SPECIAL ARTICLE

ANNUAL DISCOURSE – THE DOLLARS AND SENSE OF MEDICAL CARE AND HEALTH SERVICES: RELATION

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Abstract Traditionally the healing art was given by the people and received by the select as a sacred trust. With newer knowledge of living tissues and scientific data an elitist sense of privileged right developed among physicians in an increasingly affluent civilization. Technologic advances, commercialization of medical care and money-changers have separated doctor and patient and promise to reduce the physician – not entirely without his complicity – to mere practitioner of rational science and operator of sophisticated instrumentation. As such, he may expect "the honor due unto him for" such use. Healing or making whole requires that the whole person be addressed wholeheartedly. It is such relation that cometh of the Most High that is life-giving and death-transcending. (N Engl J Med 291:497-502, 1974)

Honour a physician with the honour
due unto him for the uses
which ye may have of him:
for the Lord hath created him.
For of the Most High cometh healing.

Ecclesiasticus 38:1-2

MR. President, fellow members, ladies and gentlemen:

The Annual Discourse of this august body has been given 164 times before, but never, I daresay, by one who came before his audience with such dubious credentials.

In 1860 Oliver Wendell Holmes's remarks[1] were publicly disavowed by the Massachusetts Medical Society of his day. So much for the opportunity accorded by this colloquium to speak one's mind even in the face of wholesale disapproval. Dr. Holmes's oration has since been remembered and quoted for over a hundred years.

Not long ago Dr. Joe Garland, as editor, suggested that the *New England Journal of Medicine* publishes "material . . . which appears at the time to reveal something new or to offer a valuable extension of something old, or at least a reasonable hypothesis concerning it."[2] Thus is the stage set to stretch our perceptions beyond the limits of scientifically confirmed data.

In contrast to the Shattuck Lectures, these discourses have stemmed from personal observations and convictions of one of our own members rather than from the investigative research of visiting authorities. In this framework I offer an alternative proposition for our future as a profession. There may be a number of physicians among us who see no need for another way, but there is evidence that only a minority of the public is content with health and medical affairs and planning as they present today.[3] And so by "Dollars and Sense" in my title, I imply a larger scope than cost:benefit ratio. By "dollars" I am referring not only to monetary but also to intangible costs of the new health industry; and by "sense" is meant the senses – common sense, sensitivities, and sensibilities. I refer to the essence of the art of healing and shall touch upon an unfamiliar dimension of the doctor-patient relation.

You should know that I speak from the perspective of the exurbian, living between circumferential highways, Routes 128 and 495. Although it has a distinct parochialism, it is one shared by the circumferential highways of all our big cities across the nation. Because it represents a new servile order of considerable and morbid import in our time, we shall return to it. From Exurbia, then, take a brief look at where we have been in the medical sense, where we are in medicine and in society, and consider what is ahead and whether we should change it.

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QUALITATIVE CHANGE IN MEDICAL CARE

Change has taken place in medicine in the last 35 years. Graduates from medical school before 1942 studied, trained, and have practiced in a medical climate and tradition qualitatively little changed since Hippocrates. In 1962 Dickinson Richards, concerned with "medical priesthoods, past and present,"[4] quoted Hippocrates thus: "It is necessary for the physician to provide not only the needed treatment, but to provide for the sick man himself, and for those beside him, and to provide for his outside affairs."

Modern medicine can be dated from Koch's postulates almost a hundred years ago, but the physician continued to heal by virtue of who and what he was more than by what he knew, for another 50 years. For a brief halcyon generation thereafter, we had the best of both worlds. The art of healing and medical science collaborated. Then came the Technological Era.

