

*On Hippocrates, Thomas Jefferson
and Max Weber:
The Bureaucratic, Technologic Imperatives
and the Future of the Healing Tradition
in a Voluntary Society*

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A year after his appointment to the faculty at the University of Washington in Seattle in 1966, Dr. Bulger was appointed assistant dean for clinical affairs at the medical school and medical director of the University of Washington Hospital.

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In 1972 Dr. Bulger began a four-year association with the Institute of Medicine of the National Academy of Sciences, serving as its executive officer and as acting president for extended periods of time between presidents. During the same time, he was professor of medicine at the George Washington University School of Medicine in Washington, D.C.

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It is of course a marvelous honor and challenge to be asked to deliver the Tanner Lectures, to follow in the footsteps of such distinguished predecessors and to, in fact, participate for even such a brief period in the spectacular intellectual life of this great university. The intent of the Tanner series is to examine important issues from the perspective of human values, which in turn requires the examiner to reach beyond his discipline or specialty; it is for this stimulation that I am most appreciative of this opportunity.

It is my purpose to reflect upon the current status of health care and health policy in the United States, exploring some essential human values considerations with an eye toward the future and the possibility of attaining the highest quality humanistic health care. In this attempt to ascertain where we Americans have been in health care delivery, where we are, and where we might be going, there will be ample opportunity for me to make comparisons with the situation here in Great Britain. However, I shall not yield to those temptations, trusting that my colleagues in their commentaries will take on the challenge of comparative examinations of the British system. Many Americans have what I call the Alexis de Tocqueville Syndrome, which is founded in deep envy of that wonderful Frenchman who came to America in the mid-nineteenth century and described it peerlessly. The patient suffering from the de Tocqueville Syndrome is characterized by an extraordinary certainty that he or she fully understands another culture or another nation after having been there for a few weeks or months or even a few years. The most severely afflicted believe they know how to solve all of the major problems in the other country and are annoyingly outspoken in their efforts to enunciate those solutions for all to hear. During my years at Emmanuel College in 1955, I received a permanent immunization to the

de Tocqueville Syndrome. Thus, I trust you will understand why I shall limit myself to occasional observations about differences in health care between England and the United States and shall leave the value judgments and things I don't know about to others.

This lecture is an attempt at an interpretive analysis of the current and future American health care delivery system with all its problems and challenges. Inevitably, there will be comparisons made with the British system, but it is important to note at the onset that the inevitable cross-cultural thinking I have had to do in preparation has led me to a deeper appreciation of differences between the two countries.

I seek not to preach a kind of societal moral relativism; rather, I seek only to observe that in contrast to the British, Americans currently give more weight to individual choice than to fairness of distribution of health services. In 1981, Kingman Brewster defined "the Voluntary Society" (which included the United Kingdom and the United States) as one which permitted the lives of its citizens to be as voluntary as possible.¹ For Brewster, as probably for most of us, freedom of the individual is the cornerstone of both our nations. But for Americans, newly arrived in a rough and inhospitable world, the Declaration of Independence held out something more — "certain unalienable rights . . . life, liberty and the pursuit of happiness."

There are *two* other basic values worth remembering about the foundations of the values of America: the first is that people didn't come to America because they were rich, satisfied with their lot, and happy; and the second is that people didn't come to America because they were in love with governments. Thus, no matter how bad the ghetto into which the American immigrant arrived, there was never a doubt that he or she or the children would be able to get out — hope for a better tomorrow seems

¹Kingman Brewster, "The Voluntary Society," in *The Tanner Lectures on Human Values*, vol. 4 (Salt Lake City: University of Utah Press, 1983).

encoded in our genes. Also, the early Americans hated governments; in 1987, the distrust of centralized power is almost as strongly felt by many Americans toward Washington, D.C., as it was by those Americans of two hundred years ago toward England.

As our restless people dealt with frustration, loneliness, failure, or unhappiness by pushing ever westward to new frontiers, there grew over generations the belief that one could *always do* something to improve one's lot, that life would get better and better for each generation, that the technological genius of each generation would increase humankind's capacity to control nature. As the frontiers closed, the American quest for a better future turned toward science and technology; our new frontier led to the land of "things," most recently high-technology "things." To our dismay, our land of things has not brought happiness, even when individual liberty is preserved and even when individual choice is emphasized; cultural boredom, anomie, personal meaninglessness, and narcissism seem to be gaining on us. Countering these forces are the advocates for personal development, for the creation of a competent citizenry instead of a cloying consumerism — and again self-determination for the individual is a value on the rise in America.

It is at least partly in this context that a revolution in health care delivery is upon us. In my view, any health care enterprise of the future must be in tune with these basic American values. That is, twenty-first-century health care in the American version of the Voluntary Society must begin with the idea of allowing the individual to fulfill his or her potential as a person, of providing freedom of choice wherever possible, of keeping alive the hope of a new beginning, of repair or reconstruction if disease should strike. It should not be under the total control of the central government. The inefficiencies which might come from a system which emphasizes diversity should also allow some room for the

development of new technologies, which offer hope even though they might not be cost-effective on other grounds.

Having thus established the principal societal values which should be held inviolable in the development of health policies, let us now turn to the great ideas shaping the modern health enterprise in Western democracies. I have chosen to group these ideas within one or the other of two major themes to be considered: (1) the theme of the healer, which can be referred to as the Hippocratic theme; and (2) the theme of the organizing and financing of the delivery of health services, which will be referred to as the bureaucratic theme. It is my view that the values inherent in the Hippocratic theme are coming increasingly into conflict with the values inherent in the bureaucratic theme. I shall discuss each of the themes separately in an effort better to understand and to articulate the thematic values essential to each. It should then be easier to understand the nature and to anticipate the seriousness of conflicts arising out of value clashes emanating from these two roots.

Central to the action at the interface between these two themes over the next decade will be an ongoing debate over how to ration or allocate scarce resources. For me, Guido Calabresi and Philip Bobbitt, in their book *Tragic Choices*, have elucidated the most fruitful conceptualization of this range of issues.² In order to illustrate the intertwining and interrelatedness of these various threads in the fabric of our unfolding future, I sometimes imagine an ongoing quadrilateral discussion involving Thomas Jefferson (representing the values of the Voluntary Society), Hippocrates (representing the modern, scientific healer), Max Weber (representing the necessary bureaucratization of modern society), and Guido Calabresi and Philip Bobbitt (representing the inherently tragic nature of making choices).

