

ANALYSIS OF THE *DISCUSSION PAPER* “THE CARE OF THE PATIENT AND THE SOUL OF THE CLINIC: PERSON-CENTERED MEDICINE AS AN EMERGENT MODEL OF MODERN CLINICAL PRACTICE” BY ANDREW MILES AND JUAN E. MEZZICH, *IJPCM* 2011; 1 (2) 207-222

Logos, ethos and pathos in balance - the care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice.

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Abstract

In a recent discussion paper, Miles and Mezzich described person-centered medicine (PCM) as a model of modern medical practice that has emerged from the intellectual currents of the past century. In this commentary, we consider what PCM has to offer as a model for the clinical encounter and for clinical judgement. The doctor-patient relationship is an important thread in a person-centered medicine that visualizes the clinical encounter as a dialogue between two persons. Person-centered clinical judgement is concerned with the individual clinical case and as such is integrative, context-sensitive, interpretive and circumstantial. A care model incorporating these elements of dialogue and individualized judgement is ideal for older patients, for whom population-level guidelines are often inapplicable, who are often dependent on other persons and who are heterogeneous in their needs. As such a model, PCM is the dialectic synthesis arising out of decades of conflict between patient-centered medicine, and its antithesis, evidence-based medicine. If PCM is to progress from a prescriptive model to a descriptive model of modern medicine, its proponents must claim its philosophical commitments, keeping in mind that a model is fundamentally instrumental and not necessarily always literal. Medicine should look to a care model that is person-centered in the ways described here and that keeps the rational, virtuous and humane elements of practice in balance.

Keywords

Doctor-patient relationship, evidenced-based medicine, individualized care, models, older patients, patient-centered care, person-centered medicine

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Introduction

“Increasingly, the profession that we appeal to in our direst need is becoming – in hospital and out – a medicine of strangers. Little wonder that contemporary physicians locate medicine’s healing authority in science rather than in its best, most authentic source, the care of patients” – Kathryn Montgomery [1].

“At its best such a [randomized controlled] trial shows what can be accomplished with a medicine under careful observation and certain restricted conditions. The same results will not invariably or necessarily be observed when the medicine passes into general use; but the trial has at the least provided background knowledge which the physician

can adapt to the *individual patient*” (emphasis added) – Austin Bradford Hill [2].

The ‘Medicine of the Person’ movement has been re-imagined, re-invigorated and re-branded as person-centered medicine (PCM). In their discussion paper ‘The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice’, published in the *International Journal of Person Centered Medicine* [3], Miles and Mezzich supply the context for what furthermore represents a *reconstitution* of the humanistic movement into a new medical model, a model for patient care. In this response to their panoramic analysis of developments relevant to the evolution of PCM over the last 100 or so years, we propose that the two core components of their person-centered

medical model are the relationship between the persons of the physician and patient and the individualization of care. These pillars are capable of serving as the basis for clinical judgment and the clinical encounter, both of which should be accounted for in a complete 'model of modern clinical practice' [3]. We make the case that PCM is a particularly pertinent model for the quality care of older patients, a fast-growing demographic in developed societies. We consider the nature of the 'coalescence' of the evidence-based medicine (EBM) and patient-centered care (PCC) movements described by the authors. Finally, we suggest what is needed if PCM is to progress from a *prescriptive* to a *descriptive* model of modern medicine.

Recapitulation

A brief reprise of the historical narrative told by Miles and Mezzich [3] will serve to illustrate the origins and foundations of the PCM model. Their story begins in the early Twentieth Century with a looming crisis in medicine, when young clinicians, enthusiastic about the rapidly expanding science base of medicine, began to practice a kind of medicine more akin to applied science than a healing profession informed by science [3]. Miles and Mezzich identify the origins of 'Medicine of the Person', a humanistic movement, with Peabody and Tournier. A caring disposition had been the mark of the virtuous clinician in previous eras when doctors could comfort always, but cure rarely. In *The Care of the Patient* (1927) [4], Francis Peabody lamented the lack of feeling for the patient displayed by novice physicians embracing the science of medicine. Paul Tournier later added his voice to the discourse with a call for a *medecine de la personne* [5] - an integrated style of practice that that was concerned with the whole person of the patient. Peabody and Tournier advocated for a re-orientation of the medical 'gaze', so that the patient would be seen as a fully contextualized person, with a unique phenomenology, situated in their own physical and social world.

