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The Changing Concept of the Ideal Physician

THE INCREASING CONCERN WITH ETHICAL ISSUES in medical practice and research over the last fifteen years exemplifies a striking change in the image of doctors and the relationship between physicians and patients. Where previously physicians' decisions were rarely questioned, patients are now frequently sceptical and may doubt both the physician's motives and judgement. Concurrently there has been a rise in concern about the nature of the physician's act and a strengthened interest in teaching physicians how to be doctors as opposed to merely teaching the scientific basis of medical practice. During the latter part of his career, Walsh McDermott was interested in Samaritanism—the human dimension of the physician-patient relationship. Because good medical care of necessity involves some degree of altruism on the part of physicians, he was interested in what fosters this altruism or defeats it. These changes in the relations of physicians and patients and the manifest interest in some systematic understanding of problems such as altruism represent a startling evolution over what is, historically, but a brief period.

Sorting out the contributory factors is complex. These changes in the conceptions of physicians and physicianship occurred during the period in which science had its most profound impact on the ideals of medicine and in which technology entered medicine on a grand scale. This all occurred at a time when the surrounding society was also undergoing a profound shift in its self-understanding. Let me use four brief points to summarize the argument.

First and foremost, medicine's total embrace of science entailed profound effects on the conception of physicians and physicianship. It is difficult for doctors trained in the last two generations to dissociate medicine and science, but the historical ideals of the two are distinctly different. Science is based on a belief that it and its methods are value-free—anything that happens in nature is neither good nor bad, it simply is. On the other hand, medicine has a historical tradition in which a hierarchy of values is firmly established. In addition to being putatively value-free, a scientific description does not ascribe *qualities* to things; adjectives like warm, tall, swollen, or painful are meaningful for persons, but, ideally, science deals only with temperature, vertical dimensions, diameters, or nociception. It is obvious that medicine could not exist without reference to qualities and their meanings to humans. Moreover, science does *not* deal with individuals; it deals with—and its methods are only suited to—generalities. Above all else, medicine is concerned with individuals. Science and medicine are inextricably bound, and medicine without science is nothing; but the paradoxes and strains produced by believing they are the *same* led to a conception of the ideal physician that could not last. Thus, part of the changing ideal of doctors over the last fifty years is the result of the impact of an unreal ideal of the connection between science and medicine that is now evolving to a more balanced view of their relationship.

My second point is that the effect of technology, in its general sense, has altered the character of physicianship in these last fifty years. I believe that the impact of technology is not fully comprehended because of the mistaken idea that the effects of science and those of technology on the thinking and behavior of physicians are the same. Because of this confusion no discussion of the changing conception of doctors can be complete without reference to the special effect that the disarming simplicity and certainty of technology has had on physicians. It is the burden of doctors to have great responsibility in a sea of doubt and uncertainty. The intrinsic promise of technology—that it will relieve uncertainty and lighten doubt—is virtually irresistible given the special circumstances of medical practice. Despite the countless benefits of technology, uncertainty and doubt remain, although often shifted or concealed.

My third point is that the effect of these factors on the character of physicians took place over enough time for the usual forces acting in

the affairs of humans—politics and the succession of generations—to combine and alter the dominant group of physicians in the United States from the academically minded clinicians (and their organizations) to the full-time medical research scientists of the academic medical centers who embraced and exemplified the new values.

The fourth point is that since the Second World War the meaning of the words "person" and "individual"—central to American beliefs—have been undergoing profound alterations. Since physicians are persons who treat persons it was inevitable that this social turmoil eventuate in a new understanding of the nature of doctors, patients, and their relationship. This redefinition of patienthood and its expectations has been sharpened by the fact that the present generation of Americans, raised in the midst of technical and scientific complexity, have become so knowledgeable that (it is believed) physicians can no longer lay sole claim to medical knowledge.

Among the changes in the social climate have been the well-known distrust of science and the rise of the bioethics movement in which the preeminence of the patient is stressed.

I conclude that the physician of the present era is buffeted by conflicting ideals within medicine itself and in the surrounding society. From all this has grown a movement within medicine to begin to redefine doctors with a stress not only on the scientific basis of medicine, but on the character of physicianship. Walsh McDermott was one of those prominent within medicine who became concerned with these issues early on. His ideas on the nature of the good physician form the basis for such a description.