²Guido Calabresi and Philip Bobbitt, *Tragic Choices* (New York: Norton, 1978).

THE HIPPOCRATIC THEME

The oath of Hippocrates means more to the American public and the average American patient than many physicians realize. This ancient oath, containing so many particulars which most young, modern physicians do not believe, remains the bedrock of the commitment made each year by thousands of graduating medical students. Most thoughtful physicians who have reflected on its meaning conclude that the ancient oath remains popular late in the twentieth century precisely because it proclaims a commitment to the best interests of the patient and to high professional competence. Now we think that Hippocrates did not write the oath and probably wouldn't have subscribed to a lot of it. Healing up to Hippocrates' time involved talking, praying and blatant shamanism; and Hippocrates was vehemently against all that. Occasionally, doctors would be hired to end a life, with or without the patient's consent; but Hippocrates based his healing on a natural philosophy that placed humankind in harmony with nature rather than in control of it; he based his interventions on observation, practicality, proof, and the constant self-warning not to do harm to the patient. His science was dedicated firmly to the patient's welfare. The physician sought honor through doing right by the sick person. No longer could the physician be hired to poison someone or to become a purposeful agent of death. He eschewed words as therapeutic, calling medicine the silent art. His written descriptions of some of his cases are masterpieces in clinical observation and deduction. He was thus the father of scientific medicine.

Pedro Lain Entralgo, the well-known Spanish psychiatrist, traced the history of the spoken word in therapy during the past three millennia.³ Of course, the blossoming of the therapy of the word came with Freud. Lain Entralgo points out, in fact, that

³Pedro Lain Entralgo, *The Therapy of the Word in Classical Antiquity* (New Haven: Yale University Press, 1970).

Aristotle understood the essentials of psychiatry's roots and even advocated the therapeutic value of the audiences' emotional catharsis through attending the tragedies of the theater. He attributes the greater than two-thousand-year wait for the Freudian insights to the severe proscriptions of Hippocrates and his followers against the use of the word shamanism and cheering speech in the medical model. This is not the place to attempt a history of psychiatry since Freud, but it is fair to say that psychoanalysis and psychotherapy by and large have traveled a separate road from mainstream medical practice, with psychosomatic medicine serving for many years as a somewhat insecure bridge between the more biochemically oriented mainstream and the softer sciences of Freudian psychiatry.

In the past two decades, however, the revolutionary advances in the neurosciences have brought mind and body, emotion and molecule together in ways that tend to give words a new therapeutic currency. Instead of the handful of neurochemicals known in the 1960s to function in the brain, it is now clear that our brain is an extraordinary pharmacy, able to modulate a situation with great precision in response to a wide variety of stimuli. It is now clear that doctoring is more than deciding which medicine to use to help a patient; the best doctors will work to create an environment in which the patient can allow his or her own therapeutic capacities to work.

Possibly, the well-known placebo effect is the best example of this; fully 30 percent of patients in certain situations will report significant improvement when given something they believe is curative but which in effect is physiologically inert. One well-known cardiologist claims that, if he can meet at the hospital emergency room one of his patients suffering from an acute heart attack and tell him or her that everything is under control and will be all right, then he can dispense with the usual dose of morphine, presumably because the patient's own endorphins have taken over.

The reverse is also true; words can have adverse effects. Words and actions that distress, anger, or upset a seriously ill person can be a negative force on the healing process. Doctors who used to belong to the most mechanistically inclined groups now can envision in molecular terms why one can get better results by establishing and maintaining a trust relationship with one's patients, or why a destroyed and distrustful relationship can contribute to a less than optimal result in addition to a malpractice suit. Scholars like Erik Erikson, who analyze the nature of the therapeutic relation now have more heed paid to them; body language, non-verbal and verbal communication skills, and interviewing techniques are getting more and more attention from a profession which for too long has been restricted by an unnecessarily narrow biochemical vision and a scientific gestalt that kept it from fully utilizing approaches the results of which couldn't be adequately explained in molecular terms. Even now, the laying on of hands inherent in the manipulations of osteopaths and chiropractors are in my view sadly undervalued by traditional medicine, both for the direct benefits of muscle relaxation and neuromuscular relief and for the indirect benefits of direct contact with the caring hands of a concerned and competent professional. A tension headache is better cured by muscles relaxed by a healer's hands than by Valium.

America is a less authoritarian place than most other countries. Still, in years past, one did what the doctor ordered, and one did it just because the doctor said to. The therapeutic relationship rested on a trust built upon a perception of the doctor's competence and an acceptance that the doctor knew best. Many forces in our society have worked against this aspect of the doctor-patient relationship. Malpractice suits have become more and more prominent, underscoring the fallibility of the doctor; public education and sophistication about things medical have led patients to have more doubts and ask more questions; health and medical affairs have become important media items such that

currently most newspapers across the United States print in featured articles the gist of the most important articles published that day in the leading medical journals, sometimes two or three days before the doctor even receives the journal in the mail.

Two major forces of the bureaucratic theme are working against the therapeutic relationship, so central to the Hippocratic theme. They are the adversarial relationship so characteristic of the legal profession in the United States and the growing bureaucratic perception that the doctor should be the rationer of health care. How can you be the patient's friend and trusted advocate while being a potential adversary and rationer at the same time?

In the early 1960s the doctrine of informed consent swept into American medicine through the clinical research window but has had since then a far-reaching effect on the day-to-day practice of medicine, where patients are required to sign documents that indicate that they have had explained to them all the details of side effects and costs and benefits of a proposed intervention before such is undertaken.

The American courts have reached into the medical record, exposing every detail to public scrutiny in nasty malpractice cases; increasingly over the past decade there have emerged serious proponents of giving the patients their own medical records, an approach which certainly requires a tactful write-up, but an honest one, by the doctor. Influential physicians began to advocate telling the cold truth to all patients about their condition, albeit they might advocate telling them in a humane and warmly sensitive way. Advocates of this approach point to the growing literature from dying patients, a literature which describes the isolation and degradation of the terminal patient, made all the worse by the doctor's denial of the truth. There are many examples of dramatic alterations in patient behavior after having someone tell them the truth; the American patient dying of cancer will generally prefer a doctor who will tell him or her the truth and will stick with him or her through thick or thin until the end over a doctor who adopts

a falsely cheerful attitude, never speaking about the disease or the likely outcome and distancing him or herself emotionally from the real situation of the patient. The belief has grown in American medicine that this candor about death, once so seldom practiced here, has allowed death with dignity to become more standard.

