American Osler Society, Inc. John P. McGovern Award Lectureship

The Coming of Compassion

Roger J. Bulger

John P. McGovern, M.D.

JOHN P. McGOVERN AWARD LECTURESHIP

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1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.

4. *The 'Open Arms' Reviving: Can we Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990 in Baltimore, Maryland.

6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.

7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.

8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.

9. *'The Leaven of Science': Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.

10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.

11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.

12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.

Cover - Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

The Twelfth
John P. McGovern Award Lecture

The Coming of Compassion

By

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Roger J. Bulger

ROGER J. BULGER

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Over the past 25 years, he has authored numerous articles and essays on medical science and health policy. His recent books include: *In Search of the Modern Hippocrates: Technology, Bureaucracy and Healing in America;* and *The Quest for Mercy.*

Dr. Bulger has been a member of numerous national advisory committees and has been chairman of two institute of Medicine committees: 1) the Committee on the Effects of Medical Liability on the Delivery of Maternal and Child Health Care; and 2) the Committee on Regional Data Networks.

Dr. Bulger is a member of the Institute of Medicine and has served on various professional and corporate boards of directors. He has been on the board of the Association for Health Services Research (AHSR) since 1991 and served as AHSR's president in 1992-93.

Dr. Bulger has been the recipient of numerous awards and honors, including honorary degrees from Thomas Jefferson University and the University of Maryland. He is a fellow in the Infectious Disease Society of America, the American College of Internal Medicine and the Royal College of Physicians. In 1987, he was the Tanner Lecturer at Cambridge University. Dr. Bulger is a graduate of Harvard College (1955) and the Harvard Medical School (1960) and attended Emmanuel College, Cambridge University (1955-56).

It is safe to say that health care in America is changing dramatically. I believe that these changes reflect much of what is happening in the rest of society, a society that is moving from the security of a belief in everlasting material progress (which we have labeled "modernism"), based upon the principles of the Enlightenment as expressed through the successes of the capitalistic, democratic, industrialized nations to a time of confusion (which we call "post-modernism"), characterized by a decreasing faith in the old principles and with no new governing paradigm readily available to direct us to whatever we may become after the Post-Modern era. The ways of Modernism have brought us many advantages, but it does not provide meaning for one's life or happiness in the living of it. Even the Provost of Yale University, Jaroslav Pellikan, noted classicist, has proclaimed (Pellikan, 1992) the end of the total reliance upon rationalism and the Enlightenment. "A third intellectual virtue is a sustained, if not significantly chastened, trust in rationality and it's processes. For a variety of reasons, such a trust has been challenged, by an awareness of its fallibility and its limitations. It seems imperative for the university to develop a deepening appreciation for other ways of knowing and thinking which cannot be accommodated easily to the criteria of the Enlightenment and rationalism."

What I propose to discuss briefly in this paper will fall under the following six rubrics: first, what are some of the major forces in the changing health care environment; second, what is health care and who actually delivers it; third, who and what is a healer; fourth, rationing of health

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*This essay has its roots in and shares much of its substance with the John P. McGovern Award Lecture presented at the American Association of Colleges of Nursing's annual meeting on October 22, 1995.

care...why do we do it...what is it...and by whom may it be done; fifth, some foundational values underlying our emerging health care efforts; and sixth, what might Hippocrates and Osler think about the implications of all this to the nature of the covenantal relationship between doctors and other health professionals and the society. I shall close with a brief sketch of what all this implies for the education of health professionals in general and physicians in particular. It is important for me to say at the outset, particularly to an audience as distinguished and knowledgeable as this one, that I fully appreciate the fact that I don't know the answers or all the possible answers to our societal and professional conundrums. If I seem to speak in positive declarative sentences, it is only to simplify the discussion and to provoke reaction, either positive or negative. I do not believe any of us knows these answers with certainty, but I do believe that more and more of those of us who really care about the healing professions and the healing tradition should become involved with thinking about and developing solutions to the questions, changes and problems that beset us as we approach the next millennium.