At the time George Engel published his seminal work 'The need for a new medical model: a challenge for biomedicine' (1977), he believed that a reductionist, disease-centered 'biomedicine' had become the dominant medical model [6]. Beyond its function as a conceptual model of the patient, Engel intended for his contrasting *biopsychosocial* model to direct a far more humane patient care [7]. Levenstein and colleagues also suggested a model of care for family practice in the form of the 'patient-centered clinical method' [8], a relationship-centered medicine in which the physician's agenda is balanced with that of the patient. These two methods for the application of a person-centered frame of reference to the practice of medicine marked the beginning of the evolution of Tournier's 'Medicine of the Person' from an ideal to a nascent medical model.

Miles and Mezzich note that as the *patient-centered* nomenclature became popular, it was inconsistently used to describe schools of thought differing in subtle or even substantial ways, though all were concerned with the

individual patient. As a diverse collection of ideologies, patient-centered care is a "patient empowerment initiative" [3], but due to a lack of agreement on theory or even outcomes, it is not a coherent model of practice. Alongside PCC, a radically different evidence-based medicine (EBM) movement grew out of the concern that modern medicine was not efficiently and effectively integrating the mounting external evidence generated by research into practice. From the outset, EBM was criticized on many points [3], including the unquestioning faith in the superiority of evidence generated through clinical research, especially randomized controlled trials (RCTs) [9-14]. Despite serial reconstitutions of the EBM model over 2 decades [15], the problem of how to apply evidence generated from epidemiological studies or RCTs to the individual patient [2,14,16-18] was never adequately addressed. Therefore, in its current form, EBM stands in stark contrast to person-centeredness and it is unclear to us how it could be modified to fit the demands of modern patient care without abandoning the core tenets of the ideology, including what it means to EBM proponents to be *evidence-based*.

Following Hartzband and Groopman [19], Miles and Mezzich propose that EBM and PCC must *coalesce* [3]. The result would be a medicine informed by evidence generated by science, deeply committed to the care of the individual patient and situated in the relationship between the persons of the patient *and clinician*. As an addition to previous person-centered models [7,8], PCM makes explicit the need to address the challenges of incorporating various warrants for decision-making into the complex process of clinical judgement [3]. Miles and Mezzich articulate "a vision...of medicine as a science-using and compassionate practice, centered upon the persons of the patient and the clinician(s) engaged in a mutual and dialogical process of shared decision-making, focused on the patient's best interests, within a relationship of equality, responsibility and trust". Person-centered medicine is offered as a potential realization of that vision and an antidote to de-personalization in medicine or, as they conclude, "an emergent model of modern clinical practice for our times" [3].

PCM and the doctor-patient relationship

As a relationship-focused model of practice, PCM concerns the clinical encounter or the interaction between clinician and patient. The humanistic movement in medicine has often associated de-personalized care with an impersonal relationship between a patient and their physician(s) [4,6,20] that often manifests when the care team is large, as is commonly the case within the hospital setting. The clinician may be more interested in the meaning of physical signs and reported symptoms in the context of their taxonomy of disease and less interested in the meaning of these manifestations for the patient, which is entirely *personal*. In order to make their experiences meaningful - to make sense of it all, persons order and express these as a narrative [21]. A person-centered model

of *care* emphasizes *caring* about the patient's illness narrative and the unique subjectivity of the patient. In PCM, the ethical character of the exemplary clinician is partly revealed by their caring disposition towards the patient as a person, beyond the respectful disposition towards the patient as an autonomous agent that is often central to appeals for 'patient-centeredness'.

Buetow notes that in a person-centered model of the clinical encounter, doctor and patient are "co-producers of care" [22], capturing the sharing of responsibility and decisions that would naturally take place in a relationship where both parties recognize and appreciate the perspective, knowledge and roles brought to the encounter by the other. Both clinician and patient have valuable self-knowledge and external knowledge. For the clinician, self-knowledge takes the form of insight concerning one's own abilities, limitations, values and goals and external knowledge consists of evidence from their own clinical experience, scientific theory and the clinical literature. For the patient, self-knowledge takes the form of insight into one's own state of positive or negative wellbeing, values and goals and external knowledge consists of evidence from past experiences, from the experiences of others and from their own investigations. In a relationship of equality promoted by Miles and Mezzich [3], no particular kind of knowledge can have universal authority over other kinds and the flow of knowledge must be bidirectional.