Candor and truthfulness have spilled over into all elements of the doctor-patient relationship to the extent that Sissela Bok believes that giving placebos is dishonest, deceitful, and ultimately destructive to the patient and to medicine.⁴ Although not everyone fully accepts Bok's rather purist approach to these points, most people now believe that candor, honesty, full disclosure, and openness on the part of the physician form the basis of that special trust which is central to the formation of the desired therapeutic relationship.

With unquestioned physician authority essentially a thing of the past, clearly and continually demonstrated integrity is required. The authoritarian nature of the doctor-patient relationship has so diminished as an operative mode in America that a popular newswriter recently referred to her new doctor as George Smith, J.P., where the J.P. stands for junior partner. Her doctor presents her with options, information, decision trees, statistical probabilities, side effects of proposed medications, both relatively benign and downright terrifying. Her J.P. also teaches her how to live "healthfully."

Although there is obviously great overlapping of values shared by the American and British medical professions, this matter of informed consent may be a key difference between them. In America, largely as a result of the informed-consent movement and court opinions, the pendulum has swung from the doctor to the patient as the decision maker. Repeatedly, the courts have punished doctors in malpractice decisions for not recognizing that the

⁴Sissela Bok, *Lying and Moral Choice* (New York: Vintage Books-Random House, 1979).

patient is in charge and in fact needs to know all the known, salient details about his case. The argument for “informed consent” in America rests on the “liberty interests” of the individual as defined only twenty-five years ago by our judiciary, making it a complex matter to reverse this new American tilt toward the patient as captain of the ship.⁵ The Supreme Court has decided that in fact the medical record belongs to the patient. In Britain, on the other hand, the Sidaway case in December 1984 produced a decision that left the doctor essentially in charge of the information flow to the patient; in England the doctor is still firmly in charge, required to tell the patient no more than is customary.

A further ramification of the informed-consent movement in the United States was indicated by Charles Begley, an American health economist, who concluded in a recent essay, “A prospective payment system that asked physicians to allocate limited resources may not be able to tolerate the patient-oriented doctrine of informed consent.”⁶ Certainly, the National Health Service (NHS) is essentially a prospective payment system; if Begley is correct, one might expect that, should an American-sized informed-consent movement strike England, there will emerge increasing conflict in the system.

Although it may be stretching the point, the informed-consent movement seems connected to the move to recapture citizen competence, to reassert the individual’s responsibility for his or her own health and welfare, and to emphasize that the next great advances in the improvement of the health status of the American people would be made through education and behavior modification. Although these efforts at health promotion and disease prevention are society-wide, it is clear that the family or primary physician is a very important player. More and more doctors,

⁵Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984).

⁶Charles E. Begley, “Prospective Payment and Medical Ethics,” *Journal of Medicine and Philosophy* 12 (1987): 107-22.

previously disease and treatment oriented, appreciate these days that some of their most effective contributions come in the prevention areas.

The whole nation takes pride in our improving statistics in lung cancer, cardiac disease, stroke, and hypertension. We know that, with the exception of lung cancer, the reasons for the advances are not clear. We believe in general, however, that the movement to individual responsibility for one's own health is important. In my view, this movement is not unconnected with the informed-consent movement and the general effort to demythologize the physician and to reduce his or her power and influence. Although this outcome of or association with the informed-consent movement must be recognized as highly positive, it is also true that, viewed strictly from the perspective of the Hippocratic healing tradition, the informed-consent movement may not prove to have been universally positive.

THE BUREAUCRATIC THEME

Policy-making in America can be characterized in Professor Don Price's famous phrase, "creeping incrementalism," meaning two steps forward, one step backward, perhaps three sideways, and then another forward. Calabresi and Bobbitt's concept of "tragic choices" overlaps "creeping incrementalism" and seems to explain many of our societal choices.

In brief, it is Calabresi and Bobbitt's view that every societal choice leaves someone out, even consigning them to death; in time, since society cannot tolerate this, a shift in values must occur to favor in some way those who suffered under the previous policy. The tragedy in a way is spread around without our ever having to admit publicly that we commit some to death. A good example is the military draft guidelines which tend to exempt from service certain people. In biology, the argument used to be whether form followed function or whether structure determined function; it

seems to me that the physical characteristics of America, its size and diversity, are an important influence on the “creeping incrementalism” of our national policy development. A democracy, particularly a large and diverse one, expresses many values through its national policies; in national policies choices are made that favor, some people and their values and detract from others — hence, Calabresi and Bobbitt’s term “tragic choices” and their view that fairness in the democratic society requires a periodic shifting to address the interests of those whose lives and values have not been emphasized under current policies; so the pendulum swings, destined only to move again in yet another direction so as to allow the entire nation to persist in the myth that it is not sacrificing some people with each decision. For America then, “tragic choices” and “creeping incrementalism” are all of a piece and are likely to be characteristic of our policy-making as long as we survive as a democratic state. But that doesn’t mean that a coherent story cannot unfold. Let us turn to the health policy story of the United States over the past four decades.

Looked at from a policy perspective, national health policy in the post–World War II period has been an unqualified success. Although the times and climate favored the fullest flowering of the great American problem-solving technique (that is, once the problem has been carefully identified, throw large amounts of money at it and eventually it will be solved), there is much of which our nation can be proud. What was evolving during the fifties and early sixties was the concept of all citizens’ right to health care of the highest order. The federal government was on a roll; Uncle Sam would deal with all important matters.

It was determined that our hospitals were old and dilapidated and contained too few beds. A law was passed, money was identified, and within a decade or so we had lots of modern hospital beds.

We needed more science and technology for the benefit of the public. Therefore, disease by disease, we attacked the research and specialty care needs of our nation; James Shannon, the director

of the National Institutes of Health (NIH); Senator Lister Hill of Alabama; and Congressman John Fogarty of Rhode Island led a small group of influential leaders in the successful fight to increase the nation's spending on biomedical research. We trained specialists and researchers, thus enlarging our medical school faculties by sixfold over the past fifteen or twenty years.

We perceived a severe doctor shortage. Congress passed a law, and the number of medical school graduates increased from 7,000 in 1967 to 16,000 in 1985. We perceived a need for more specialists. We passed a law to support specialty training. We perceived a need for more primary care doctors, so the Congress appropriated the requisite dollars to stimulate the growth of family practice residencies.