The Changing Health Care Environment

The dominant myth of modern medical care being those dramatic interventions capable of bringing stricken patients back from the brink of death or severe disability is changing. High science and high technology being administered in a highly paternalistic mode by a specialist physician according to his or her view of the patient's best interests is no longer the preferred mode of operation. As the definition of health care expands beyond the emphasis upon the acute intervention in the curative mode, a new rhetoric of patient-centeredness has taken hold with significant implications for the substantive nature of the delivery and decision-making process. American individualism seems now to be expressing itself poignantly through the patient-autonomy movement as it gives evidence of having become entrenched in our collective thinking about health care. Although physicians can appropriately claim to have always been committed to the patients' best interests, there is more than a subtle difference between for example assessing the processes and structure of medical care as compared to assessing patient outcomes in the quest to determine quality. Patient-centeredness implies a new perspective, even for the most enlightened physicians, requiring them to think beyond what they have done for their patients to what the system has rendered and what

the outcome has been for the patient, including his or her satisfaction.

Managed care, especially as expressed through the HMO has been around for a long time, but its penetration to include the majority of patients is a recent phenomenon. There are those who say that when capitated care reaches the fifty percent mark in a community, its effects upon practice and costs are as though it had a one hundred per cent penetration. Thus its sweep to dominance will affect all practitioners and the public has already assumed that all doctors are operating under different economic rules, such that citizens increasingly do not trust that their doctors will act counter to economic incentives in order to advocate the patients' best interests. One can see that the government, the nation's largest purchaser of health care, has shifted its role from that of careful oversight of the care it finances for its citizens to that of a prudent buyer, seeking to cut costs, reduce the national debt and balance the budget.

Behind these shifts are the expanding definition of health care and the ever-growing influence of science and technologic development. The translation of scientific discovery to new technology provides the upbeat hope of every American, that if they are suddenly stricken, ours is a can-do society that will pull out all the stops to achieve a cure. This American characteristic, so often downplayed or underestimated by health economists is what I sometimes refer to as the *epidemiology of hope*, a hope that infuses all of us, even though the high tech stuff is applied at any one moment to a relatively small subset of the population. It is not always so in other societies.

What is Health Care and Who Actually Delivers It?

There is a haunting cartoon that illustrates the heart of what I believe is the central moral issue regarding access to health care which our society has not yet fully confronted. The picture shows an old woman, bent over her cane and clearly disabled, casting a shadow which is larger than she is; the shadow is in the shape of a dollar sign, suggesting that the cost of caring for the patient is larger than the patient and may be becoming more important than the patient. William Blake once wrote the following couplet, "The dog starved at his master's gate/Predicts the ruin of the state." (Bartlett, 1968, p.490). In the post-modern health care context, the couplet might warn us as follows, "The patient suffering unattended at the health system's gate/Predicts the ruin of the state." In my view, it is how we decide to care for all of our people and how much of what is

available we decide to offer everyone in need of care that will largely define the quality of our society in the years ahead.

If we are increasingly to think in terms of raising our citizens' health status through the equitable distribution of services, we must first agree on the nature of those services. For me, health care is no longer adequately characterized by the curative miracles of modern therapeutic advances; rather it must be thought of as *preventing, curing and caring*. These three fields of care describe: 1) the prevention of disease and the promotion of healthful life styles, governed by the population based, epidemiological paradigm and operating within those fields usually included in public health; 2) the curing of disease, governed by the reductionist, biomolecular intellectual paradigm has become almost synonymous with modern American high tech medical care; and 3) the caring for those whose diseases we cannot prevent or cure refers to the care of the chronically ill....a growing population whose treatment involves more of what has become known as the bio-psycho-social paradigm than any other. It is too simplistic to think any longer as the first area to be solely in the hands of public health professionals, the second being in the hands of physicians and specialists, and the third being dominated by nurses. In fact, a variety of health professionals are essential to each sector of the health care enterprise; no one profession can claim hegemony over the whole arena; rather it seems axiomatic that what is needed is the delivery of health care via a seamless web of health professional services oriented to the patients' and the public's best interests rather than each profession's own self-interest. This latter goal would seem to require a degree of coordination, mutual respect and determination to collaborate not yet experienced among our leading professions. And yet, more and more expert critics of the emerging systems of care are calling for a new alliance between the health professions and the patients in order to overcome the management imperatives of cutting costs with insufficient regard for quality. Such a new alliance is seen as essential to sustain the balance of cost and quality control so important for this avaricious sector of our nation's economy.