THE EFFECT OF SCIENCE ON THE IDEAL OF THE DOCTOR

Perhaps apocryphally, it was said in the 1950s that, in a display case in the Department of Radiology of the Massachusetts General Hospital, a stethoscope was shown as an obsolete instrument. That display case is symbolic of the belief commonly held during the same period that scientific medicine and its attendant technology would render obsolete the individualism and subjectivism that, the same conception held, had so hindered medical progress. The time of great clinicians, some of whom were Walsh McDermott's teachers and contemporaries, was believed to be over. How different from the end

of the nineteenth and beginning of this century, when American physicians were greatly concerned with the part their individual traits and behaviors played in their physicianship. A book called *The Physician Himself* by D.W. Cathell was popular for many editions as it discussed in detail appropriate dress and demeanor for the successful physician.¹ In the early decades of this century, as in previous centuries, clinicians might achieve prominence, and be regarded highly just because of their individuality. During the decades that followed World War II, on the other hand, such individualism came to be viewed negatively—science was the physician, although it necessarily worked through the hands of individuals. Similarly, the term “anecdotal medicine” came to be seen as the equivalent of subjective contamination and to stand for sloppy, unscientific medicine. Since individual experience is ineluctably anecdotal (one can have no other kind of experience), and individual clinical judgements ineluctably contain subjective elements (they are the product of a subject), banishing the subjective and anecdotal from medicine necessarily demotes the individuality of the physician to the level of a contaminant.

The philosophical basis of early twentieth-century science that medicine embraced could have it no other way. Medical science is founded on several postulates that allow of no divergence. Science attends to objects that are free of value and quality, separate from one another, and whose workings can be known by the analysis of their parts. The basis of all function is structure, and any alteration in function must be related to a change in structure. Everything about the human condition will ultimately be explained in physicochemical terms—things like mind, soul, or what have you, are an illusion or at best an epiphenomenon.² (The reader will recognize that current concepts of science have softened some of these stances—albeit without satisfactory alternatives.) Because of these postulates medical science could not deal effectively with individuals, value-laden objects, things that change over time, or wholes that are greater than the sum of their parts. Since that list contains the characteristics of persons (be they patients or doctors), medical science could not handle persons—but disease lay clearly within its purview. The phenomenal success of medical science in showing how the body works in health and disease requires no comment.

THE PROMISE OF SCIENCE: TO KNOW THE DISEASE IS TO KNOW THE ILLNESS AND ITS TREATMENT

Knowing about disease was what counted. The history of the era of scientific medicine really starts with the “discovery” of diseases by the Paris School of physicians in the 1830s, the first to provide clinico-pathological correlation. The enormous success of modern medicine appears to rest completely on the combination of disease theory and science. Thus, physicians could come to believe that to know the disease and its treatment is to know the illness and the treatment of the ill person. This provided further grounds for the idea that individual physicians count for little, *as individuals*; it is their knowledge of disease and medical science that cares for the patient. In this thinking, a disembodied knowledge connected to some sort of effector agent would do as well. With this in mind, one should not be surprised at the numerous attempts to formulate computer diagnostics or therapists. That they have all failed (unless making the diagnosis of a *New England Journal of Medicine* Clinical-Pathologic Correlation is to be considered success) should have given pause to the underlying conception, but it does not appear to have had that effect as yet. The uncomfortable fact that remained was that doctors could not get at diseases without dealing with patients—doctors do not treat diseases, they treat patients. Further, the same disease in not treat diseases, they treat patients. Further, the same disease in different individuals may have a different presentation, course, treatment, and outcome, depending on the individual and group differences among patients—from personal idiosyncrasies to genetic or anatomic variations. The scientific basis of medicine neither recognizes nor provides a methodology to deal with such individual variations on the level of patient-doctor interactions. Such issues were relegated to the “art” of medicine or to individual judgement.

But that does not represent a successful solution to the problem since much of medical practice is thereby swept under the rug. Science has solved only half of the problem, a systematic basis has been provided for understanding the body and its ills, but the other half—that having to do with sick persons—remains “art.” Art is, by definition, based on individual skills so that medical practice remains shackled to the problem presented by the differences among individuals—both patients and doctors—and to subjectivism. Attempts to get around this by establishing a scientific basis for dealing with

values and human qualities, such as Feinstein's proposal for "clinimetrics," are doomed to failure because science cannot deal with that which it does not recognize as existing.³