Today, patient care is still the abiding charge of the physician. The doctor-patient relation is still the vital life-giving force, whether in the clinic, office, or at the bedside. Recently, however, Paul Beeson has perceived the "danger . . . that care of patients may come to be looked upon as annoying interruptions," and he noted that during the preceding 15 years, "up to one-third of the papers presented in the *Transactions* of the A.A.P. dealt with research which neither involved disease nor even man." "Surely we are aware," he pleads "that the genesis, expression and even treatment of human ill-

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ness must involve factors not likely to be disclosed by laboratory research."[5]

While medical research is burrowing ever deeper into the unknown, it makes little provision for the orderly use and disposition of the obtained data in the care of the patient or the service of the community. Meantime the health industry, Johnny-come-lately, but impressively, in the industrial-economic complex, accounting for 8 to 12 per cent of Gross National Product in the early 1970's, promptly seizes upon each research tool and makes its commercial adaptation available to community hospitals and medical centers alike. Being available, it must be used. Such is the principal law of our age, the age of Technique. "Since it was possible, it was necessary," said Jacques Soustelle in May, 1960,[6] in reference to the atomic bomb. Thus, it becomes indefensible not to use the newest medical techniques and instrumentalities. Such use becomes almost indiscriminate. The health industry is riding the crest of this wave of almost frenetic activity. There is an almost indecent impropriety through the physician's involvement with the explosive neoplasia of medicine-become-manufacturer, the profession become party to the peddling of pharmaceuticals, prostheses, and physiologic adjuncts and sophisticated hardware at any cost. The rising cost of drugs and doctors by national standards appears to some shocking and indefensible; in global perspective, malignant and consuming; and as physicians we comply and participate. The medical profession lets it happen, sometimes pleading helplessness in the trend of the times. Too often, however, we deny jurisdiction over or knowledge of the economics of medical care. Yet, most often, feigning a preoccupation with medical care and medical science, we have looked away and chosen not to see the indiscretions of a profligate health system at the very apex of a social affluence unprecedented in the world and in history. And even this undignified professional incongruity is not the kernel of our concern.

Before we pursue my thesis further let me say here that I find the miracles of scientific disclosure truly awesome. The far reaches of human scientific exploration in all directions — space, time, energy, biology — beggar the imagination. And the realized instrumentalities of the industrial system to implement the technically possible command our admiration and gratitude. All three, scientific knowledge, finite inquiry, and technologic implementation, warrant our continued approval and support. I do not fault the inquiring mind, the scientific method or even commercial research and development, per se.

La Technique: the Technological Society

Human experience is a complex of stresses and strains, a system of dichotomies under tension. Medicine today is such a system, stretched to the breaking point by scientific method, the hard objective scientific critique on the one hand and by what has been termed our common humanity on the other. What we understand as "Technique" appeals to and serves well man's intellectual aspirations. Exercised to its fullest potential, however, it will establish first a pattern of thinking and acting, and later a climate that must suppress spiritual inspiration and human relations. It is unrestrained Technique that we must guard against rather than Technique itself. There are already indications that Technique is fragmenting the community's common humanity. As we enter the last quarter of this century, who would deny that the community must be global in scope? And so let us consider briefly this larger scene as background to the medical care and health services we must provide closer at home.

Technique has been described by Jacques Ellul, French sociologist, lay theologian, leader of the French Resistance and one-time mayor of Bordeaux, as "the totality of methods rationally arrived at and having absolute efficiency in every field of human activity."[7] Technique is related to every aspect of life. It runs the gamut: food, population, agriculture, vocation, education, economics, surveillance and control, the state, all our institutions, recreation and amusement, mass man, totalitarian man, and, ultimately, the dissociation of man. The influence of Technique is ubiquitous and inevitable. "It is vanity," says Ellul, "to pretend it can be checked or guided. Who is too blind to see that a profound mutation of man is being advocated here? A new dismembering and complete reconstitution of the human being." Although technicians themselves have tried and continue to try to control the future of technologic evolution, their formula is predictable and limited. "A technical problem demands a technical solution." The argument for one, and only one, means to the solution of problems generated by Technique is a forceful one — i.e., a worldwide totalitarian dictatorship, which will allow Technique its full scope and at the same time solve concomitant difficulties. "In comparison," Ellul concluded in 1952, "Hitler's was a trifling affair."