Who and What is a Healer?

The concept of personal development and working at enhancing one's own personal competencies may be more fully developed in the nursing literature than in medicine, perhaps excluding the psychiatric literature.

A more recent sortie into this area is taken by Carol Taylor (1995) of Georgetown University School of Nursing who in her article, *Rethinking Nursing's Basic Competencies*, argues that moral competence should be added as the fourth nursing competency to the more traditional first three, i.e. intellectual, interpersonal and technical. Taylor asserts, *"An increasing tendency to focus primarily on the intellectual and technical competence of nurses is radically redefining nursing and threatening nursing's ability to respond to human need"* (p. 2). She describes some practical strategies for developing and maintaining interpersonal competencies among nurses and in effect shows how it could be incorporated into total quality improvement efforts.

William May (1983), in his book, *The Physicians Covenant*, describes five images of the physician as healer. The five images are shown in Table 1; it is not entirely clear whether May thinks that any one healer might adopt any and all of these images at one time or another or whether he thinks that most physicians tend to fall into one of the image categories. Further I am not certain that he sees the fifth image, the physician as teacher, as the final step to maturity as a healer, but I do have that general impression.

Table 1

Images of the Healer

Fighter........makes war on death and disease

Parent........compassion and benevolence

Technician........technical performance is ultimate

Covenanter........responsibility, service, fidelity

Teacher........assists patient in coping with incurability

In Table 2, I have listed the elements of the progression I believe characterize the evolution of the mature physician, nurse or dentist healer. Against a background of scientific competence, the healer must learn about the richness of human suffering; such awareness will elicit the felt need to communicate more effectively with patients to better understand the nature of their personal circumstances and their sense of their pain. Clinical experience soon brings a growing awareness of the need to confront one's own death to whatever extent one can prior to having to face the prospect first hand. All this attunes the clinician to the subtleties of the placebo effect and the human role in the optimization of the beneficial effects of treatment.

Table 2

On the Personal Evolution of the Healer*

1. scientific and technical competence
2. understanding suffering
3. ability to communicate
4. knowledge of the placebo effect and its role in scientific medicine
5. coming to terms with death
6. expanded roles and three paradigms
7. commitment and loyalty

* For a fuller discussion, see Bulger, R.J. (in press). *The Quest for Mercy*

For my part, one of the most extraordinary examples of the therapeutic effect of a human interaction connected with a professional intervention is described by physician-author Fitzhugh Mullan (1975) in his autobiographical book, *Vital Signs...A Young Doctor's Struggle with Cancer*. As Dr. Mullan tells it, after an almost unbelievable hospital stay of several months duration during which he and his family and care-givers endured a dramatic series of clinical ups and downs, he was at last ready to be discharged home. The morning of his planned discharge, he suddenly became frightened and overwhelmed with a desire to kill himself, a feeling he had never known before. He felt himself on the verge of jumping out of the window, when he informed the nurse of his situation and asked for help. She contacted the psychiatrist on call. The physician who turned up was unknown to Dr. Mullan and appeared to be approximately the same age and level of seniority. The psychiatrist listened to Dr. Mullan's words and then asked only one question, which according to the patient turned the whole situation around. The psychiatrist asked Dr. Mullan, "Do you want me to hold you?" Dr. Mullan broke down and one leaves the scene with the picture of two people holding onto one another, the one gaining the strength necessary to go on to the next laborious stage of recovery from the other strong and healthy person who somehow knew enough to use the right seven words! I personally cannot imagine myself having the skill and sensitivity to decide to say that sort of thing in that situation. The encounter empowered Dr. Mullan to overcome his panic, to go home, and to undertake successfully the rest of his long and laborious return to the full health he now enjoys.

The Placebo Effect....a Pill or Operation, an Healing Person or an Institution....or All of the Above?

