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It is important to state at the outset that I am not a qualified philosopher and do not even know with certainty what the word "ethics" really means. My goal is not to attempt a theoretical analysis of the "ethics of the clinical process," but to explore briefly some of the societal forces and pressures which may be impacting on our professions, and then to develop in some detail a perspective that I believe to be central to the continued existence of the health professions as professions. It is important to point out that my words should be taken to refer to all the health professions, even though my examples may be drawn primarily from the world of the physician, which of course I know best. One does not need to underscore to a readership such as this that health care is now, and will be even more so, a product of the work of all the health professions and in any given clinical situation, the traditional lines separating the professions are often blurred.

People often talk about their own limited, or local perspective on issues that concern them; frequently, they refer somewhat wistfully to a national perspective — the broad view that is occasionally afforded other people who may live and work in Washington, D.C. I have had the unusual opportunity for the past four years at the Institute of Medicine of the National Academy of Sciences, to have a very intense exposure to the "national perspective" and to the cadre of growingly sophisticated health policy people working in and around the executive and legislative branches of the government. I come out of that intense exposure uncertain as to whether gaining the "national perspective" was a professionally broadening or constricting experience! But I wish, nevertheless, to share with you in summary form some of my perceptions about what "they" in the public sector are saying and thinking about "us" in the health professional world.

I shall construct my picture of a set of professions suffering a crisis of legitimacy in the public mind, under scrutiny which is often doubtful and cynical.

Health professions, as professions, share in the post-Watergate suspicion of any group of people which has or is perceived to have power. Scientists, hospital administrators, nurses, dentists and any group of professionals are seen as self-seeking groups, needing always to protect their own parochial interests first and sometimes even at the expense of the public interest, whereas individual health professionals are still accorded the highest respect. Take, for example, the relatively low esteem in which the AMA is held contrasted with the fact that year after year the physician comes out on top as the most respected and trusted among the usual list of politicians, lawyers, journalists and so forth.

Economics cannot be minimized as a force in this public concern about the health professions. The cost of health care seems beyond human control, now apparently outstripping defense and behind only education in terms of national expenditures. The time has come for us to stop arguing that one less battleship will provide some new health initiative; we are approaching the point where we are being asked which existing health activity we'd like to eliminate in order to undertake a proposed new one. At the same time, more and more people are realizing that many expensive health care technologies do not influence very much any currently measurable health status indicator. Changes in life style and the environment are likely to be most beneficial in causing future improvements in this country's mortality statistics. Huge outlays for artificial hearts, artificial kidneys, EMI scanners and even coronary care units are measured against data often suggesting only marginal benefit from these technologies in *aggregate* health data.

Epidemiologists like Archie Cochrane are pointing out that some therapeutic and diagnostic interventions from coronary care units to Pap smears are carried on at great total cost and are not effective in achieving their stated purpose. Some critics are going a step further and saying (e.g., Ivan Illich and Rick Carlson) that the medical model of the modern industrialized West actually does more harm to the society than good. They point out not only that toxic side effects and adverse reactions of all sorts seem to be growing in frequency and importance, but that the societal reliances on a professional for care and a pill for restoration of whatever is distressful cause major roadblocks in the path to individual health. They believe that each individual has the responsibility for sustaining his own health by improving his living habits and life style. "Demythologize the physician," (and, by extension, all health professionals) is an important part of the rhetoric for some of these folk, to the point where it sometimes seems that the physician has become the anti-Christ symbol.

Defining 'Health Care'

Health care has been proclaimed a "right" and the nature of that right is being debated in various ways, under different guises, in many forums. Barriers to equal access to health care for all our citizens must be removed. But access to what health care and how much of it? Does this society want to insure that every citizen has either cavity-free or cavity-filled teeth or is it our societal will to guarantee that all American teeth shall be straight? Are we seeking to determine a guaranteed minimum of care including emergency and major medical coverage or do we wish to provide psychiatric services to the worried well? These questions once again raise the issue of cost and have, in turn, led distinguished economists like Victor Fuchs to suggest that we consider a "leveling-down" rather than a "leveling-up" of the care all of us should receive — and to which we should have equal access.

