Physicianship Curriculum: function and persons. It culminates in an exploration of the popular yet incompletely understood idea of 'person-centeredness'.

Section II looks at important features of medical practice: the goals of the physician, the doctor-patient relationship, and notions of the 'good doctor'. The clinical method is discussed in detail. The clinical method is the general term that refers to the means by which doctors gather information about their patients and enter it into their process of care. The importance of subjectivity to medicine and in particular to the clinical method is discussed.

Section III gives an overview of important issues in medical education. It starts off with a brief survey of major reform movements in medical education over two centuries. It expresses our doubts about the now highly popular 'competency-based' educational framework and explores the ups and downs of clinical teaching. Teaching the elements, new and old, of a revamped and repurposed clinical method are introduced.

Section IV describes the Physicianship Curriculum in detail, from theory to practical aspects. It discusses how the proposal is anchored in the curricular innovation project that unfolded at McGill from 2005 to 2015. It presents its theoretical foundation, most importantly, its basis in interpersonal relationships, in practical knowledge and character development. The latter is approached using insights from Aristotle (notably in Nicomachean Ethics) and neo-Aristotelian philosophers. A panoramic view of the curriculum is first outlined. This is followed by concrete details, including instructional strategies and scheduling, of each of the four phases of the curriculum and the four transition periods between each phase.

The book is intended to be accessible to a varied audience. It speaks to educators and students in the health professions; leaders and managers of the academic enterprise; clinical supervisors and teachers; clinicians in all disciplines; and interested laypersons. Although it is not aimed primarily at educational theorists or philosophers of medicine it is hoped that they may engage with some of its conceptual tenets, arguments, and recommendations.

We named this book "The Physicianship Curriculum: A Rebirth of Medical Education" for several reasons. It is based on a *new* definition of illness. It is *actually, truly* and *irrevocably* person-centered. It reconceives the knowledge base required of students to work with patients; it teaches about the well and sick person in the same richness and detail that in the past was reserved for the natural sciences. Yet, it retains the necessary medical allegiance to the sciences and their methodologies— pillars of modern medicine. It places persons and inter-personal relationships at the center of the educational process. The Physicianship Curriculum is grounded in three foundational relationships: doctor and patient; doctor-teacher and student; student and patient. The emphasis of this educational process is not solely the transfer of medical knowledge or acquisition of skills; it is about the transformation of a 'student-person' into a 'doctor-person'.

This curriculum remains connected to the past of medicine. Certain intellectual traditions (e.g. empirical methods) have been unabashedly adopted. Honorable educational methods (e.g. apprenticeships) have been renewed and

updated. Time-honored clinical methods (e.g. observation) have been adapted to current needs.

The curriculum is described without educational jargon. Where at all possible, it favors commonly used English words and traditional meanings.

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