Lain-Entralgo (1970) identified the seminal importance of Hippocrates' cleavage of the science and practice of medicine from the intervention of words and the incantations of the shamans who practiced their art at the time. According to Lain-Entralgo, Hippocrates created the tradition of medicine as the silent art and in so doing led to the separation of medicine from psychiatry, which from then on developed along a separate track. Freud and Jung and their various followers evolved the practice of using words in therapy in ever more arcane and separate venues from the traditional activities of scientific medicine, which in turn had become more closely associated with the reductionist, biomolecular paradigm,

which seeks answers to medicine's questions in our molecules and genes. However, recent developments in the neurosciences (neuro-endocrinology, neuropharmacology, etc.) have seemed to draw the two areas together (Kiecolt-Glaser & Glaser, 1986; Pert, 1985; National Institute of Medicine, 1989). As the molecular biology of emotion gets addressed more effectively by traditional science, all of us can understand how a person's emotions and beliefs can influence the incredible pharmacy we carry in our own brains. As it becomes clearer in more and more specific situations how a person's neuroendocrinologic or neuropharmacologic response may change under different environmental circumstances, it becomes easier in principle to conceive of the nature of the well-known phenomenon we call "the placebo effect"

The placebo effect is defined as any effect occurring in association with an intervention but not resulting from any known physiologic function of the intervention. In fact, placebo effects are not always beneficial; such things as major skin rashes and other reactions have been demonstrated to come from non-allergenic placebos in small percentages of subjects. Since Americans have been enamored of technology virtually since our nation's inception, and since our medical profession is known worldwide to be highly interventionist in its utilization of the many new drugs and other techniques constantly being made available, the American patient is being presented more often than patients in other countries with new instruments of hope and new venues through which to profit from the combination of the intrinsic effectiveness of the therapy and its associated placebo effect.

In days gone by, physicians were essentially bereft of effective therapies and were left only with the placebo's benefits (Bulger, 1991). Thus, one of France's greatest early nineteenth century clinicians was quoted as advising the use of all new medicines as often as possible before they cease to become effective. Oliver Wendell Holmes echoed these sentiments when he postulated in the mid-nineteenth century that if all of the medicines in the world were tossed into the sea, it would be good for the people and bad for the fish. Finally, in Flexnarian times, L. J. Henderson, the famous twentieth century biochemist said, *"Sometime between 1910 and 1912, it became true that for the first time in history, a random patient visiting a random doctor would have had a greater than fifty-fifty chance of profiting from the encounter"* (Bulger, 1991, p. 285). Because the placebo effect generally is believed to be in the range of 30-50%, Henderson can be interpreted as saying that finally in the twentieth century, physicians had

the tools to improve upon the placebo effects of their interventions.

Most of us in modern health care practice have tended to minimize the placebo effect and in fact have studied it all too infrequently. For example, we have no idea about individual variation in healers' abilities to elicit the placebo effect from patients, although Benson declares that the elicitation of such benefits depends on the degree of trust in the relationship between the healer and the patient (Benson & Epstein, 1975; Benson & McCallie, 1979). It is the conventional wisdom of many experts that the most pervasive and intense placebo effects are elicited when both the patient and therapist believe that the intervention will work, and that benefit is less marked when one or the other doesn't really believe the therapy may work. This point was made in the 1950's when, based upon convincing evidence in experimental animals, a well-known surgeon concluded that tying off the internal mammary artery in patients with compromised coronary artery blood flow would increase the blood flow through the impaired coronaries such that those with severe angina and cardiac dysfunction might experience symptomatic improvement. He performed surgery on a series of the most severely ill coronary patients and got highly gratifying results, with 85% of his patients experiencing dramatic improvement, some even returning to work pain free. As word spread around the country, others performed the surgical procedure with only half to two thirds of patients experiencing improvement, thus justifying a randomized controlled trial in which every other patient had a sham surgical procedure. When it became apparent that the sham surgery produced results comparable to those from the real surgery (Beecher, 1961; Cobb, Thomas, Dillard, Merendino, & Bruce, 1959), the trial was stopped, and the surgical procedure was never performed again. It has been said, however, that many of the original patients continued to stand behind the validity of their surgery and of the improvement they enjoyed from it.