Instead, each physician must solve the problem internally. The fundamental paradox and strains caused by conflicting demands on the doctor were not apparent because the transition from the dominance of the eminent clinicians to medical scientists was not abrupt. Academic physicians of Walsh McDermott's cohort, such as Paul Beeson and Eugene Stead, had been trained by the clinicians of the previous era; while they may have passed on to their students the ideals of scientific medicine, they contained within themselves the values of the Samaritan functions of the personal encounter system, an important aspect of the art of medicine. Walsh has noted that the change in hospital architecture from large open wards to small rooms effectively moved the human-support functions of the professor making rounds from the public to the private arena. Whereas previously every act of the attending was open for all to see, it became common to demonstrate the physical findings or discuss the patient's disease in the presence of students and house officers, but then to ask them to leave the private or semi-private room as the attending physician turned to more personal matters of supporting the sick person. But hospital architecture alone cannot be blamed. I remember, in the 1950s, an attending physician teaching students in the outpatient clinic about the care of patients with congestive heart failure. The discussion was couched in terms of the pathophysiology of the failing heart, and neglected entirely such issues as acquiring some understanding of who the patient was, empathy, support, and the understanding of everyday life and function necessary to insure that the patient followed the prescribed diet, took medications as ordered, and in general lived a life that would maximally enhance the function that his failing heart might support. I suspect that the attending physician was living up to the new ideals of scientific medicine and attempting to pass them on to the students, and that the subjectivity inherent in the other issues was actively demoted from importance.

THE IMPACT OF TECHNOLOGY

Physicians have a reputation for conservatism, at least politically, that is generally attributed to their economic standing. But anybody who has ever tried to get them to alter their ways in medicine itself would be happy to tell you that their resistance to change (a characteristic usually associated with being conservative) is as great in medicine as in other aspects of their lives. That resistance to change appears to be related to the combination of the uncertainty and the dire responsibility that are dominant characteristics of the physician's life. The simple fact is that it is frequently difficult to be certain of what is the best thing to do in the face of serious illness. In response to both the burden and the uncertainty, physicians and surgeons may become set in their ways, dependent on recipes for diagnosis and treatment rather than on the thoughtful examination of alternatives.

The physician's resistance to change melts away at the promise of greater certainty—witness the truly rapid embrace (and even overuse) of effective therapies and many current diagnostic techniques from endoscopy to computerized axial tomography. It is not surprising, then, that doctors often embrace clinical methods and systems of thought that promise greater certainty even when the promise deceives. The clinical certainty promised by scientific medicine to the degree that it was believed that personal experience could be dispensed with, was such an illusion.

Uncertainty exists not only within the patient and because the future course of the illness must be judged, but also within the practitioner. In this regard, uncertainties that arise because of ignorance on the part of an individual doctor and the incompleteness of medical knowledge in general are most often cited.⁴ Such uncertainty, I believe, is not what weighs most heavily on the practitioner. In the clinical setting, judgements must inevitably be made on the doctor's personal experience of past cases; the comparison of the present size, sound or feel of something with what is remembered; and on what a clinician believes to be the problem, based sometimes on very scanty evidence. The opening sentence of the first aphorism of Hippocrates—"Life is short, and the art long; the occasion fleeting; experience fallacious, and judgement difficult"—suggests that this has always been the case for physicians.

Objective clinical techniques such as x-rays, indeed the whole panoply of modern medical technology, seem to offer the possibility of banishing the uncertainties of subjectivism. It is not clear why the fact that the x-ray may be objective but that the physician's assessment is subjective and varies from individual to individual becomes lost from view—but that is the case.⁵ Call to mind an ICU with monitors blinking and beeping and remember how all eyes (even family members') go to the monitors—and away from the patient. It requires effort *not* to watch the monitors. Technology—machines, instruments, drug treatments—like blinkers on a horse, restrict and define and thus simplify the viewpoint. But, unlike blinkers, technology also defines the values that represent good or bad, success or failure. The values of technology are unambiguous and non-metaphorical, unlike other things in the clinical world. Numerical readouts seem certain; they do not announce their fallibility. Watch a cineradiogram of the heart and you believe you are watching the patient's heart, instead of a movie of one representation of a heart (which, because of the possibility of mislabelling, may not even be the films of the patient's study). The existence of antibiotics provides the pressure to find an infection to treat—even if infection, while perhaps present, is not the patient's problem. Endless examples could be provided to document the well-known phrase, "technology is sweet." Its power to oversimplify the inherently complex and to produce certainty where doubt is necessarily present has proven irresistible not only to medicine but to the whole culture. Even the modern quack provides patients with computer readouts of blood, hair, or what-have-you analyses to give credence to the incredible. Wistfully, some have believed that the only solution to the dilemma posed by the enchantment of technology is its banishment. That seems patently ridiculous; none of us will willingly return to lesser effectiveness even if our patients would permit it to happen—and they will not. Little wonder, then, that the image of the physician has been transformed by technology so that technical wizardry has become more important than the cognitive skills previously associated with the ideal doctor. It is important to see that this effect of technology is separate from the transformation wrought in medicine by science.