Inevitably, such considerations are leading to analyses aimed at determining how our society can make the greatest gains in mortality statistics at lowest costs. Such analyses may emphasize certain preventive measures or screening techniques, but all inevitably have the effect of re-emphasizing the growing tendency to view health care in terms of its impact on aggregate health data and statistics. One can easily jump from a consideration of these matters to the conclusion that we have an industry run by fat cats (the physicians) who invent their own new technologies, create the demand for them, drive up the costs and their profits, without making any significant contribution to the health of the nation.

Paralleling these trends is beginning evidence to suggest that the great god of technology is losing its American following as more people seek to fill the void left by the previous departure of orthodox religions, patriotism, nationalism, internationalism, expansionism, and the simplistic materialism prevalent in the '50's. Medicine and the health professional cloaked in the mantle of all his scientific power cannot solve the quality-of-life riddle or defeat cultural boredom.

All this, though, misses the basic point of the clinical process, but places all the more pressure on the health professions to fully understand, articulate and develop that central part of the clinical interaction. For me, this central point is the concept of "the Healing Relationship." This concept is, I believe, crucial to the very existence of the health professions, such that if we cannot postulate and successfully demonstrate and defend such a relationship, I doubt that we shall have for long the privilege of being counted among the learned professions.

What is the nature of this special relationship? Most people would bring up the Hippocratic oath fairly early in any attempt

to develop an answer to that question. Most experts, in assessing the extraordinary staying power of this outmoded set of precepts, believe that the oath is effective because of the sense of commitment it conveys, because of the dignity and importance it places upon the patient, and because it binds the swearer in a pact with supra-human principles or the gods or whatever. The fact that Hippocrates did not author the oath, and would not have uttered it if it were around during his lifetime, (because it is antithetical in some details to his own philosophy) only serves in part to explain why the oath is diminishing in popularity among physicians. But the profession should be warned not to shed its oath lightly! I believe that, in the public mind, the existence of such an oath is of great importance to both the pre-eminent position of esteem held by physicians and to the establishment of the "therapeutic relationship." When the patient believes his physician is committed fundamentally to the patient's best interests, then the groundwork for mutuality and trust is in place. Erik Erikson has eloquently cast the ethics of the clinical process in terms of the Golden Rule but extends it to include a healing relationship which, in fact, helps both the healer and the healed to grow. Anthropologists are busy studying primitive tribes and their medicine men for clues to the nature of healing, but one could argue that it is no more mysterious than the establishment of a trust relationship based on a non-judgmental acceptance of the patient.

Surely, in our day, a new oath or delineation of our contract with our patients would include a commitment to technical excellence — an excellence which must be continually updated. The other side of that coin should be prominent too, i.e., a promise to constantly appreciate one's limitations, to welcome consultations or other opinions. One wonders whether we shouldn't give almost as much credit to the student who answers a question by saying correctly that he doesn't know as we give to the student who gives the right answer. Certainly least credit should go to the student who thinks he knows the answer and doesn't, for he does not know his limitations. Sir William Osler talked about this quality some three quarters of a century ago in the following, almost prophetic quotation:

> "In these days of aggressive self assertion, when the stress of competition is so keen, and the desire to make the most of oneself so universal, it may seem a little old fashioned to preach the necessity of humility; but I insist for its own sake and for the sake of what it brings, that due humility should take the place of honour in the list. For its own sake, since with it comes not only a reverence for truth, but also a proper estimation of the difficulties encountered in our search for it. More perhaps than any other professional man, the doctor has a curious, shall I say morbid? sensitiveness to (what he regards) per-

sonal error. In a way this is right; but it is too often accompanied by a cocksuredness of opinion, which, if encouraged, leads him to so lively a conceit that the mere suggestion of a mistake under any circumstances is regarded as a reflection of his honour, a reflection equally resented, whether of lay or professional origin. Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, healthy or diseased, that slips in observation are inevitable, even with the best trained faculties, that errors in judgment must occur in the practice of an art which consists largely in balancing possibilities — start, I say, with this in mind, and mistakes will be acknowledged and regretted; but instead of a slow process of self deception, with ever increasing inability to recognize truth, you will draw from your errors the very lessons which will enable you to avoid their repetition."