We perceived a need for broader accessibility to health care for all sectors of our society. We developed Medicare and Medicaid, gave tax credits to employers who provided health insurance for their workers, and elevated the proportion of our population with health insurance to greater than 85 percent. Over the past ten years, minorities and the poor have clearly improved their access to health care, with blacks visiting the doctor as often as the average white client and, in many states, achieving equal access to all hospitals. In other words, great strides were made toward the achievement of a single class of care for all.

In all of these changes, the profession of medicine through its primary organization, the American Medical Association (AMA), fought to preserve what it perceived to be the best interests of the doctor. In the late 1940s, and early 1950s, the AMA successfully fought off the U.S. government in all major health initiatives. As pointed out by Wilbur Cohen, the passage in 1965 of the Social Security legislation establishing Medicare demonstrated for the first time that the power of the AMA could be broken; and it has been diminishing more or less ever since.

The one area in which the AMA has retained its success rate in the policy arena has been in the maintenance of the fee-for-

service system of payment for physicians. As the financing system evolved in both the public and the private sectors, the physician always received “reasonable and customary” fees. Until the widespread advent of health insurance, both public and private, there was a proud and important tradition among physicians, wherein they freely devoted their services to people who couldn’t pay and equally generously gave their time to educate medical students and residents. The so-called Robin Hood syndrome occurred, in which the well-to-do supported the physician and those efforts he or she was able and willing to give away.

Within a decade, that tradition of contributing free care and free teaching dissolved. Payment was received through “third party” insurers (including Medicare and Medicaid), who paid for whatever the physician did according to “usual and customary” standards. Now, therefore, the third-party payers were paying physicians at rates that previously allowed them to carry on like Robin Hood, except that the Medicare and Medicaid programs provided reimbursement for the elderly and poor, assisting the trend to some dramatic income increases for many physicians. Increasingly, teaching physicians learned how to bill for their services while teaching, again especially for the poor. A significant characteristic of much of medical practices was disappearing too; and that was the direct payment of the physician by the patient for personal services rendered. Though the loss of this way of transacting business was fought by the profession, and very sincerely so, the rapid expansion of physician incomes and the obvious enhancement of accessibility to health care for those previously unable to pay rendered this opposition ultimately insignificant. This same trend toward cross-subsidization of care for the poor and for teaching costs occurred with hospitals; and, almost imperceptibly, these two major efforts were loaded onto the cart being pulled by the private insurers on behalf of employers.

In the 1930s, at the Rip Van Winkle Clinic in New York State, a successful prepaid program was established wherein for

a flat fee all necessary health care would be provided to participants, This was the first Health Maintenance Organization (HMO). During World War II Henry J. Kaiser provided a system of total health care for his workers which evolved in the postwar era to include a growing number of subscribers, largely in Hawaii and the West Coast of the United States. Other similar institutions sprang up here and there and flourished in modest ways through the 1960s and 1970s; the HMO effort was a crusade for some and was strongly advocated by many experts, but it experienced great difficulty in getting widespread national acceptance. Far less than 10 percent of the population was ever enrolled in these health care plans prior to the past few years. Most doctors preferred the solo practice of medicine or group practices, which generally allowed for more independence, were more professionally satisfying, and were usually more lucrative than employment in an HMO. Organized medicine and other elements of society actively opposed the flourishing of HMOs. It was not uncommon for people to be HMO members until they got really sick and then they would go outside the HMO to get the level of expertise they wanted or thought they needed.

Health care benefits became an important item in labor relations as contracts which provided health care as an increasingly major fringe benefit for large numbers of workers were negotiated by labor unions and management. Complete health insurance is a wonderful fringe benefit, because it is of potentially great financial value should serious illness strike the individual. It was very appealing for both labor and management to negotiate; therefore there was a rapid expansion of private insurance programs available to the working population and to their families. For reasons that have always been obscure to me, but must obviously have related to financial performance, the insurance carriers persisted in covering in-hospital care more rapidly than out-of-hospital care. They also paid more for procedures or laboratory tests than they did for the doctor's time. Thus, the patient would typically have

to pay from his or her own pocket for a diagnostic evaluation done in the out-patient clinic, whereas, if hospitalized, the insurance company would cover all expenses. Further, the doctor would frequently find that his or her patient or the patient's family would prefer to have the patient stay in the hospital for continuing therapies or rehabilitative services which could have been provided on an out-patient basis. Such a course of extended hospitalization seemed to hurt no one and often on the surface seemed to help everyone, impacting only on the insurance premium which was, of course, spread across a large, impersonal, and unaware group.

This approach to paying hospitals and doctors obviously encouraged the provision of more services, more procedures, and more tests, because, in general, they seemed to be "free" to the patient. There were other results from this kind of approach. For example, as malpractice suits began to increase, doctors found it easier to practice "defensive" medicine, ordering tests that were largely unnecessary for diagnosis but might come in handy in case they were sued. Another example is the incentive this reimbursement mechanism provided to family physicians to become adept at certain procedures which were reimbursable in the ambulatory setting to make up for income not forthcoming for the time that the doctor might spend talking with the patient.

As one might have guessed, in addition to increased accessibility to effective health care for our citizenry, the net result of all these policies has been a steady annual growth in health care costs and expenditures. Along with these signs of success, there naturally came the detractors or the advocates of the "other side of the coin." For the detractors, the costs were too high; the hospitals were over-bedded and therefore must not be running efficiently; doctors' incomes were growing more rapidly than others' and their conspicuous consumption was annoying; pharmaceutical companies were seen to be controlling our lives, encouraging us through advertising to becoming a pill-taking society and thereby profiting from our weaknesses; new technologies and drugs were

being utilized on patients too soon and without adequate testing. As the proportion of the health care dollar that was paid by the government increased, the federal dollars available to other significant constituents diminished, and pretty soon the health care dollar became a worthy target for competing constituencies.

As a result, the federal attempts to regulate and control health care costs grew, and each of these governmental efforts was seen as an intrusion by the basically politically conservative profession of medicine, which therefore resisted them. The forces for centralized governmental approaches gathered strength and we saw a wide variety of regulatory and planning efforts flow from the administrations of Lyndon Johnson, Richard Nixon, and Jimmy Carter. In some states, hospital charges were strictly regulated by state agencies. Highly intrusive innovations labeled as “quality assurance” mechanisms were widely implemented, even though these massive governmentally sponsored efforts were really aimed at cost control rather than quality enhancement. In spite of this, there was little demonstrable effect upon the ever-escalating costs of health care.

I remember clearly an informal meeting in 1973 in Washington, D.C., at which a distinguished British physician listened to a description of the new Professional Services Review Organizations that the U.S. government was putting in place. His response was one of amazement, because, he said, the National Health Service would never agree to intrude on the independent authority of the physician to practice medicine to such an incredible extent.