Technique, then, is to affect us all, individually, professionally and socially. Not only does the medical profession function within and interact with broad social and political realities, but every aspect of human existence is of medical interest and concern. Therefore, the climate of the larger scene is of immediate relevance to the practice of medicine and to the care of the patient.

Whether real or contrived, the recent oil and gasoline shortage, with its continuing inflationary costs, was the first harbinger of a socioeconomic flaw in our technological age. Economists, geologists, biologists, and students of natural resources have long predicted the limitations of a consumption economy. Industrial-economic powers, however, have only accelerated their programs of planned obsolescence. Our thinking has yet to change.

Last month Uncle Sam went on a television-sales promotion: "Invest in U. S. Bonds. The U. S. is growing. *It always has.*" In April also, the United States Secretary of State told the assembled nations of the world "*systems that* sustain industrial civilization and *stimulate*

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growth must be maintained." (Emphases mine.) Is there in these assertive declarations a mindless insubstantiality? Every index of civilization's dynamics tells us that exponential growth is to be our undoing. Furthermore, the technologic society necessary to maintain industrial growth must become more confining and regulating of the public at large for its survival. Mr. Kissinger's six-point program[8] is a preamble to the world's first blueprint to global totalitarianism. One must speculate that it is the reaffirmation of a historic Germanic authoritarianism. It is not perhaps only accidental that it sounds like the National Socialism of 40 years ago. Actually, it is the "logical" extrapolation of the technological era.* Let me explain.

The 128 Syndrome

The American public, and to a lesser degree the population of Western civilization, is increasingly constrained and regimented in its way of life. Surely, we have long recognized though seldom acknowledged the economic extension of ante-bellum black slavery in both the North and South of the United States. Long before the Civil War plantation owners had found that the black man, if allowed a shack, a garden, wife and children, "took on airs," became an "uppity nigger," "thought he was somebody," and had a tendency to incite others to insubordination or worse. Often, it was necessary to sell him down river and sell his family elsewhere. Thus evolved barracks near the plantation center for the men and quarters for women and children down at the bottom of the fields. Men without attachments, without roots, without human ties were men without convictions and made better slaves.† It was earlier suggested that Exurbia, that social quicksand of affluent middle America surrounding our large urban centers, is the residential area for a segment of our population condemned to an economic servitude.

Since World War II we have generated an affluent slave class (the term is perhaps too strong?) of well paid employees of the national companies, conglomerates, or multi-national corporations whose unquestioning adherence to company policy is encouraged and enticed by rising wages and ready advancement within the company, and coerced by the company subsidy of disproportionate scales of living, ensuring crippling indebtedness on severance from the company. Thousands of families are moved between plants within the company every 18 months to five years for one purpose: to prevent a man's putting down roots, developing a home, a place in the community and a sense of his own worth. (This is a long established custom within institutions such as the diplomatic corps, the military, the state police, and even some of the churches.) Thus is the corporation established as the only foundation and base for the man's social and economic stability. A man's wife and later his children move with him. Ever more rootless, groundless, increasingly insecure, they are strangers in their ever changing abodes, without old friends or firm ties, no certainty of relations, no confidence in the future, in one another, ultimately in themselves. The man is emasculated, the husband alienated, the wife abandoned, the children made homeless orphans — yet all numbered in an economic group that "never had it so good." We have seen something of the change wrought in this new breed reflected in their children — the "now" generation of campus dropouts, stop-gap workers and "hip" street people. Transient coupling, loose communes and overt homosexuality among some have provided a climate engendering broken marriages, fragmented families and agonizing disenchantment with marriage bonds among others — scant thought of progeny, less for a future.

Even if this were a caricature of the new Industrial-Economic Society, we can all see elements of these influences at work in our own neighborhoods. Only Technique thrives on this formula. As Relation is fragmented, humanity suffers.