Doctor-Patient Relationship

The medical profession has always emphasized that the doctor-patient relationship is one which both parties enter into and terminate of their own free will. In my own experience, this usually translates into, "I don't have to take anyone as a patient I don't want to take!" This, it seems, is grossly insufficient. What is needed are some specific guidelines as to legitimate grounds for not taking someone as a patient.

Finally, any new oath dealing with the clinical process ought to include a commitment to communication with the patient at the optimal level possible; communication which demonstrates a willingness to involve the patient as the most important decision-maker in the process. The patient is not an input in a system managed by the physician; rather it ought to be the patient who is the manager and who has control of his destiny and the technology being applied for his best interests.

The following is offered only as one example of how one health professional has made explicit his understanding of his responsibilities toward his patients. (pp. 226-227).[1]

> "In order for the primary therapeutic physician-patient relationship to become established, the patient must learn, in some way or other, that the physician accepts the patient in a nonjudgmental way and accords that patient a necessary and basic human respect. Once this has been achieved, I believe there are then at least three important messages to get across to the patient. To the extent that I can convey these points successfully to the patient and to the extent that I live up to them is the measure (aside from the crucial matter of the quality of the technical medical ability and knowledge brought to bear on the case) of my success in achieving an effective therapeutic relationship with that particular patient. These three important messages which may or may not be delivered by explicit oral statements follow:
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> "I, as a physician, accept personal responsibility for you as a patient. I will do all I can to find out what is wrong with you and get the best available treatment. If I can't find out or am confused in any way, I will seek consultation and help from others. If you develop a fatal disease, I will stand by you and do all that is possible to minimize suffering and pain." Once the physician understands the reality of

this basic underpinning of the most creative kind of doctor-patient relationship, then he can begin to explore at a conscious level whether he is well-suited to deal with all patients, or whether some patients will be more difficult or impossible for him. If he can't look a badly burned or disfigured or quadriplegic or dying patient in the eye and make this kind of commitment, then he shouldn't attempt to be that patient's primary physician.

"I, as a physician, wouldn't recommend anything for you as a patient that I wouldn't do for myself or my immediate family under the same circumstances." Implicit in this message is the principle that the patient shapes or participates in the critical decisions involving his care. The patient may elect to delegate these decisions entirely to the physician or he may need to participate more actively in the decision-making process. For better or for worse (and I think it's for the better), physicians are having to deal more and more frequently with patients who demand full participation in the crucial elements of their care.

"I, as the physician, am not emotionally involved with you as the patient." Implicit here is a guarantee of scientific objectivity, a steady hand in surgery, a clear mind in diagnosis.

What may be considered a distressing example of a set of practices and a value system that seems antithetical to the third principle above is contained in the recent study of practicing physicians in a southern California county. Reportedly, some 13% of physicians canvassed had engaged in some form of overt sexual activity with their patients, while 25% of medical students apparently felt that sexual intercourse with patients was all right under the right circumstances. From my point of view, those "right circumstances" could only be that the patients involved had become lovers and not patients, unless we postulate that the professionals involved really do not understand the nature of the healing relationship that is the heart of their profession. Perhaps most alarming was the commentary on the part of the authors that these findings indicate a significant shift in attitude and had implications for medical sex educators!