SHIFT OF POWER IN THE MEDICAL ESTABLISHMENT

Related to the changes wrought by science and technology was the manner in which the rise of scientific medicine undermined the status and power of medical authorities whose eminence was based primarily on clinical achievement. Since many of these elite clinicians were private practitioners as well as members of medical college and hospital faculty, the increasing prominence of scientific medicine accelerated the shift of power in medicine toward the full-time faculty of the medical schools. These changes in relative power are reflected in the authorship of Cecil's *Textbook of Medicine*.⁶ Originally Cecil, in the authorship of Cecil's *Textbook of Medicine*, realized that one individual could no longer stand as an authority in all of internal medicine, so his book was written by specialists in the diseases about which they wrote. With the passage of time and the rise in scientific medicine, he invited Loeb, a full-time academic, to join him as editor. Ultimately, the editorship of the book passed entirely into the hands of full-time academic physicians. It must be understood that these changes in the relative power of clinicians and the new breed of medical scientists were not occurring in a cultural vacuum. During the same period that saw a shift in power within medicine from the clinician (to use a shorthand) to the medical scientist, the American public was accorded increasing prestige and power, based on a growing respect for science.⁷ Thus, as is so often the case, the change in what was to be beheld as the ideal physician, arose from a complex of reasons related to beliefs about science, to the superiority of scientific medicine, to the impact of technology in the doctor's world of uncertainty and doubt, and last but not least, to matters of power.

MEDICAL POWER SPREADS TO THE LAY

It is not surprising, then, that a generation of physicians should have come to power for whom the scientific and technologic aspects of physicianship represented not *part* of being a doctor, but medicine and its practice incarnate. These changes in the model of the ideal physician from individualistic clinician to research scientist were coupled with logarithmic increases in the therapeutic and diagnostic power of individual doctors. As discussed elsewhere in this volume, the American public embraced the wonders of medical science and

technology, further enhancing the reputation of medicine as a science, and of medical scientists. Funds for research poured in, and the enterprise of modern technologic medicine grew. Americans not only supported medicine's expansion, but became *knowledgeable* partners. For hundreds of years the power of physicians has come from their specialized knowledge and their status. During this last generation the scientific knowledge of medicine has become increasingly accessible to lay persons. Indeed, the public has shown a voracious appetite for scientific information so that, for the past several decades, science has been front-page news. It is apparent that the possession of some knowledge of medical science does not make a person a doctor. While physicians enjoy stressing that fact, they miss the point. *The promise of scientific medicine is that the knowledge does the work.*

Knowledgeable patients do not believe that they are doctors; their belief is that a piece of knowledge that is the same as the doctor's will do the same work for the patient as for the doctor. Witness the phenomenon of the *Physician's Desk Reference*, which many physicians find so irritating. The patient calls the doctor after arriving home and looking up the prescribed drug in the PDR. The patient is upset that a drug with such side effects was suggested. Wasn't the doctor aware? The physician knew what the side effects were, but believed that they were of such small probability that they were of no consequence. Further, the doctor is upset that the patient was not trusting. Trust is not the issue (at least in part); a fact is a fact—as true for the patient, it would seem, as for the doctor. If the doctor—an individual with trained judgement—is left out of the picture, a fact is a fact. Another fact is that no piece of knowledge floats free. All are connected to other facts and to underlying beliefs, and all are applied only on the basis of individual judgement. Where did the patient ever get such an idea? Individual physicians may argue that they do not believe that they themselves are insignificant or that only medical science does the work. Individuals may not hold such beliefs, but the system of medical education of the last several decades is clearly founded on that belief. That is the basis of the current practice of having the intern be the patient's doctor and of excluding attending physicians from writing orders on their own patients. Science, this practice implies, makes all of us equal before the mysteries of disease, and technology is the great therapeutic equalizer. Those who know

best what nonsense this is and who pay the heaviest price for it are, of course, the interns (and the patients).⁸ If it was not believed that the scientific facts about disease do the work, physicians would be manifestly trained about how to be doctors, how to make judgements, how to use their own individuality as part of their medical skills. If the doctor and not medical science is the agent of cure, why have physicians not been trained in that belief? It is only in the past few years that systematic attention has been given to such training.