Priests, Profiteers or Technicians

What, you will ask, has this to do with the doctor and his practice? We have seen the technologic society develop in our lifetime, indeed in our professional lifetime. We can recognize around us many of the advantages and hazards of the technologic system. Technologic thinking has been particularly manifested by the selection of medical students. Intellectual keenness, mathematical prowess and scientific objectivity (with an attendant material acquisitiveness) assumed disproportionate importance in the choices made. For a decade this tendency grew before admissions committees took steps to modify the trend. The G.I. Bill had already long supported higher education. Postwar affluence provided a broader base for candidate selection. The legitimate demands of black and other non-white minorities have been felt; their slowly increasing entry into medicine is being followed by a major increase in the number of women entering medical schools.

Yet medical education, facing its own difficulties, lags behind in meeting perceived needs with progressive change.[10] Liberal education is being curtailed. Preclinical and clinical departments compete for curricular time in a disjointed and accelerated course reduced to three years by elimination of time addressed to human concerns and social needs. Academic specialists proselytize to win converts to their subspecialty from a student body still predominantly inclined to the practice of primary medicine.[11] Since graduates from medical schools now will constitute medical faculties 10 years hence, these ascendant philosophies of specialized medical science over holistic care of the patient in his environment will continue at least so long.

*Only the day before, historian Arnold Toynbee wrote in the *London Observer:* "Man's plundering of nature now threatens him with pollution and depletion. In so-called developed countries like those of Western Europe, the United States, the Soviet Union and Japan, growth is going to cease. They are going to find themselves in a permanent state of siege . . ."[9]

†The economics of our modern welfare system effectively encourages the separation of man, black or white, from his family by penalizing their living under one roof.

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Other elements separate physician and patient. Advances in medical diagnosis and therapy require postgraduate study of the physician. Long overdue, fair recompense to ancillary staff has increased hospital and office payrolls. Medical instrumentation for diagnosis and treatment has added a new cost factor exponentially to "quality medical care for all the people." Inevitably, to pay increasing medical expenses, third-party payments have burgeoned.

These intrusions on the practice of medicine – newer knowledge, higher costs, industrial advances and money-changers – are not new. They have taken on new dimensions and hence altered the doctor-patient relation, distracted the attention of both, widened the gap between them. The "team approach" to patient care recognizes these difficulties and may introduce social service, psychiatric counseling, home nursing, etc. Such ancillary services have merit, if they do not dilute further the healing process, aggravate cost:benefit ratio, or compound the complexities of personal interplay within the family.

Visible and measurable components are not the only factors alienating the physician from his patient. For they in turn work subtle changes in the physician's perceptions of the problem case before him and the hospital climate in which he works. Today, to manage a case one must use a battery of sophisticated techniques – laboratory, radiologic, pulmonary function, cardiovascular, fibroscopic. Still others are being offered constantly to community hospitals. Staff equipment committees must consider them all, more perhaps to "keep up" in the new competitive business of health care than to improve patient care (more sales than service). Admission history and physical examination are, of course, still required. To give quality care, it would seem one must look to the protocol first, and the patient secondarily. The priority is not of temporal sequence; it is the altered priority of the once subservient become ascendant. Technical aids were once mere adjuncts to clinical judgment. Today, new tests have become per se indispensable, too often for irrelevant and insupportable reasons.

Hospital laboratories of all types, whether run by physicians on salary, concession, percentage or other basis, understandably must generate as much activity as possible. High utilization, it is argued, is necessary to keep unit cost down, to assure familiarity with the procedures, and hence to provide better technique, better interpretation. Multichannel auto-analyzers make each test less expensive, and more information available at less cost. But overall cost to the patient and the public climbs. Invasive studies, repeat studies, close follow-up observation – the arguments are legion. Who dares call a halt? When? What criteria can be drawn for limiting scientific search for a treatable disorder or surgical intervention for transient relief? Who can gainsay the outside chance of miraculous cure, or fault its presentation at hospital rounds? Which young and new member of the staff can do less than "everything" for his first patients?