One might argue with Erikson that this healing relationship is the ideal model for all mature human relationships — and that may be true — but there seems a special expectation, a special opportunity, and a special responsibility in the health professions. Ivan Illich notwithstanding, such a relationship can tap vast stores of potential therapeutic energy, having no toxic side effects and with no possibility of blighting the environment!

Societal Pressures

If it is true that the healing professions need to focus with renewed vigor on the nature and function of their central interactions with their clients, it is equally true that the societal pressures alluded to at the beginning of this talk are appropriately forcing an expansion of responsibilities for health professionals. Sometimes these societal pressures can cause a conflict with the ethic of the healing rela-

tionship. For example, an informed health professional has the responsibility to help society come to grips with this process of priority-setting and choice-making in the health field. Thus, a physician might have concluded that society is poorly advised to provide some new technology in place of some other alternative or priority; but if a patient comes to him who could use that new technology and it is available, it would be a breach of faith if the physician did not seek it for his patient solely on the grounds that it was unnecessarily driving up costs.

The health professions must expand the ethic involving individual interactions to include a corporate ethic as argued so persuasively by Pellegrino. The argument goes that each professional has primary responsibility for his own activities, but shares a corporate responsibility for the quality and accessibility of care delivered throughout his profession or perhaps by all the health-related professions. An associated dimension has to be an increased sensitivity to the preventive mode, to the promotion of those sets of activities which are likely to keep people from becoming sick patients, the encouragement of health-enhancing changes in life style.

In essence, there is a new and important obligation to help the professions focus more clearly on the public good and less intensely on what seems best for the profession. Such a shift in emphasis to the establishment of the primacy of the public interest is, in my view, the most significant kind of enlightened self-interest for the professions over the long term. This expanded corporate and individual sensitivity to societal pressures and to changing public needs will continue to play an important role in the determination of the nature and relative importance of the professions in health.

It is, however, not these societal interfaces which lie at the heart of the question as to whether our professions will grow or wither in their most creative societal function. For that, to reiterate in summary, we will need a special commitment redefining the nature of the contract between client and professional, a contract aimed, I hope, at creating the atmosphere in which a healing relationship may flourish. To achieve consensus in such an effort requires a considerable agreement on some value issues, not a simple matter in a society as diverse and full of change as ours is. We can't begin with the Torah or the Bible or with God or with a Chairman Mao or with the will of the people in a classless society; and perhaps this is why we have not gotten further in this up to now. Perhaps, though, we could begin with an agreement that a healing relationship is the basis of what we want to do and then proceed with analyses like Erikson's to define that more precisely so that eventually a new code could

evolve. I am personally attracted to the idea of an oath — a special commitment — freely taken, perhaps renewable periodically and administered by a public person rather than a dean as has been traditional. If we cannot collect ourselves sufficiently to achieve this kind of professional renewal, I fear we shall all observe in the years ahead the inexorable decline of the health professions into a series of occupations. This collection of occupations in the future, perhaps, might become more efficiently melded into a system of delivery for a commodity called "health care," which might more properly come to be called something like "health maintenance strategies" and "disease intervention instruments." We shall have watched as the nation demythologized itself right out of a cadre of healers!

I feel two brief quotations are pertinent, and will leave it to you to determine how pertinent. There is this from Albert Schweitzer:

> "Wherever there is lost the consciousness that every man is an object of concern for us just because he is a man, civilization and morals are shaken, and the advance to fully developed inhumanity is only a question of time."

and this from Dag Hammarskjöld's *Markings:*

> " 'To fail' — Are you satisfied because you have curbed and canalized the worst in you? In any human situation, it is cheating not to be, at every moment, one's best. How much more so in a position where others have faith in you. . . .
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> "For someone whose job so obviously mirrors man's extraordinary possibilities and responsibilities, there is no excuse if he loses his sense of 'having been called.' So long as he keeps that, everything he can do has a meaning, nothing a price. Therefore, if he complains, he is accusing — himself."

REFERENCES

1. Bulger, Roger J. (ed.), *Hippocrates Revisited,* Medcom Press.