Important societal voices (in addition to those of the detractors discussed above) began to be raised in opposition to these increasing costs, to the domination of high technology in health care, and to the seemingly unlimited authority of the physician. Critics aimed to demythologize the physician and the so-called medical model through which, it was claimed, the profession had for years maintained its stranglehold on health policy and health care. Such critics pointed out that relatively large proportions of patients

entering a hospital acquired other, sometimes lethal, diseases while there. Epidemiologists poked holes in long-established treatment modalities, showing in one famous situation that a sham operation produced results at least as positive as did the venue then in vogue.

Archie Cochrane, the well-known British epidemiologist, was for a time in the mid-1970s an extremely influential force in policy circles in Washington, D.C. He frequently referred to a published British study, which showed that those people who received treatment at home for an acute myocardial infarction did better than those who went into the coronary care unit in the hospital. This came at a time when U.S. hospitals had just gone into competition with each other to put in place, at great expense, the highly expensive coronary care unit. The British study, as well as Dr. Cochrane's appealing personal presentation of the data, did much at that time to cast doubt in the federal bureaucracy about the unqualified success of high technology and underscored the growing belief that cost control was too big an issue to be left solely to the judgment of the physician, who directly or indirectly controlled 70 percent of the total health care bill. That Dr. Cochrane's results could not fairly be transposed to the United States (partly because most American males did not have a wife at home willing or able to nurse him through a heart attack) made no matter to the impact on federal policymakers.

At this point, my history must be interrupted for a discussion of a movement in the American polity, which at first seemed completely unrelated to health care but which was gaining strength and momentum. When the windmills, at which this movement aimed, actually were toppled, it became clear that analogous efforts might succeed in health care. I refer to the process of deregulation of a series of American industries, thought of since the 1930s as quasi-public utilities requiring oversight by especially created, specific federal agencies to protect the public interest. Martha Derthick and Paul Quirk, in their recent book *The Politics of Deregulation*, have made a convincing argument that, contrary

to popular belief, the successful deregulation of the trucking, airline, and telecommunications industries represented a victory of rational analysis by expert economists acting in concert with the regulatory agencies and the Congress to overcome the powerful special-interest coalitions, represented by the corporations and unions, which profited for so long through the regulatory arrangements.⁷ The steps taken in each of these three instances of dramatic executions of the sacred cows of government regulation are matters of public record in the 1970s and early 1980s. The outcomes from the public's perspective, and even to some extent from the business community's, have been laudatory, more positive perhaps than most people expected. The changes were accomplished quite rapidly, are working to people's benefit, and seem irreversible for the foreseeable future. In each instance, competition in the marketplace was encouraged, government control and influence were minimized, the power of the unions were diminished, and new wage schedules were established to meet price competition. Pro-competition economists and lawyers like Alain Enthoven and Clark Havighurst argued that the same thing could and should be done for health care, a service industry which should be placed in the marketplace like everything else.

By 1980, when Ronald Reagan swept into power, the scene was set for dramatic change in the health care arena. The profession of medicine generally supported the business-oriented, deregulation approach espoused by Reagan and his commitment to the reduction of government power and its capacity to interfere with market forces. He was, by and large, the doctors' cup of tea. The airlines, trucking, and telecommunications industries had been deregulated or were close to that condition; but, piece by piece, under Reagan and the Congress, so has the health care industry been deregulated. In the process, organized medicine appears to have lost forever its ability to preserve the fee-for-service system.

⁷Martha Derthick and Paul Quirk, *The Politics of Deregulation* (Washington, D.C.: Brookings Institute, 1985).

In successfully holding off Big Brother in the form of Uncle Sam as the major employer of physicians, America seems ready to substitute corporations as major employers of physicians as part of total health care delivery packages for large segments of the population. Joining forces with the Reagan government in its approach to cost control was a powerful new ally in the form of the business associations of corporations seeking to improve the market success and sophistication of the aggregate purchaser of health care and committed to reducing the costs of providing health care for their employees. Unions were losing their credibility and their clout; the president's trouncing of the Air Controller's union early in his first term proved that point. The fact that over \$500 in health care costs went into every new car meant that health care got partially blamed for the U.S. loss to the Japanese of world preeminence in automobile sales. For the first time, businesses decided to become prudent aggregate buyers of health care, and a variety of new initiatives to cut costs came into being.

The most striking personifications of these changes are represented by Lee Iacocca, Donald Fraser, and Joseph Califano.⁸ In the fifties and sixties, they represented industry, labor unions, and government, respectively, in seeking to increase access to health care, advocating the individual's basic right to health care, and promoting centralized planning and regulatory apparatus to control costs of health care. Now, they all serve on the Chrysler Corporation Board, linked in their effort to reduce the company's costs, attempting to eliminate cross-subsidization so that no Chrysler health care dollars go either to care for the poor or for the education of future doctors.

For-profit hospital chains attracted attention and have had such a meteoric rise into the national consciousness that the Institute of Medicine (IOM) of the National Academy of Sciences conducted a major study of the impact of the for-profit chains on

⁸Joseph A. Califano, *America's Health Care Revolution* (New York: Random House, 1986).

American health care.⁹ Completed in 1986, this study showed that for-profit chains were neither more efficient nor less effective in delivering care than their not-for-profit counterparts and that they often provided their stockholders with profits to an amount equal to an excess of charges over those levied by their not-for-profit counterparts. Further, the IOM study showed that the rise in the number of hospitals and beds owned by for-profit chains came largely as a result of their acquisition of so-called proprietary hospitals (that is, hospitals which were previously owned by individuals on a for-profit basis); the acquisitions usually resulted in an upgrading of the facility and an increase in quality over that produced by the often local (frequently physician) ownership.

Finally, the enormous success enjoyed over a relatively brief period on the stock market by the more successful of these companies disappeared when it became evident that these profits came only because of their companies' adroit manipulation of the old system of reimbursement, which had been standard through 1983.

When the government changed in 1984 to payment of hospitals according to a diagnosis-related pre-set formula, the incentives changed to favor care provided with a minimum of laboratory tests, procedures, and consultations. Thus, if a hospital could take care of a patient for X dollars less than the formula designated for that disease, then the hospital could realize X dollars of profit. Under these new conditions, the for-profit chains lost their edge. They had failed to appreciate the need to switch to out-of-hospital care to make a profit in the new order and they were left holding the bag; the doctors stood to profit just as handsomely from caring for people out-of-hospital. Suddenly, the incentives were reversed and behavior was changed; the ill-prepared for-profit chains have been suffering, and it seems highly unlikely that they will dominate the industry.