Today's dictates of medical scientific inquiry are powerful indeed. Some physicians, though skeptical of the merits of extended survival without meaningful life, too often temper their best judgment in the care of a patient in compliance to the conventional pattern of the day. Since we are practical men, our declared intent is to return the patient, betimes, to his family, his work, and his untrammeled aspirations; or perchance ease his passage to eternity. Others (physicians no less than has been shown of others)[12] become so absorbed in the narrow technical aspects of a case presentation or case study as to lose sight of its broader consequences. In either case, at staff rounds, both point to protocol dutifully followed, academically authoritative. We seek approval for proper procedure, for living up to the expectations an arbitrary authority has established for us. Conspiratorially silent, our peers discreetly and purposefully avert their attention from the salient duty of the physician – patient care, care for the patient. Responsibility for the patient defers to response to the scientific critique.

Already (in hospital more than office or home) the physician is practicing "defensive" medicine. Though his defense is more often medical or scientific than litigative it detracts from his more important mission. With the extension of peer review from hospital to office practice, patient care bids fair to be more by fiat than by holistic professionalism – more by fragmentary and fragmenting subspecialty attention than by care of the whole man. Yet Dr. Holmes warned us, in his controversial address in 1860, of "the physician, who, calling himself a practical man, refuses to recognize the larger laws."

Even now a time-honored, societally approved delegation of the power of healing to the elect continues. Throughout history there has been a need for the community to endow its chosen with the power and authority of priesthood and healing. They are, of course, inseparable as Scripture reminds us: The physician Luke reported, "He sent them to preach the Kingdom of God and to heal the sick." They are, perhaps, one and the same thing.

This priesthood of healing, derived from the people, is threatened today by the increasing trust medical scientists and the public alike place in man-made instrumentalities. As we become increasingly artisans of new tools, technicians subject to the intricate machines that we program, we forfeit this bestowed power and authority to cure diseases or to minister to needs and to heal the sick at heart or sick of mind.

The present dictates of our teaching, training and practice direct us then to use costly techniques to seek for the unusual. We shun the prime need of a sick, soft, self-indulgent, anxious and driven people, their crying need for a sensible, sensitive and concerned doctor. As a profession we are silent about the flagrant inadequacies of our system. We are embattled and determined in the defense of a privileged and protected guild. We guard jealously our traditional prerogatives, discourage the training or authorization of practitioner assist-

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ants, deny proper range of responsibility and autonomy to nurses, recognition to community health workers, etc. As a profession we are eager, and knowledgeable about medical entities, advances and rewards. We are laggard about care of the patient and his family. One cannot be involved with people's lives in primary, continuing or ultimate care and not question the wisdom or propriety of these trends.

Relation

"Primum non nocere." Franz Ingelfinger, with his accustomed editorial timeliness, recalls L. J. Henderson's expansion on this ancient dictum[13]: "So far as possible 'do no harm.' You can do harm by . . . telling the truth. You can do harm by lying . . . you will inevitably do much harm . . . But try to do as little as possible." Then without Hasselbalch, Dr. Henderson reformulates an old theorem: ". . . To modify his sentiments to his own advantage, remember that nothing is more effective than arousing in the patient the belief that you are concerned wholeheartedly and exclusively for his welfare."[14]

"To modify his sentiments to his own best advantage . . ." That's it. To enlist the patient's total participation in effecting his own healing (making himself whole) the physician must give of himself — not only his skills, intellect and specialized expertise, but his very essence. Our total presence at the bedside must be clearly evident to the patient if we are to elicit his will to live or his capacity to transcend an inevitable demise. There's the crux of the matter.

Too often the harm done the patient is one of omission. Anxious about his biomedical dysfunctions and biochemical disarray, we forget the patient as a human being, address him absentmindedly and perfunctorily. Cockeyed, we study the cold scientific data, one eye on our peers, on the literature, on the clock; the other turned inward, focusing on our own deeper insecurities. The patient suffers by our distraction, feels more alone, is made more anxious by our "absence." The conflict within each one of us is manifest. The physician's choice is neither free nor clear. There has developed a coercive and irrelevant pattern of health care that dictates a defensive, competitive and ultimately exploitative practice. The physician is becoming the victim of technology, and the instrument of the health industry. Technique is self-destructive. Technique in medicine at best is a mere attenuation of death. Tomorrow, it will be worse.