In my mind, one of the most powerful, scientifically sound experiments to demonstrate the power of the placebo effect was performed by S.Wolf (1950), a famous and respected gastroenterologic physiologist who undertook a study of the nausea associated with pregnancy. Each pregnant volunteer subject agreed to have a tube placed in her stomach through which Dr. Wolf could record intragastric pressures. Thus, he recorded the reverse peristalsis in the stomachs of the pregnant women when they reported feeling a wave of nausea. When their stomachs were quiet, he dropped in some Ipekak and measured the immediate and ex-

pected reverse peristalsis response along with the reporting of the subjective feeling of being nauseated. Then he told each of them that he was about to deliver through the tube into their stomach a medicine that he believed would stop their nausea. He then waited until the subjects were experiencing the nausea, and then he delivered his medicine, which invariably did in fact stop the nausea and reverse the antiperastaltic movements. The striking fact is that the medicine he delivered was Ipekak, whose pharmacological effect is exactly the opposite of that which the subjects experienced. Dr. Wolf interpreted these results as showing that the patient's trust in him led them to believe that the medicine would work and that their belief caused the *in vivo* secretion of some blocking agent, which prevented the action of Ipekak as well as of whatever molecule caused the naturally occurring nausea of pregnancy. He concludes, "Placebo effects which modify the pharmacologic action to drugs or endow inert agents with potency are not imaginary, but may be associated with measurable changes at the end organs. These effects are at times more potent than the pharmacologic action customarily attributed to the agent" (Wolf, 1950, p.104).

The previously scientifically tenuous connections between our minds and our bodies are being more fully explicated and explored by a talented array of modern investigators and clinicians (Benson & McCallie, 1979; Kiecolt-Glaser & Glaser, 1986; Pert, 1985; National Institute of Medicine, 1989). The holistic movement in general speaks to treatment of individual patients by individual therapists. But can we think of beneficial effects occurring to patients on the basis of the trust relationship with groups of people or with institutions? Nurses are well aware of the studies which purport to show that mortality rates in an intensive care unit are lower when the level of communication between doctors and nurses is high rather than low. A most telling illustration of a kind of institutional placebo may be found in the report from a recently published report from a Houston hospital (Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991). The study was a randomized control led trial involving 616 primiparous women and the care they received during delivery. All patients were cared for by the same team of nurses and doctors applying the same logic and practice standards to each patient throughout the study. In the control group, 18% required a Cesarean section and 55% had epidural anesthesia. One of the two experimental groups had only one added feature to the control treatment and environment: a woman who stood in the corner of the delivery room in a white coat with a clip

board and who neither introduced herself nor spoke to anyone during the birthing process. In this group, the rate of Cesarean Section dropped to 13%. The second experimental group, differed from the control group only by the presence of a douhla, i.e. a woman who introduced herself by name to the patient; who told the patient that she had no expertise in obstetrical care, except for having had a baby herself; and who further told the patient she would stand by her side holding her hand and would be available to talk or answer questions for the patient as needs be. In this third group, the C-section rate fell to 8%, and the rate of use of epidural anesthesia dropped to 7.8%. There were analogous progressive improvements in administration of pain medication, neonatal problems and length of hospital stay for mother and child. These results have been substantiated in other studies done subsequently in other settings.

In the Houston hospital, the hiring of the douhla proved to be cost-effective. The importance of studying such interventions by caring figures in different clinical settings has been recently demonstrated by the Robert Wood Johnson Foundation financed study of terminal hospital care, in which the addition of a trained nurse to the care team was evaluated (Support Principal Investigators, 1995). The function of the nurse was to 1. facilitate physician-patient interaction, 2. develop of patient-directives, shorten the period during which patients who die are on mechanical life support, and 3. ultimately reduce the total cost of terminal hospitalizations for seriously ill older patients. In this randomized trial of patients determined in advance to have a life expectancy of 6 months or less, a quarter of the patients presenting to the hospital died in the hospital; one-third of those who died lost their savings and/or those of their family in paying for the terminal hospitalization. It was believed that the intervention of a trained nurse would lead to a breaking of the communication logjam and a reduction of all the worst statistics. The trial to everyone's surprise, proved otherwise, showing that the nurse had a positive effect only upon the patients families view of the terminal event. Thus, the addition of a person to facilitate communication and caring in this instance produced no measurable benefits sufficient to justify the expenditure of funds necessary to do the job.

Rationing! Why? What? and by Whom? Its Relation to Renewed Efforts to Measure and Assure Quality of Health Services....