⁹The Institute for Medicine, *For-profit Enterprise in Health Care* (Washington, D.C.: National Academy Press, 1980).

The average length of stay in a hospital has dropped by as much as four days per stay, and out-patient surgeries have emerged; and one can foresee the day when the hospital will be essentially a large intensive-care unit.

The HMOs are ideally placed to take advantage of this new situation. In Minneapolis/St. Paul, where HMOs now have greater than 50 percent of the market, much of interest is being learned. For example, subscribers will change HMO's for a fifteen-dollar-a-month differential; they will change for more convenient or for more courteous service; and they assume that there is high-quality medical professional care in each situation until they become convinced otherwise.

HMOs deliver a full range of health care to a population by reversing the trend in America from increasing numbers of specialists to a distribution of physicians more heavily laden with family or general physicians. They also employ the primary physician in a gatekeeper role much as occurs in the NHS, except that HMOs tend to be large group practices wherein primary care doctors share offices and resources with specialists; and therefore, these gatekeepers tend to concur with specialists about the proper time for referral.

The large aggregate purchaser of health care has become highly sophisticated and is generally seeking a contractual arrangement that will guarantee a lower cost but preserve quality. To provide these elements requires health facilities — both in-hospital and out — financial support, and good doctors. In the past, it was the doctor who was in short supply; but now, thanks to the so-called surplus of well-educated young physicians, there are plenty of talented people willing to work for a salary in order to be able to practice at all. The revolution in health care delivery is thus being fueled by the increased size of the physician pool; and it is this fact that explains the ambiguity in health policy circles about the need or value of reducing medical school class sizes.

While some people are seeking a return to past conditions, other health care experts, like Paul Ellwood, predict a sweeping change, with the great majority of health care in the United States by the year 2000 being delivered by health care corporations of various sorts. Ellwood thinks there may be ten or twenty mega corporations providing health care nationally, backed up by a larger number of regionally based and smaller companies. While his predictions may be extreme, the trend is still going in his direction. Whether for-profit or not-for-profit, the vertically integrated corporations' domination of health care in the United States is a distinct possibility. How these changes will get implemented and how they will affect the Hippocratic tradition is unknown.

Organized medicine appears deeply disappointed. After fighting so valiantly against the forces advocating increasing government control, which remained in the ascendancy throughout the sixties and seventies, it helped to elect the anti-big-government forces of the Reagan administration. At last, no more health planning or regulation; no more giveaway programs providing all patients the potential to receive care anywhere; no more professional service review organizations (PSROS), health planning agencies, or National Health Service Corps; no chance of Uncle Sam becoming the doctors' employer!

Alas, it is now dawning on the AMA that it has been hoisted on its own petard. Health care got deregulated all right. The enterprise got treated as a business. The Federal Trade Commission refused to allow any discussion of proper fees and banned the ban on physician advertising. The government reversed financial incentives so as to discourage hospital care; it took steps to open hospital staffs to more physicians and other personnel; it struck down barriers to HMO development; and it has done nothing significant to stem the tide of foreign medical graduates swelling physician ranks and has thus not implemented a policy favoring a diminished output of new physicians. Financial incentives and

budget cuts have made for a fiercely competitive business environment as doctors' groups, hospitals, and other companies fight over the population for market share, sometimes with advertisements that would make an automobile salesman blush. There is even a for-profit clinical research company in Tennessee.

Gradually, it is dawning on medicine's leaders that doctors are in danger not of employment by Uncle Sam but of employment by any one of a number of health care companies. The companies can be expected to pay as little as possible to attract the necessary talent and might discharge those doctors who make trouble, who do not see patients rapidly enough or who are too noisy in their patient advocacy. What previous presidents couldn't do in twenty years of believing that health care was a right — that is, control expenditures — this president has accomplished in six years, even though it is now clear that health care is no longer considered a "right."

Health care has become a business and it has become a melange of big businesses; the solo or small businessman is out. Thus, the rules of big business will govern the enterprise increasingly. The manager will become more powerful than the doctor; market-sensitive practices will guide the behavior of the group; price and profits will become major considerations; wholesale deals and cut rates will become commonplace as negotiated contracts increasingly govern daily practices; advertising, loss-leaders, market-share, and interest in consortia or related businesses will become commonplace and will dominate the rhetoric and context of the business. A characteristic model might be that a for-profit hospital chain would buy an insurance company to provide know-how and financing for large-population health care; then the new conglomerate would hire doctors and build medical office buildings, acquire nursing homes, psychiatric hospitals, pharmacies, and hospital supply companies. This is called vertical integration and will occur just as readily with not-for-profit chains. The conglomerate is so big, it might as well be the government from the perspective of the individual physician.

Whether we should cap our nation's health expenditures at 12 percent of the gross national product or 15 percent or 18 percent, there is no doubt that demand already outstrips what we are happy to spend on health care. Therefore difficult choices must be made and priorities set, often based upon institutional or governmental policies. These sorts of choices in a democratic society, where adherence to values is never the result of a top-down mandate, must inevitably entail a constant shifting to emphasize values apparently neglected by previous policies. The winners and the losers are subject to change, so that the fact may be disguised from public view that societal choices in fact consign some people to the loser category.

Shall we ration and how shall we ration are key questions facing us in the years ahead. As a first-year medical student in 1956, after observing a dramatic and life-saving repair of a tiny baby's congenital heart defects using the then-dramatic technique of extracorporeal heart-lung bypass, I overheard two visiting Russian doctors say, in congratulating the American surgeon, that in Russia they would have simply had a new baby. So far apart in 1956, I'm not so sure of the distance today between that Russian view and ours.

As our life-styles and technologies increase our life expectancies, our mortality rates decrease, but our incidence of morbidity or years of life associated with some disability increase. Thus, the choices of the present and future will not always be between this or that life-saving intervention and its attendant costs but increasingly will be tied to the years gained of quality life per dollars expended based on cost-benefit analyses. Careful and quantitative analytic studies will be able to determine with ever-increasing accuracy the number of years of acceptable quality of life that can be purchased by a set number of health care dollars; the temptation will become strong and the pressure compelling always to go with the most good for the dollars available. Such an approach may have much to recommend it, but it could lead one to replace

all the hips that need fixing in the country before transplanting any more hearts or livers, because the hip transplant produces such dramatic improvements, usually for over ten years.