Remedies

There are reasons and remedies for these recent and threatening developments in medical care. Etiology at the moment is speculative. Meantime, as is necessary in so many human affairs, immediate remedies must be found for ills (in this instance, of medical care and health service) while ultimate causes await clarification. If, as may be on this occasion, physicians can be identified as carriers of the illness, treatment will properly be directed toward the relief.

Let us consider some minimal remedies considered at a pragmatic level with consumer-patients who have given careful thought to the needs of the public-as-patient. The implementation of each suggested remedy will, I believe, effect positive, profound and lasting healing of an ailing system.

1. *Maintain the free choice of primary physician.* Free choice presumes multiple choice. In many areas of sparse population or marginal economic resources, this would require shared facilities, shared equipment. To varying degrees this would encourage shared medical proficiency, group practice (de facto if not structured). I would leave to others the resolution of the question of whether we should or will have more primary physicians.

2. *Assure the equitable national distribution of physicians.* This will require many and varied inducements.[15] Such inducements as are necessary, however, should be locally developed between doctors and what we shall describe as consumer-advocates. There are no areas in the country that could not provide such inducements to two or more physicians. We can no longer endorse the isolated solo practitioner concept for the medicine of the future. Solo practice will, no doubt, long continue, but increasingly as an exceptional phenomenon. Finances are not the sole consideration for physician location. Professional inducements will include: local facilities with regional hospital affiliations, helicopter transportation where necessary, adequate ancillary personnel and scheduled physician replacement by a locum tenens physician for vacation and study time. The last item should be derived as part of the curriculum of the regional medical-center house staff. Personal and familial attractions must be acknowledged and negotiated locally, perhaps with federal subsidy.

3. a. *Take the financial incentive out of the piecework practice of surgery and medicine.*

 b. *Take the profits out of the hospital services.*

 c. *Remove the law of supply and demand from the office or clinic care of ambulatory patients.*

4. *Provide financial inducements for more socially constructive professional practices.* I visualize physician participation in revitalized public and social health and hygiene in our cities, the restoration of our elder citizens to the community and the family,[16] the gradual and subtotal abolition of our total institutions (prisons, mental hospitals, nursing homes, military schools and services — asylums all). These are not utopian fantasies but have in varying degree been effected in other nations in our own time. Such programs should be tailored to community needs by the collaboration of professionals with specially trained spokesmen for the public.

5. *Encourage development of the consumer-advocate for medical affairs,* trained in the field and schooled to the socioeconomic implications, for the physician and public alike, of medical-surgical practices. Such consumer-advocates would be both sympathetic and sensitive to the physicians' concerns, and spokesmen for the public's collective interests, capabilities and chosen economic limitations in the field of medical care and

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health services. Independently financed, deriving from larger consumer groups, free of professional, hospital, government and third-party bias, the function of the advocate would be that of an intermediary, not a dictator; an expediter, not a dispenser of sinecures.

6. *Initiate and develop the patient-advocate* as a well paid grass-roots inservice trained professional guardian of the patient's individual interests. There are an increasing number of consumer health and primary-care matters. The trend is inhibited by the resistance of the medical profession to move on ideologically from symptomatic care and laying on of hands. Yet doctors have in fact abandoned such personal attendance of patients, thereby leaving a generally felt vacuum in the community's care. It is from such groups that we might look for likely candidates for patient-advocates and consumer-advocates. Watching over personal professional, economic, social, occupational, familial matters, the patient-advocate provides a third eye, lending a new perspective to the increasingly complex interaction between physician and patient we have seen earlier. As disinterested spectator, knowledgeable and independent, he might be expected to exert equitable and stabilizing influence on the shared decisions of doctor and patient.