SOCIAL TURMOIL AND THE CHANGE IN THE CONCEPTION OF PERSON

The matter does not end there. It does not seem reasonable that simply owning a piece of knowledge should embolden patients in its use. Something has happened to displace physicians from their previous preeminent status, something powerful enough to allow patients to express the common belief that "doctors aren't Gods."¹⁰ In fact, the fall of doctors from absolute authority on matters of health occurred at a time when all authority found itself challenged. We are all aware of the turbulence of the 1960s and the change in the relation of individuals to authority that began to occur at that time. So much confusion attended the changes of the sixties that it will require decades for historians to sort it all out. The anti-Vietnam War movement muddles the issue, because it is possible to see the period as primarily concerned with the war. However, the authority of the Catholic Church was crumbling at the same time; German students were on the barricades; the French were in turmoil. These aspects of the social disturbances of the times cannot be blamed on the Vietnam War. Rather, it would seem (in retrospect) that a new wave of individualism was breaking over the Western world—most marked in the United States. In this instance the old political individualism of the United States found itself being succeeded not merely by the individualism of effort considered so characteristic of the United States, but rather by a personalized—me, myself, and I—not previously known. Have individuals in any culture *ever* revealed so much of their private lives? (There is some irony in the fact that physicians were the bastion of individualism in the thirties through the fifties when American society was dealing with the problem of

anomie created by advancing industrialization—see Chaplin's movie, *Modern Times*—and the growth of the modern corporation. Then, at a time when individualism was again becoming a vital force in the culture, physicians became almost faceless.)

It is no surprise that the changes in the society have had a profound effect on medicine. These effects can be noted in the relationship between patient and doctor and in the rise in the bioethics movement.

CHANGES IN THE DOCTOR-PATIENT RELATIONSHIP

During the period spanned by Walsh McDermott's career as a physician, the belief that "doctor knows best" virtually disappeared. During this era, the nature of the relationship between doctor and patient has come under scrutiny, and it has become apparent that the relationship itself is a powerful force in medical care, that it can be endangered, and that it can change as a result of social as well as personal forces.¹¹ From being seen as effectively passive in relation to the physician (except that patients have always been expected to be active in the sense of "fighting to get well"), patients now frequently believe themselves to be active partners in their care. They want to take part in decisions formerly reserved for the doctor; they want to exercise choice in therapy and they have high expectations about the outcome. These expectations have been nourished by the media and the exploitation of medical achievements by medicine itself in its quest for public support. The force of these changes can be demonstrated by examining the change in the way cancer of the breast is treated. The radical mastectomy of Halsted remained the treatment of choice from the early part of this century until this last decade. When I entered practice in 1961 it would not have been uncommon to tell a patient who had awakened after surgery for a mass in the breast, that, "we had to remove the breast because there were some suspicious cells." The patient would not be told that she had carcinoma of the breast. Telling patients the truth about their malignancies was considered bad for them—a potential cause of suicide. It is essential to realize that these deceptions were not something "done to" unsuspecting patients, who, themselves, were the same then as now, because that is not the case. McIntosh has documented the attitude of patients and doctors in this regard in Great Britain where ideas about truth-telling lag behind the United

States. There, doctors do not believe patients should be told the painful truth and neither do patients. The patients generally know the truth nonetheless.¹² To understand how both physicians and patients have changed during this period, it should be remembered that thirty years ago personal sufferings, unhappiness, and even doubts were largely kept private, whereas today such matters are much more likely to be ventilated. Doctors were not thought to be interested in their patients' personal problems (except as mere kindness), but to confine themselves to the "medical" aspects of a case—i.e., the physical. It would now be virtually impossible, in the United States, to conceal the diagnosis of malignancy under euphemisms such as "suspicious cells." A doctor who does not understand this, or who is insensitive to the unhappiness of his patients, would now be considered a technician. Many women have definite ideas about proper treatment for breast cancer, and, further, they may feel that the surgeon is as much their enemy as the tumor. I consider it is these beliefs that have forced surgeons away from the Halsted radical mastectomy as much or more than developing scientific evidence which followed the changing opinions of patients. Changes in patients' attitudes are manifest throughout the range of medical services and are matched by the rise of commercialism, free-standing, for-profit emergency care centers, advertising, medical marketing, and other evidences of the demystification of physicians and medicine.

THE CONCURRENT RISE OF INTEREST IN ETHICS IN MEDICINE

In 1966, Henry Beecher demonstrated the failure of investigators to protect the interests of their research subjects in a number of major projects.¹³ His 1966 paper is frequently cited as a landmark denoting the start of the present interest in bioethics. Catholic ethicists had always addressed specifically Catholic concerns in medical care, and the theologian, Joseph Fletcher, published a work in the fifties discussing ethical issues in medicine, but it was not until after Beecher's paper that concern became widespread. In 1966, for the first time, prior review for protection of human subjects was required of all United States Public Health Service grants. The Institute for Society, Ethics, and the Life Sciences (The Hastings Center) was formed in 1969, specifically to address moral problems raised by

biomedical advances. In 1973, The Department of Health, Education and Welfare (now the Department of Human Services) published its first set of proposed regulations on the protection of human subjects. Then, in May 1974, investigators were presented with final regulations that specifically discussed the nature and duties of Institutional Review Boards. The requirement was widened in 1981 so that all institutions receiving federal research monies had to establish Institutional Review Boards to insure that research is conducted according to ethical standards. By now, concern for the rights of research subjects and patients has become an established fact of medical life.