My intention here is not to engage in an extensive philosophical and ethical analysis of rationing; rather I would like to raise a variety of issues about the way we think about rationing and its impact on health care as we have defined it. All health professionals understand that we are already rationing health care in the United States as well as in every other country on earth. As the costs escalate and as the technologies proliferate, we shall have to continue dealing with the issue of the most rational and equitable distribution of health care goods to our population. We cannot all have everything that is available.

At the heart of our efforts at rationing (synonym for cost control) in the United States over the past decade or so has been a debate over who shall ration rather than what or how we shall ration (Bulger, 1988a; Eddy, 1991; Reiser, 1991; Wennberg, 1989). The options for the answer to the issue of who shall ration include the following: 1) the politician and/or government, 2) the manager, 3) the physician or care-giver, 4) the patient, and 5) all of the above. Until recently, the debate has been between choosing the government or the physician. In the background, the characteristic American emphasis upon individual liberty and autonomy has been reflected in a trend towards putting the patient in charge of his other destiny; such a trend is consistent with everything from informed consent to our tendency to supply our people with multiples of goods and services from which they can choose. But patient autonomy appears to have lost ground as the market revolution to managed and capitated care provided largely by for-profit corporations has gained the initiative. If the nation becomes 50 to 70 percent capitated by the turn of the century, then clearly, rationing will be predominantly in the hands of the manager of the plan in which the patient is enrolled. The implications of that outcome promise to be significant, not only in terms of reduced patients autonomy and decision-making but in terms of reduced clinical independence for the care-givers. This issue is clearly one which must be followed closely by individual physicians as they seek to inform the public of the implications of changes in the health care system and by the medical profession as it seeks to preserve the essence of physicianhood.

Another way of considering the rationing issue is to ask what may be rationed. In my mind, the answer is three-fold: technology, time and per-

sonnel. If the teaching hospital had become the cash-cow which has funded and facilitated the evolution of new technologies and clinical interventions from the findings of basic and applied science, then its conversion from cash-cow to cost-center in a large population based system runs the risk of so reversing our incentives as to reduce the flow of innovations too drastically to sustain the level of hope our population finds in the high technology system we now have. The most important aspect of our thinking about how to reduce costs associated with technology has to be to devise the best ways to assure that the technologies we do make available are effective and efficient. By doing that assessment better, we can go a long way to controlling costs and keeping as many effective interventions as possible available for all to use.

The second target of the rationer is time. Time is an element that is not so widely appreciated by the public, which generally regards the issue of time in terms of the ease of gaining an appointment and the convenience of the time and place. Capitated care encourages a more efficient use of time, clearly an important dimension to caregivers. A second dimension is much closer to home for care-givers in general, and this dimension is illustrated most dramatically in a study carried out twenty five years ago at Princeton University's divinity school by John Darley and C. Daniel Batson and published in 1973 in the *Journal of Personality and Social Psychology*. I refer to this study as "The Parable of the Modern Day Good Samaritan" and have described it in more detail elsewhere (Bulger, 1988b).

In essence, a study of the graduating class of divinity students was carried out in which almost every conceivable aspect of the students' personalities, achievements, life, and professional goals were documented in preparation for the unsuspected experimental defining moment, which occurred for each of them one December day. The group had been divided in two, with half receiving an assignment to write a paper on the Parable of the Good Samaritan and the other half receiving an assignment to write a paper on another passage from the Bible not overlapping substantively with the Parable. Each student was assigned a faculty member that day and had a one-on-one interview concerning the nature of the paper the student had written to satisfy the assignment. During the interview, a messenger arrived with the news that a visitor wanted to see the student in the administration building concerning a job for the next year. Each student was told one of three things: to run over there post- haste because time was so short; to go over with all deliberate speed to

make the appointed time; or to leave now but take your time because the visitor couldn't see the student for some twenty or thirty minutes.

On the way to the administration building, each student passed a person lying in tatters on the ground, moaning and groaning in a way analogous to the way we all envision was the case when the original Samaritan encountered his person in need. The sufferer in this case however was a trained observer who noted who stopped, how long they stopped and what they did when they stopped. In brief summary, when all the data was analyzed, the only variable that had a relationship to who stopped and what they did when they stopped was how much time the individual had.