Most frequently, when thinking about rationing health care dollars, the focus is on controlling access to technology; seldom is physician or nurse time considered. In this regard, two true stories are relevant. The first involves the 1970 studies involving graduating Princeton divinity students who, in what they thought was a real-life situation, one at a time passed a groaning suffering man lying beside the path.¹⁰ In reality, the modern-day sufferer was a trained psychological observer who scored each person on their reactions to his plight. Each of the students had been placed in different situations: some were in a great hurry, others less so, others not at all; some had just read the Parable of the Good Samaritan, some had not. When the results of the experiment were analyzed, the only factor which correlated positively with whether the students stopped to offer assistance was how much time the individual had to spare.

Allow me to juxtapose that study with the plight of a recently graduated obstetrician. This lady, a single parent with two relatively young children, was precluded from entering private practice in the city where she lived because she was already \$65,000 in debt and couldn't afford the \$60,000 required for malpractice insurance. Therefore, she joined a group practice providing pre-paid care to a large population of subscribers and was promptly informed by the nonphysician clinic manager that her "quota" was to see five patients per hour. She felt it was impossible to give good care or to educate adequately either pre- or post-partum patients under these circumstances, but she had no alternatives other than quitting. To quit was economic suicide for her and her children, and yet she was prevented from rendering to her patients

¹⁰John M. Darley and C. Daniel Batson, "From Jerusalem to Jericho: A Study of Situational and Dispositional Variables in Helping Behavior," *Journal of Personality and Social Psychiatry* 27 (1973): 100-108.

what she regarded as reasonable care. She turned to a senior colleague (and friend of mine) for moral counseling; I wonder what he told her, for this represents the quintessential conflict of the decade before us as the Hippocratic theme meets the bureaucratic theme on the playing field of “rationing.”

In this case, the commodity being rationed is not a technology but the time necessary to establish and develop the therapeutic relationship between doctor and patient, and the rationer is the manager and not the doctor. Where will it all lead? To the unionization of doctors, to protect not only their economic interests but their role as advocates for their patients and the final arbiters of their own time management as it relates to contact with individual patients?

In the United Kingdom, the political process makes the macro-decision as to how much money is to be spent but has maneuvered the doctors into the position of rationer (a position which it seems to me will ultimately have devastating effects on the trust between patient and doctor so essential to a healthy transaction). In the United States, the political process has been unable (and I believe will always be unable) to make the rationing decisions necessary to keep the lid on costs; politicians and bureaucrats frequently berate the doctors for not carrying out this function of deciding not to give treatment to some patients. However, the malpractice courts await those U.S. physicians who deviate from the normal standard. Thus, there is little chance that doctors will be placed in the system as the “rationers”; nor, in my opinion, should they be so placed, with the exception of that situation surrounding the attempt to have a dignified death. In that situation the doctor may withhold an available therapy, not because it is to be saved for someone else, but because such restraint is actually the best treatment for the patient.

And now it is time for me to admit defeat, to admit that I too have contracted the Alexis de Tocqueville Syndrome (at least a modified form of it) and to pass along my current analysis of

what has been for me one of the more perplexing differences between the American and the British practices of medicine. More than a common language separates us. The issue to which I refer was identified in 1963 by the American Nobelist in Economics, Kenneth Arrow, when he noted the intrinsic conflict between the doctor as the supplier of services and the doctor as advocate for the patient. Intellectually I understood that statement, but in practice I thought it presented no real problem; therefore I took it as a rather arcane insight, although somehow I have continued to remember it from time to time. More recently, the American authors Henry J. Aaron and William B. Schwartz in their book *The Painful Prescription* make no bones about their observation that British physicians, both general practitioners and specialists, are making the rationing decisions in certain key instances.¹¹ The most striking example for an American reader is that of turning down patients for dialysis because of age. I know Bill Schwartz and he is a thoughtful and careful person. I also know several British physicians quite well, and they all claimed that they did not make rationing decisions; they made medical decisions. One physician with many years of practice in London to her credit said she had never had a patient turned down by a specialist. I found it hard to bring these two perceptions of the same phenomena into some sensible alignment until I understood more clearly the significant differences in the doctrines of informed consent in our two countries. The informed-consent decisions of the American judiciary essentially make the patient the decision maker, not the doctor. It is expected that the doctor presents all the reasonable options to the patient and family, that the authority has become so decentralized that it in effect rests within each patient and, by implication, that the trust of the patient in the doctor rests upon the latter's demonstrated competence and the honesty and integrity with which he or she deals with the patient.

¹¹Henry J. Aaron and William B. Schwartz, *The Painful Prescription* (Washington, D.C.: Brookings Institute, 1984).

In the United Kingdom in 1985, the House of Lords, by split vote to be sure, decided the Sidaway case by explicitly denying the informed-consent doctrine extant in America and declaring that the patient had a right to hear only what was customary and necessary from the doctor's point of view. Further conversations convince me that most British doctors and patients agree with the implications of the lords' decision. When it is common sense to the doctor that an expensive, extraordinary intervention is unnecessary, it is consistent with the gatekeeper policy for him or her simply to make that decision for the patient by not recommending referral. In fact, these decisions to the British doctors are medical decisions, whereas to American doctors, the very same decision is a rationing decision and not a medical decision. For example, even if an American doctor was personally unenthusiastic about putting an elderly patient on chronic dialysis, he would undoubtedly feel that the option must be presented to the patient and that, if the patient chose dialysis, he the doctor would be obliged to carry it out. The British patient would be confused by the American physician, and the American patient would feel badly short-changed by the information and choices offered by a British doctor.

This is the intellectual context out of which the American economist Charles Begley, from Kenneth Arrow's view of the conflict between physicians as suppliers and advocates, adopts the position that the role of gatekeeper (as in the NHS and in American HMOs) is fundamentally incompatible with the American doctrine of informed consent. I believe the lawyers and the doctors and the policymakers have a lot of hard thinking and negotiating to do on these matters. It is gratifying to me finally to understand how the British doctors and patients have maintained the integrity of their relationship in the face of these tough decisions, but I fear the turbulence which may emerge if the American view of informed consent is adopted in England.