Both parties also bring different roles to the relationship. Physician roles have recently become important as part of the CanMeds Physician Competency Framework, which describes 7 roles for the physician: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional [23]. Designed by The Royal College of Physicians and Surgeons of Canada, the CanMeds Framework is now used to generate curriculum objectives and assess trainees in undergraduate and postgraduate medical training around the world. Regrettably, while the Person role was taken to be an important physician role in a precursor to CanMeds [24], it was subsequently abandoned. Person-centered medicine laudably reclaims the person as the lost physician role - one that should be brought to the clinical encounter to ensure frank honesty about the fallibility of the Medical Expert and the imperfect nature of their clinical judgement. Only models that admit, rather than conceal, the uncertainty of clinical practice and the personal nature of clinical judgement in a way that EBM never fully has, adequately capture the true nature of medicine. A frank recognition of all of the roles and responsibilities of the two persons engaged in the therapeutic relationship, including the doctor's obligations to the healthcare system and profession and both parties' obligations to themselves and each other, within a trusting relationship, is necessary for establishing a mutual understanding and mutual expectations. The doctor-patient relationship modeled by PCM is, therefore, a more thoughtful and valuable depiction of the clinical encounter than either the inherently *clinician-centered* EBM or *patient-centered* care.

The description of PCM as a 'dialogical process' [3,25] invites the recognition that there is a multitude of

different dialogues that take place in the clinic, not all of which consider a decision to be the primary outcome of the conversation [17]. Doctor-patient dialogues may have the expressed or unexpressed purpose of persuasion, the negotiation of therapeutic goals, the seeking of information or deliberation and decision-making [10]. In some of these dialogues there is an obvious pull in one direction or the other (either doctor or patient may persuade or seek information from the other). In the rest of these dialogues, the process should be completely shared (negotiation and decision-making should involve a mutual consideration of the perspectives of both clinician and patient). A person-centered practitioner would add to this list of dialogues those encounters concerned with comforting and consoling, which necessarily polarize the clinician as the person caring *for* the patient and the ill person in the relationship as the one being *cared for*.

The doctor-patient relationship remains central for medicine, but in keeping with Upshur's analysis [26], Miles and Mezzich propose that "medicine does not have or need a base" [3]. Thus, PCM does not rest on a foundation built from this relationship or from any other singular element of practice, in contrast to the way medicine is said to be *based* on evidence, narrative or values, according to other schools of thought [25]. As a metaphor, a base is highly restrictive and in fact only useful in relation to simple, static entities that require an equally simple and static grounding. To capture the complex and interprofessional nature of medicine, Upshur brings to mind a metaphor employed skillfully by C.S. Peirce: that of a cable. "With its intertwined strands, the cable gains its strength, not by having a single golden thread that winds its way through the whole. No one golden strand defines the whole" [27]. If medicine is a cable, then the doctor-patient relationship represents an important strand connecting both persons across a great divide. When the strand frays, doctor and patient are cast apart and the whole is weakened. When the strand is reinforced, it brings both parties together and strengthens the fundamental enterprise of medicine.

PCM and the individualization of care

Those who have sounded the alarm in response to what they perceive to be an increasing de-personalization of clinical practice have often emphasized one particular prong of this claim, that is, a forgotten clinical imperative to comfort, console and care for the patient [11]. However, *de-personalized care* can encompass a plurality of meanings, including patient management that neglects the particularity of the presenting patient and their circumstances. In the contrasting approach to clinical judgment offered by a person-centered frame, *individualized care* is integrative, context-sensitive, interpretive and circumstantial.