7. *Establish openness in relations* between doctor and patient as they pertain to:

a. the physician's credentials, training and professional privileges, and fees.

b. ready access of the patient or his agent and the patient-advocate to his own medical record, whether in the office or in the hospital.

Openness is not an idle suggestion. It has precedence in the literature.[17] Such a proposition must generate stress. Our responses to stress must be conscious, directed, purposeful and creative. If they are not, they are likely to be leveling rather than elevating. The open record will gradually inculcate more doctor-patient candor. Openness invites and commands trust, a liberating and exhilarating sense of sharing in an adventure, of benefit to doctor and patient, to physician and his colleagues, to the profession and society. Imposed formulas of bureaucratic standards of performance or the adversary challenge, too often a part of peer review, discourages candor and leads to devious, covert and constrained actions in patient care or the case record. The ramifications of openness are germane to the summary and conclusions in this discourse. Openness is basic to the equitable and fluid operation of the first six suggestions above.

Conclusions

In the time of medical priesthoods the doctor-patient relation was primarily the responsibility of the physician. Care of the patient included being careful and caring.

In the era of the scientific method the physician has learned to look critically at the case and at its component parts, a valuable and useful process that has nonetheless separated the medical scientist from the sick person.

Technique operates similarly at a societal level to achieve marvels of human *doing* – at the cost of human *being*.

In tomorrow's medical care, as healing physicians, we must again learn to be no less solicitous of the person than attentive to his disordered state, and to temper the management of his disease with love for our patient.

Similarly, in the social context, the profession must seek to temper Technique with renascent humanity. The development of health services will require the interplay of all forces – physician, hospital, health industry, third parties and public-as-patients.

Our civilization hangs on mankind's capacity to reestablish a balance between doing and being, to balance one's life-work with life-style, to involve oneself with neighbor, to weigh individual social needs against the needs of the community.

If there is to be another Era, and we are poised on the brink of that uncertainty, it will be built on a renewed idealism, a rediscovery of man's need for man, and on the God-given healing power of a shared relation.

References

1. Holmes OW: Communications of the Massachusetts Medical Society – 1860. Cited by Garland J: Annual Oration – *The New England Journal of Medicine* and the Massachusetts Medical Society. N Engl J Med 246: 801-806, 1952
2. Garland J: Shattuck Lecture: "The Proper Study of Mankind." N Engl J Med 270:1137-1142, 1964
3. Kennedy EM: In Critical Condition: The crisis in America's health care. New York, Simon and Schuster, 1973
4. Richards DW: Presidential Address: Medical priesthoods, past and present. Trans Assoc Am Physicians 75:1-10, 1962
5. Beeson PB: Presidential Address: The Academic Doctor. Trans Assoc Am Physicians 80:1-7, 1967
6. Soustelle J: Quoted by Ellul J:⁷ p 99
7. Ellul J: The Technological Society. New York, Vintage, AF Knopf, 1964
8. Jhabvala DS: Kissinger bids rich, poor fight inequality of wealth. Boston Globe, April 16, 1974, pp 1, 17
9. Toynbee A: Toynbee says "siege" economy will replace free enterprise. Boston Globe, April 15, 1974
10. Stimmel B: The "Crisis" in medical education. Ann Intern Med 79:119-123, 1973
11. Magraw RM: Trends in medical education and health services: their implications for a career in family medicine. N Engl J Med 285:1407-1413, 1971
12. Milgram S: Obedience to Authority: An experimental view. New York, Harper and Row, 1974
13. Ingelfinger FJ: Ivory-tower humanist. N Engl J Med 289:862-863, 1973
14. Henderson LJ: Physician and patient as a social system. N Engl J Med 212:819-823, 1935
15. Aring CD: The distribution of physicians. JAMA 219:606-607, 1972
16. Gustafson E: Day care for the elderly. Gerontologist 14:46-49, 1974
17. Shenkin BN, Warner DC: Giving the patient his medical record: a proposal to improve the system. N Engl J Med 289:688-691, 1973

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