The conclusion has to be that even the best educated and the most intellectually prepared to consider compassion, and those whose characters most dispose them to be compassionate, cannot show compassion if they do not have enough time. It takes time to listen to a patient and to build the trust necessary to empower the patient's own healing capacities. It is easy to see how an efficient scheduling of patients might so reduce the time and trust that the placebo effect is reduced and patient outcomes are less positive than they otherwise might have been.

The third target for the rationer will be personnel or payroll and in some cases this may be related to the time element discussed above. For example, in the United Kingdom, Michael Ashley-Miller (1996) recently reported that a consulting group to a British hospital, seeking to reduce costs, concluded that the hospital's financial target could be met by reducing the nursing staff by 350 people. The remaining nurses could pick up the tasks of those who had been released if they simply stopped talking to the patients! Apparently the consultants in that case failed to understand why the nursing staff is the heart and soul of the hospital.

The forces requiring cost control and efficiency in delivery are the same as those that lead to whatever venues our society uses to ration; but these forces also should encourage health professions' educators to more effectively and aggressively prepare students to work collaboratively in teams with other health professionals, giving new credence to the concept behind the multi-professional academic health center.

Because of the cost problems, there is a tendency to see all evaluative research, whether it focuses on structure, process or outcomes, as thinly veiled efforts to cut expenses; our goal must be to transcend the interest in cost control to focus instead on value for dollars spent and on the overall quality of the enterprise. Thus, continuous quality improvement is a

movement we must truly embrace; it must become more than a rhetorical device used to convince outsiders that we understand the modern management world; it needs to become a central focus of all our efforts if we are to help the public decide that rationing must not include the withholding of truly effective interventions and services from the people. Quality of care must come to be seen in terms of overall process and outcome for the patient. It must be perceived as more than technical competence and as the net result of the work of all people and institutions that provide services in the attempt to prevent and cure disease and to minimize suffering. Seen in this way, our struggle for high quality will never end.

Some Foundational Values For Any American Health Care System....A Slightly Different List.

Over the past three years, I have had, for the first time since I was seven years old, the necessity (opportunity?) of engaging the modern American, high technology health care system as a patient suffering from a life-threatening illness. In the course of working through that experience and processing its meaning with other information from the worlds I usually have inhabited as a physician, health professions educator and policy wonk, I have developed a slightly different list of foundational values than the one I had before I got sick (Happily by the way, I'm better, no longer deserve sympathy and will likely cross the bar ultimately from plain old age).

The first three on my list of foundational values have been discussed or alluded to in this essay. They are justice, patient autonomy, and hope. Most of us agree that we would prefer an equitable distribution of effective health care across the entire population. Most of us would also agree that the trend towards patient autonomy is an important and major contribution of our culture to health services in general; and we would certainly not want to remove patient decision-making from our agenda. Hope may not be so widely embraced as the first two. By hope I mean the hope we all have that if serious illness or disease or disability strikes us as individuals, that we would have a chance to receive the care and interventions that might restore us to health or to a decent quality of life. The interests of the group do not always coincide with those of the individual; but the social value of hope links heroic individual interventions to the concerns of everyone. It is hard to put a market value on hope;

although without it, no one would really want to pay very much for health care.

It is in presenting the fourth value that I feel uncertain as to its general acceptability. Clearly, this fourth value dented my consciousness only as a result of my recent illness and my attempts to consider what this gigantic jigsaw puzzle of specialists, services, institutions, technologies and human beings really meant. The concept first hit me when I was reading something autobiographical by Thomas Merton. Thomas Merton gained fame as the modern Trappist Monk, who left a secular life as writer, artist, and teacher to find meaning in the development of his spiritual life outside the mainstream of the modern world. He said, in an attempt to summarize the lessons he had learned during his long sojourn in the monastery, the following: that the entire meaning of his spiritual life was bound up in the words of the ritual the Trappists have used for centuries when a new monk enters. They are as follows, Questioner: *"What do you ask?"* Supplicant Monk, *"I ask the Mercy of God and of the Order"*.