Integrative refers to the incorporation of diverse kinds of knowledge into the process of clinical judgement. Insofar as every clinical decision is made toward some

desirable outcome, every decision has an ethical component that is addressed by integrating patient values and desires into decision-making. In an *evidence-informed* individualized care model, the clinician also weighs general, external evidence against a particular knowledge of the patient. The general/particular challenge of integrative care is discussed elsewhere [1,9,12,28] and is especially vexing when determining how general evidence from epidemiological studies or clinical trials can be applied to the care of the individual patient [2,14,16-18], given his/her unique biology, demographic characteristics, history, health status, goals and values. As a *context-sensitive* model, individualized care recognizes that the patient is also situated within a particular socio-cultural space, that the patient's relation to the world and their psychological state influence care and that these biopsychosocial dimensions of the patient may, in fact, be a *vera causa* of disease [6]. Individualized care sees clinical knowing as an *interpretive* or hermeneutical [29,30] exercise, in which cultural and historical context, including personal experience, shapes meaning for clinician and patient alike. Finally, clinical judgement is highly *circumstantial*. This final statement hangs on the conviction that every patient is unique and as such, clinicians must avoid so called 'cookbook medicine' and overly categorical thinking.

As Miles and Mezzich have identified [3], a casuistic approach to clinical judgement, resembling the case-based approach to ethics [31], is well suited to a model that individualizes care. In the method advanced by Tonelli [13,32], the clinician *integrates* several kinds of warrants into decision-making (empirical evidence, experiential evidence, pathophysiologic rationale, patient goals and values and system features). Unlike in a hierarchical approach to the evidentiary basis of decision-making, in medical casuistry "[t]he relative weight to be assigned to each of these potential warrants for action depends upon the particulars of the case at hand" [13]. Most of the kinds of warrants listed are of a general nature, but they must be integrated with knowledge of the patient's particular goals and values, as well as their physical findings and details from their illness narrative. Implicit in the casuistic approach is the reasoning that clinical thinking must be *circumstantial* or 'case-based', rather than formulaic and must not be constrained by dogmatic rule-following. Conscious of the importance of *context*, the physician may choose to widen his/her 'gaze' upon the contextual background of the case at hand and must bring particular aspects of the case into the foreground at different times. Finally, casuistry is a fundamentally *interpretive* exercise and, as such, permits multiple contrasting inferences to be drawn from the same warrants [13,30].

While Tonelli's approach offers a good starting point upon which to develop a person-centered model of clinical judgement, his is not the first identification of a link between medicine and casuistry [33], nor is his the only approach, in general, that recognizes the importance of the particulars of the clinical case. *Phronesis* or practical reasoning [1,34], narrative-based medicine [35] and interpretive medicine [36] also rest on the uniqueness of each case and these methods can offer further insight for

proponents of PCM seeking to advance a casuistic model of clinical judgement.

The act of judgement is not confined to clinical encounters in which a decision is to be reached. Warrants can more broadly serve as premises supporting any argument taking place within the clinical setting. While Horton described the argument as "the fundamental unit of medical thought" [36], it can also be seen as the syntax of clinical reasoning, which is a kind of *explicit* thinking. Argumentation is both the grammar of the clinician's internal monologue when deliberating over the details of the case and the grammar of certain doctor-patient dialogues, such as those involving persuasion or decision-making. A great strength of the relationship-centric account of the clinical encounter modeled by PCM is that it supports a dual locus of clinical reasoning, where reasoning takes place both within the traditional context of the physician's internal monologue and also within dialogical contexts. In Walton's concept of dialectical argumentation [37], the nature of the dialogical argument depends on the nature of the conversation taking place. Walton's typology, which includes 6 'contexts for conversation', can be applied to the clinical encounter [10] to categorize the dialogical types of clinical reasoning. Taken together, dialectical argumentation and medical casuistry provide a powerful approach to clinical judgement and an equally powerful description of the personal nature of clinical practice.

The care of older patients

The unique difficulties of caring for older patients, whether in our communities, hospitals or care facilities, challenge our modern methods of healthcare delivery and indeed our very philosophy of care [38]. Countries are in the midst of an escalating global crisis of aging and chronic disease [39,40], which neither EBM nor PCC have adequately addressed. From an EBM standpoint, evidence-based, disease-centered clinical practice guidelines, which are intended to optimally direct care, often lack understanding of or have a poor evidence base for this population [41-43] and may even conflict with one another when applied concurrently for a single multi-morbid patient [43]. Geriatric patients are usually excluded from RCTs due to their advanced age or co-morbidities [44-46] and the inferential leap from the existing trial evidence to the older patient (a leap of faith, to be sure) is perilous. On the other hand, the lens of PCC is often too narrowly focussed on the patient alone [22,25], which is not ideal for those older patients who are heavily dependent on others, whose autonomy is compromised by disease or disability and whose needs and preferences can only be considered alongside those of their caregiver(s). In their discussion paper, Miles and Mezzich are justified in saying that PCM "is of very particular applicability and value in the management of chronic disease" [3]. Person-centered medicine is, then, also valuable in the management of older patients, as a population suffering with a high burden of

chronic diseases and for whom current teaching and practice models are inadequate [47,48].