Thus, the American politicians have turned to the marketplace to do their job for them —and who's to say whether this

approach might not have great benefits. This decentralization has had some interesting if unexpected fall-out. For example, I have a friend with a complex neurological disorder who is a subscriber to a prepaid comprehensive care plan; when it became clear that he would benefit by having an expensive, new high-tech intervention to speed his convalescence, he was interviewed by a special group of people not including his doctor to determine whether the plan would purchase it for him or not. This of course is similar to the much-maligned process used in Seattle, Washington, to determine which few patients would get into the chronic dialysis program; the doctors advocated their patients and a board of anonymous lay members made the decisions. The intellectual world scoffed, saying logic and justice required random selection or universal availability.

Under the deregulated, decentralized systems approach to health care evolving in the United States, the main problem will be how to guarantee a requisite level of care for the poor and underinsured. How we answer that problem will be the true measure of our values, of our national character, and of the quality of our beliefs. If we deal successfully with the issue of the poor and underserved, we may well have achieved an approach to providing adequate health care for all in a context fully supportive of the American values of voluntarism and freedom of choice that apparently is, for us, better than the more centralized approach we were following toward a single, NHS-like establishment.

A period of confusion, rapid change, and great debate over value-laden issues (such as is now being experienced in the United States regarding health care) cries out for the emergence of philosophers who can clarify issues, define central questions, and help the society toward a rational resolution of the policy crises with which it is dealing. I'm pleased to say that bonafide card-carrying philosophers have entered this fray, and one of them has recently published what is, in my view, a comprehensive and illuminating

analysis which has the potential to help shape and clarify our nation's thinking on some of the crucial health-related questions. I refer to Norman Daniels's treatise published in 1985 by Cambridge University Press, *Just Health Care*.¹² Professor Daniels attempts to extend John Rawls's principle of distributive justice to health care and courageously attacks the most pressing and difficult issues.

In brief, he argues that health care is of a different order from other commodities or services and that the principle governing health policy should be what he calls "the fair equality of opportunity account," implying that society has the obligation, based upon the Rawlsian theory of justice as fairness, to see to it that each person has access to the health care required to allow him or her equal opportunity as a citizen within the constraints of his or her own innate talents and skills. Daniels further concludes that the arrangements necessary to provide this care would not violate any basic provider liberties and should not necessarily do economic injustice to doctors. In his view, the restrictions on autonomy in treatment decisions derived from just resource allocation policies will not harm the rights of either patients or doctors or the essence of the doctor-patient relationship as long as the society understands its obligation to exclude the rationing decisions from the physician's portfolio of responsibilities.

Although I lay no claim to being a professional philosopher, I commend Professor Daniels's work to you and find in it the best set of arguments I have yet come across yielding some principles for policy development. Whether his views can gain enough exposure to impact the body politic in a timely fashion is problematic.

While we seek greater justice for our people in the more appropriate dispersal of services and strive to control the costs of health care, we must take care not to discourage our best potential

¹²Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985).

scientific healers from entering the profession. There is strong evidence that this may be happening. The so-called malpractice crisis is driving doctors out of practice and is a strong factor in redirecting promising students into non-health care fields.

In a recent newspaper article, Dr. Thomas B. Ducker, a Baltimore neurosurgeon, clearly places the blame on malpractice suits for the loss of trust between doctor and patient and between doctor and doctor.¹³ He states that he no longer is forthcoming about his own mistakes at morbidity and mortality conferences — consequently he learns less from his mistakes and others learn nothing from them. Dr. Ducker concludes his essay as follows: “Somehow, some way, we must begin to restore the relationship of trust that once existed between doctor and patient, and between doctor and doctor. Otherwise, today’s troubles will pale against the grief that awaits medicine in the future.” These are words that accurately describe the feelings of many excellent American physicians now in practice.

Clearly our primary societal values (such as freedom for the individual, hope, distrust of government) and our major bureaucratic values are in conflict with the best expression of our Hippocratic values. Our desire for high technology is, in some ways, self-defeating; the more we yield to the technologic imperative, the more alienated patients seem to feel. Doctors sometimes are at the eye of the storm, receiving blame from bureaucrats, politicians, and the public. Some doctors seem to blame their woes on the so-called medical-industrial complex if not the malpractice lawyers.

I believe it will not be easy to sustain and nurture the Hippocratic tradition and its twenty-first-century off spring, the scientific healer. To succeed, doctors must retreat to a definition, articulation, and defense of the core of physicianhood, the core that rests in the Hippocratic tradition, and they should leave unto Caesar

¹³Thomas B. Ducker, “We Need a Cure for the Lack of Medical Trust,” *Houston Chronicle*, February 2, 1987, op-ed page.

those things that are Caesar's. The profession of medicine is not doing a good job protecting Hippocrates' turf. We have forgotten that death is not an option but a certainty; that the doctor's job is to minimize suffering and pain just as much as it is to cure. Pain is, after all, not a single gene, single protein, single defect lesion. It is a symptom which is the sine qua non of suffering, the very stuff physicians are here to minimize. It can be treated sometimes with surgery; sometimes with medicine; sometimes with placebos, massage, or physical therapy; sometimes with words; and sometimes by techniques without known scientific basis. Often, pain can't be overcome, and the doctor must help the sufferer to endure.

I believe this means that, just as our biomedical sciences continue to produce new curative technological interventions, just as our social and behavioral sciences develop new strategies to encourage life-style changes in healthful directions, so the medical profession should extend its intellectual boundaries to include the fuller exploration and understanding of the therapeutic relationship or, if you will, healing. Anthropology and psychology can, in my view, forge a constructive, productive linkage with the neurosciences (including neuropharmacology) to extend our knowledge in this important area. Along the way, we must continue to ask the question, How can the physician be the patient's friend and trusted advocate while being a potential adversary and rationer at the same time?

Thoughtful physicians must rally more intensely around the vision of their Hippocratic tradition; they should encourage their leaders to worry less about the governmental threat, less about the threat of the business coalitions, less about the threat of the for-profit chains, less about the corporatization of medical practice, and to worry more about preserving the essentials of the profession of scientific healing, begun by Hippocrates and threatened as never before by our incredible scientific, technologic, and financial successes and by our own ignorance, inattention, and misunderstanding of the very essence of physicianhood.

In sum, I believe an accommodation can be reached between the values of the Hippocratic theme and those of the bureaucratic theme; a stronger Hippocratic theme will lend a necessary balance to the societal and bureaucratic values such that the United States can have a humane, fair, and effective health care delivery system built around the therapeutic relationship between patients and health professionals dedicated to their service. In our fanciful ongoing discussions including Thomas Jefferson, Max Weber, and Guido Calabresi and Philip Bobbitt, surely that is what Hippocrates would be arguing for.