I puzzled over that answer of Merton's, which seemed vacuous and rather bland to me until I read elsewhere in another context that the word mercy actually means, the enveloping love of the womb. When I applied that meaning to Merton's answer, it became a much richer answer; and made even more sense to me when I turned it into a dialogue between a seriously ill or damaged patient in our modern society. In such a situation, the dialogue might go as follows: Questioner, *"What do you ask?"* The patient answers, *"I ask the mercy of the health care providers and of the community in which I live."*

The more I reflected on my own interaction as a patient with the health care system, this dialogue rings true and I, therefore, include on my list of foundational American values for our health care system the value of mercy. How you sell it, how you price it, how you provide for it in the organized delivery system's expense column are all difficult questions. Nonetheless, I find it to be a key societal value, about which we should be talking more. I am equally certain that nursing knows more about this value than any of the other professions and that we must look to nurses to teach us and the public about it. As far as I, a former patient am concerned, if health care is the game, mercy or compassion is its name.

Hippocrates and Osler Revisited

Hopefully, by now, the reader will see the rationale behind my insistence upon the health care team and the inherent deduction that our separate covenantal oaths should add something in common to all about the importance of interprofessional collaboration. Each of the major health professions shares with the Hippocratic oath an avowal to competence, to compassion and to commitment; to these three there should be in my view a fourth "c" added, collaboration. A multiprofessional group has developed the following proposed amendment in common to each of the major profession's oath:

> *"As a health professional dedicated to enhancing the health care status and well-being of individuals and communities, I pledge collaboration with all of my health professional colleagues similarly committed, and promise, should tensions or conflicts of interests arise, to place patient and public interests above the perceived self-interests of my individual profession."*

It may be of some interest that nursing, dentistry, pharmacy and allied health professional deans have all agreed, but allopathic and osteopathic medicine deans have not on the grounds that their oaths already say as much! It seems there is a way to go before the concept of teamwork in the patients' interest is fully accepted.

I sometimes muse about Hippocrates and the followers he gathered under that plane tree on Cos. If he were to gather scientific healers around him again today in our context, would he restrict his circle to physicians and if so would he include all physicians, even those doing epidemiology or laboratory investigation? Would he include clinicians of various stripes with direct patient service as their common bond? Would this grouping then include physicians, nurse practitioners, nurse midwives, dentists, clinical psychologists, physical therapists and physicians assistants? Would he adapt to the patient-centered focus, placing it ahead of short-term perceived professional issues? Where would Osler be on these issues? Osler, the science-based clinician who spent many hours visiting a terminally ill child talking with him in the presence sometimes of the parents about death and separation, with seeming success in relieving some of the agony and pain of the passing for patient and family alike, would it seems to me take great pains, were he operating in our post-modern condition, to do that sort of thing when he could, but to be certain that someone from the therapeutic team did so.

Educational Implications

If we are to sustain the millennia-old tradition of the therapeutic person or professional, we shall have to be more explicit about how we educate for this result. Our physician education has of necessity been oriented to the never-ending quest for technical competence. In my own mind, there is a second educational path (see Table 2.), which goes on in parallel, but over a different time course, both in and out of the formal educational processes, than does the education for technical competence. This second pathway involves the personal growth of the care-giver, includes some study and skill acquisition (as in interpersonal communication skills), but goes far beyond that to include every day experiences, values, character, service-orientation, involving also interactions with the arts, anthropology and a curiosity about the community with which one is involved. Clearly my idea of the second path is not everyone's, but equally clearly it seems to me, all who pretend to be serious medical educators should be thinking about these matters seriously and trying to see how they can include aspects in the formal and informal curricula, that constitute undergraduate and postgraduate medical education.

For example, societal values undergirding the health care system (my list includes *justice, autonomy, hope and mercy*) and foundational professional values (my list includes *competence, compassion, commitment and collaboration*) should be expressed and pointed out within the formal medical curriculum and should also form a series of prisms through which evaluative efforts are viewed. In summary, we need to remember that the continuum of health care represents a vast and culturally-important societal expression of mercy and compassion, from all of us to each of us. As professionals we have a crucial role in this entire enterprise. Our value rests not only in our collective competencies to diagnose, to prevent and to cure, but in our commitment to caring, to seeing the patient through to a decent end and to persistently demanding quality services from ourselves, from our filial health professions partners and from the managers. As physicians, we are the natural leaders of the enterprise and although the time is past when we can, simply assume that position on the basis of our status, we can with Osler's equanimity, competence and humanity, earn that position.

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