Older patients constitute an unusually heterogeneous group [48,49]. These patients vary greatly in their comorbid conditions [50], health services utilization [51], social history [49] and functional status [38], among other characteristics. Thus, a one-size-fits-all approach to their management is unsatisfactory. A new, personalized approach to the care of the elderly is much-needed, in addition to one that is holistic in its consideration of the patient. Snaedal identified that the psychological and social needs of older patients are pronounced compared to those of younger patients [49]. There is a high prevalence of dementia and cognitive impairment among the elderly [52], along with an increased need for support with daily living. In addition to psychological and social needs, older patients have complex treatment needs that are not being met by conventional therapeutic approaches [38,48]. Lastly, their existential needs, which are often overlooked by existing care models, are in critical need of addressing within each consultation. Existential needs include the opportunity for the patient to define their own health and wellbeing, dictate their conditions of living and goals for life and, importantly, determine their own care near the end of life. None of these diverse needs can be met outside of a medical model that includes, within the therapeutic circle, multiple persons beyond the patient.

Older patients require medical care described by Mezzich and colleagues as being (1) *of* the person, (2) *for* the person, (3) *by* the person and (4) *with* the person [3], a care model that: (1) admits knowledge of the unique functional and health status of the patient, (2) strives to address the psychological, social, therapeutic and existential needs of the patient, (3) recognizes the limitations of the knowledge and evidence that the physician brings to the encounter and (4) maintains that the goals of therapy should be decided in partnership with the patient and often their caregiver(s). This is the kind of medical model that, in our interpretation, PCM seeks to be.

A coalescence of EBM and PCC?

In an article in the *New England Journal of Medicine*, Hartzband and Groopman call for the coalescence of the EBM movement and medical humanism, where medical humanism is the movement that “seeks to understand the patient as a person, focusing on individual values, goals and preferences with respect to clinical decisions” [19]. This rendering of medical humanism captures much of the definition of patient-centeredness offered by the Institute of Medicine (IOM) in the U.S. [53]. Along the same lines as Hartzband and Groopman, Miles and Mezzich propose that “the time has come for EBM and patient-centered care to *coalesce*” [3]. However, they also point to “a foundational irreconcilability between the fundamental principles of EBM and those of patient-centered care”. What at first might seem like a contradiction between these two statements can be clarified by speculating on the nature of the coalescence suggested by the authors.

A clue to the meaning of *coalescence* as it is used by Miles and Mezzich is found in their explanation for the appearance of PCM as the result of a “Hegelian synthesis” [3]. The authors allude to the dialectic triad of thesis, antithesis and synthesis commonly (mis)attributed to the German philosopher Georg Wilhelm Friedrich Hegel [54]. According to this pattern, one of PCC or EBM would be seen as a thesis and the other as its antithesis, thus capturing the ‘foundational irreconcilability’ between the 2. This irreconcilability arises out of the primacy placed on individual patient-determined outcomes in PCC and the privileging of study designs that measure population average, ‘evidence-based’ outcomes in EBM. As a resolution to the conflict between PCC and EBM, the ‘Hegelian synthesis’ is not the triumph of one movement over the other, but a wholly new model that reconciles the relative strengths of both. Through a dialectic process, out of decades of conflict between an evidence-based and a patient-centered approach to clinical practice, an apparent synthesis has been achieved in PCM, the evidence-informed, person-centered model described by Miles and Mezzich [3].

If PCM truly combines the strengths of EBM and PCC, as suggested [3], it is worth considering what the relative strengths of both movements are. In EBM, we find the mantra that the clinician must stay abreast of the constantly accumulating medical literature [55]. In the earlier EBM literature, we also find the idea that the critical evaluation of external evidence is an important clinical competency [56]. In PCC, we see that important consideration is given to the patient’s preferences, needs and values, as well as their involvement in their own care [53]. We believe that these aspects of EBM and PCC are worthy of inclusion within a new medical model. Further thought should be given to how EBM and PCC can constructively collaborate to enhance person-centered care.