Central to any understanding of the moral is the concept of person. Ethical standards, rules about good and bad, right and wrong, rights and their corollary obligations, matters of custom and conscience that guide the moral aspects of life are always in terms of persons (even though they may be directed towards non-human matters, such as animals or the environment). It follows that all understandings of the moral are based on some idea of the nature of persons, whether manifest or latent. In our era in the United States, the picture of the person that has most often been embodied by the bioethics movement is of a free-standing, autonomous individual, whose highest values are freedom and independence. The impact of this picture of persons on medicine, and its distance from older American concepts (still embodied in Europe) can be found in a paper by Pedro Lain-Entralgo on the subject of the "good patient,"¹⁴ and the commentary on that paper by Childress.¹⁵ For Lain-Entralgo, just as the physician has obligations to the patient, the patient has obligations to the physician and to the work of getting better. Both are embedded in a social matrix, and their obligations stem not only from themselves, but from the *fact* of their relationship and the *fact* of its ineluctably social character. For Childress, who represents a stance much more common among American writers on bioethics, the disease, the doctor, the relationship with the doctor, and the social setting fall in importance next to the patient's rights as an autonomous being. Freedom and self-determination represent values more important than recovery from illness.

Clearly, autonomy is threatened by sickness. Most physicians believe that the patient's independence and freedom of choice are removed by the effects of disease—by the uncertainties and impediments to understanding and action that inevitably accompany serious

illness. In fact, helping patients regain autonomy would seem to be a prime function of medicine.¹⁶

Often, in the current scene, physicians are seen as the threat to the patient's autonomy—they are believed to be paternalistic, authoritarian, and too concerned with profit to be reliable servants or partners in care. (It has frequently been pointed out that these characterizations are usually attached to doctors other than the speaker's or respondent's own, who is generally believed to be more caring and compassionate.) In the same manner, modern therapeutic agents are often viewed with the suspicion that their side effects are more prominent than their benefits. During their convalescence from serious infection, for example, patients may attribute their fatigue to the effects of the antibiotics, rather than to the illness from which they are recovering.

There is some evidence that a single-minded concern with autonomy is beginning to pass from the bioethics scene.¹⁷ Ethicists are beginning to focus more on the contact between doctor and patient as a relationship, and to broaden their interests to include understandings of not only rights, but corollary obligations.¹⁸ There are other indications that the study of ethics in medicine is maturing and coming to be more concerned with moral problems in medicine than with moral philosophy *per se*.¹⁹ However, Stephen Toulmin has made it clear that the relationship between philosophy and medicine has been two-sided, that philosophy has benefited greatly from the infusion of real-world problems and the sense of urgency that always attends issues in clinical medicine.²⁰

From faint whisperings in the late 1950s that gathered strength in the sixties and emerged in force in the seventies, bioethics has become an established presence in medicine. Very few American medical schools are without some program in ethics; Institutional Review Boards are an accepted feature of the research scene, and both patients and physicians are very conscious of patients' right to refuse treatment, of the need for informed consent, and increasingly, of the importance of the patients' participation in their own care. All of these changes have occurred *pari passu* with the expansion of the notion of person to include, as matters of public concern, interior sources of happiness, suffering, achievement, and even illness—things previously held to be private—and with the rise of a radical individualism as a political force.

CONTRADICTIONS

Space permits only brief mention of the commercialism that has arisen over the same period during which the importance of the personal has permeated medicine. Both the shift to primarily monetary values, and the phenomenal increase in the number of malpractice suits and the size of their awards are having profound effects on medicine that are largely in directions away from a major concern with individual values and the importance of the relationship between doctors and patients. It is almost as if patients are asking for a medicine that is at once both intensely directed at their personal needs, desires, beliefs, concerns and fears, as well as being inexpensive, and sufficiently uniform so that fixed pricing for services makes sense. These are mutually incompatible goals. It may well be that the breakdown in authority and tradition that heralded the new directions of individualism also heralded other ruptures with the medical traditions which have held commercialism at bay during this century. Whatever their sources, these changes are in conflict right now, and the outcome is difficult to predict over the medium time—particularly in view of the political retrenchment and conservatism presently reigning. In the short view, nothing but turmoil seems apparent, while a farsighted look suggests the reemergence of the personal values that seem to have been coming to dominance in medicine and the society during this last half century.

THE PHYSICIAN AS PERSON

In the later years of his career, Walsh McDermott turned his attention to the individual development of physicians. (It is interesting to see the increased attention given to the individual development of student and physician in the prefaces and introductions to the Beson-McDermott editions of the *Cecil-Loeb Textbook of Medicine*.) This direction in his work is a natural extension of his attention to what he called the Samaritan function of physicians in personal encounter medicine, and it seemed to stem in part from an effort to counter a recent public belief that the health status of a society has nothing to do with the work of individual physicians.²¹ His interest in these issues was in advance of other academicians. As can be seen from previous paragraphs, however, concentration on the physician as a

unique individual whose actions as an individual make a difference in the patient's care is directly derivative from the social trends of the era. After all, if the patient is a person, so is the physician. It was clear to Walsh that medical training—particularly in the postgraduate years—is strongly directed toward the moral development of physicians, not only the technical. This point has been well documented by Charles Bosk in his study of surgeons-in-training.²² But while many have stressed the importance of the moral values implied in the relationship between physician and patient, McDermott appeared to be after those aspects of the behavior of individual physicians that would both undergird the scientific and technological tools of the modern physician, and be *teachable*. The difficulties involved in teaching virtue have engaged humankind since Hellenic Greece. Too often the problem is written off by saying that virtue is unteachable; students either have the propensity or they do not. But it has become apparent, once again, that the tools of modern medicine, with their enormous power, must be directed by human faculties whose guiding precepts in the use of the technology will be moral as much as technical. Wherever power is present, it is the case both that responsibility exists that may or may not be accepted and that it is as logically possible that the power be used for ill as for good. With this in mind, it seems inadequate to stop at the notion that virtue in medicine is unteachable. What is necessary, then, is some idea of what is to be included in the idea of the good physician that might provide a basis for the beginnings of systematic understanding and disciplined training.

WHAT DEFINES A GOOD PHYSICIAN?

McDermott believed that one could define a good physician as one who is trustworthy, and a trustworthy physician as one who has self-discipline.²³ Without wasting words he gets to the center of physicianship—trustworthiness and self-discipline. I believe that it is possible to build on this insight in a manner that both permits an increase in the efficacy of training in these regards, and provides a better basis for the evaluation of training programs.

Let me go back a step. The fact that good doctors are worthy of trust does not tell us why the care of the sick requires that trait. Doctors are persons who apply a specialized body of knowledge to

the care of sick persons. The sicker the person is, the more accurate knowledge is absolutely necessary, and the more inadequate it often is. Both because of the inadequacies of knowledge, and because of the fact that knowledge cannot act on its own, sick persons require doctors. Even if, as is often the case these days, the sick have the knowledge they still require doctors, because of the nature of sickness.²⁴ Further, sickness always contains a threat to existence (real or imagined) and it is always filled with uncertainties which impede or even paralyze effective action.

Uncertainty is intolerable at all times but more so in the ill because their existence seems threatened, and yet they are required to make decisions about themselves. Unfortunately, as they perceive themselves to be increasingly endangered there is an increased urgency to act. But decisions and actions that are seen as having to do with one's very life require levels of certainty that are not available to the sick person—they simply do not have enough information, as does no one in such circumstances. Trust in others is one of the central human solutions to the paralysis of unbearable uncertainty. It is for these reasons that the sick put the kind of trust in doctors that they do.

Sick people, then, are people who are forced to trust. The better the doctor, the more trustworthy he is. But doctors are also faced with uncertainties and doctors are also threatened. Space does not permit a complete analysis of why whatever threatens the patient also threatens the doctor, but let physician readers remember their training days and how scared they always were that something untoward might happen to one of their patients. One important element of the threat to the doctor inherent in the patient's illness is the physician's responsibility for the patient. The doctor acquires the power to act on the patient's behalf because of the patient's trust. (In a complex society such as ours, cultural and legal factors have come to play a part in ensuring that the doctor is responsible, but these factors are derived, I believe, from the basic need of the sick person to trust the doctor.) Wherever power is present, there is always the communal demand for responsible action—power always implies responsibility.²⁵ It is true that the physician is not threatened unless responsibility is accepted. But society acknowledges the responsibility that physicians acquire because of their power by holding them accountable morally and legally in certain situations when they do not fulfill their responsibilities. The equation is complete. Doctors are

people who, because of their special knowledge, are empowered to act by virtue of the trust given by patients, and who acquire responsibility thereby. As they act on behalf of the sick person, they are endangered by the possibility of failing their responsibility, and become threatened by what threatens the patient. Doctor and patient are bound in a reciprocal relationship—failure to understand that is failure to comprehend clinical medicine.