From emergence to prevalence: the road ahead

Person-centered medicine is both an emergent movement and a patient care model. As a patient care model, PCM encapsulates both the clinical encounter and clinical judgement, which together account for the doctor-patient relationship, the doctor-patient dialogue, the ethics of practice, physician roles, clinical reasoning, clinical decision-making and the traditional domains of patient management, including diagnosis and treatment. As a *relationship-focused* model of care, it is currently most applicable to primary care, where continuity in the doctor-patient relationship is most common: this is also where complex older patients are most often managed. The model which Miles and Mezzich advocate to replace “impersonal, fragmented and de-contextualized systems of healthcare” [3], is normative, but not yet descriptive, of modern patient care. In order for PCM to become an ascendant model and describe the way physicians practice, further work is needed in establishing its theory and application.

In their discussion paper, Miles and Mezzich discuss what is needed to successfully implement person-centeredness in medical practice, including the need for the development and testing of person-centered approaches specific to various aspects of care [3], building upon approaches to diagnosis [57], disease management [49,58] and medication management [59] recently proposed. From a theoretical standpoint, PCM proponents must also explicitly claim the philosophical commitments of their model, including the metaphysics of personhood. Here, Miles and Mezzich endorse the holistic conception of the person advanced by Cassell [60] and could further draw upon perspectives in phenomenology [61], organicism [62] and mind-body dualism [63], among others. A fuller description of this autonomy is needed - this too is a task for philosophy, as well as bioethics. Medical epistemology has burgeoned over the past two decades as scholars have considered evidence and reasoning in relation to practice. The philosophy of science has contributed directly to the debates on medical statistics and clinical study methodology. These last two areas of inquiry have much to offer an emergent medical model that must struggle with how to apply scientific knowledge as part of individualized care.

As proponents of PCM endorse certain philosophical positions, they should keep in mind that a medical model is fundamentally *instrumental*. Analogous to the way in which the instrumentalist perspective conceives of scientific theories in the philosophy of science [64], a medical model is not a collection of statements about the medical world that should be evaluated as true or false, but rather a tool used to achieve patient health and wellbeing. If a kind of instrumentalist position is adopted by PCM, it matters not whether the nature of the person, as depicted in the model, is true to reality or presents a constructed version of reality. The only relevant consideration in deciding what metaphysical positions on personhood to assume is how these will influence patient care when the model is put into practice. Instrumentalism may offer useful insight for philosophers interested in reflecting on the nature and function of models of clinical practice.

Conclusion

One of us was recently engaged in conversation with a second-year medical student, explicating the problems with EBM. The student agreed with the logic of the arguments presented, but perhaps influenced by the rhetorical force of the term *evidence-based*, they replied, "if not evidence-based medicine, then what?" Miles and Mezzich provide an inspired answer to that question in their discussion paper [3]. There is a rapidly developing alternative to other dichotomized models of practice that could have its greatest impact on the care of individuals with many medical, psychological and social issues, such as older patients. In these contexts, only a personalized approach will do. In our analysis, PCM is an emergent model of the clinical encounter and clinical judgement for all clinicians

involved in patient care, which endeavors to be a complete, descriptive medical model.

Two decades ago, evidence-based medicine arose with a focus on science and rationality, the *logos* of medicine. Meanwhile, a separate patient-centered care movement was developing with a focus on the individual patient and the moral character of their physician, the *ethos* of medicine. In their current incarnations, neither EBM nor PCC are sufficient as care models. Long before either of these movements, medical humanism called for physicians to return the profession to its caring roots, the *pathos* of medicine. Marcum also discusses the relationship between medicine's *logos*, *ethos* and *pathos* [65]. In his view, "only a wise and loving stance will resolve the quality-of-care crisis in modern medicine". Medical humanists declare that we must restore the *feeling* to the medical profession, which has been lost over a century of unprecedented progress in the science of medicine. It seems undeniable to us that medicine must embrace a model of care that keeps the *logos*, *ethos* and *pathos* of medicine in balance, if it hopes to heal itself and rise to the challenges of caring for patients in the Twenty-First Century.

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