In the light of this understanding it is possible to examine trustworthiness and self-discipline. The sick person bestows trust on a doctor in the context of sickness, the practice of medicine and medical science. That is to say that patients always have at least social or cultural knowledge of medicine, and nowadays very much more than that. In these contexts, knowledge and competence are given. That often-heard question, "Would you rather have a technically competent doctor or one who is humane?" is beside the point. A doctor without technical competence would be inadequate and unworthy of trust. The knowledge by itself cannot choose which patient it is to be used on and how. To be effective, physicians must be adept at working with patients—taking histories, establishing rapport, achieving compliance with regimens that may be extremely unpleasant, being sensitive to unspoken needs, providing empathetic support, communicating effectively, and even getting paid after the illness. Doctors who cannot do these things would not be adequate or entirely trustworthy.

THE RELATION BETWEEN TRUST AND ALTRUISM

Altruism, which seems important in physicians, is a concept that is muddled by the unfortunate history of the word. In the eighteenth century the idea was much debated in black or white terms: one was *either* altruistic *or* acted out of self-interest. Because many actions on behalf of others were seen to have an element of self-interest, altruism was denied. This all-or-none idea of altruism has, unhappily, been continued by the sociobiologists where the term is applied when an animal sacrifices itself for the continuation of the group. One would hope that sophistication about human behavior has increased enough in the last two hundred years so that we can be free to accept the idea that when humans act in behalf of others the central question is not whether they also gain, but what it means to act in behalf of another.

In keeping with modern usage I am using the word altruism to denote actions on *behalf* of another.

It should be clear from the above that when a physician acts on the responsibility to care for a patient based on the sick person's trust, then altruism is implied. (Responsibility alone is not sufficient to demand altruism; a prison doctor may be responsible because of his duties, not because of the sick prisoner's trust.) It is quite clear that to act on behalf of another in medicine no longer means to act only on behalf of the other's *body*. The changes in the notions of person, of patienthood, and of the doctor-patient relation that have occurred over these last decades underline the fact that when the doctor acts for patients it is meant to be towards the goals that the patients would choose if they could act on their own. What patients believe to be in their own best interests may well require the active participation of the physician, but can almost never be known without the knowledgeable participation of the patient. Altruism in medicine requires more than knowledge of medical science, it requires also understanding illness—its causes, course, and outcome—from the patient's viewpoint, and then acting on the knowledge. It requires knowing about sick persons.

SELF-DISCIPLINE

It is obvious that what threatens the sick is their diseases. Pneumonia is dangerous, but generally responds to good care. Appendicitis is dangerous, but a relatively simple operation is curative. What gets in the way of good care for pneumonia or efficacious surgery for appendicitis is the *wrong* diagnosis. A diagnosis is not simply "pneumococcal pneumonia," or "appendicitis," but also must include appreciation of those factors—from the subcellular to the community—that underlie the disease or affect the treatment. One wants to know whether the pneumonia is present because of underlying malignancy; or did the patient aspirate; is the host malnourished or otherwise compromised; will the patient follow the prescribed regimen? The question is not merely whether appendicitis is present, but is some hidden factor present that increases the risk of surgery? The proper diagnosis results, above all, from thoroughness; from examining the details, the dull, interminable details that are involved in the treatment of the sick. Clearly Walsh was correct that

a trustworthy doctor is thorough and self-disciplined and that the "*deep belief in thoroughness is the most important element of medical education.*" (Emphasis in the original.)²⁶ It takes self-discipline to stay with the details. The internship is the place where the introduction to the details takes place. Alas, interns often believe that when they finish their internship the details will get relegated to someone else—it certainly appears that way in modern training programs where the resident has been elevated to the position of "advise and consent." But experienced physicians, when they are good, are good because of their mastery over the details as much as their mastery of medical knowledge. It should be no surprise that one of the signs of the waning power of a surgeon is the loss of patience with the tiny moment-by-moment details of the operation.

Self-discipline and trustworthiness are involved in more than control of the details. Constancy to the patient is necessary. It is not difficult to provide constant attention and maintained presence when things are going well. It requires self-discipline to maintain constancy when the case is going sour; when errors or failures have occurred; when the wrong diagnosis has been made; when the patient's personality or behavior are difficult or even repulsive; when impending death brings the danger of emotional closeness. When constancy is absent or falters too frequently, patients lose that new-found part of themselves—the doctor—that promised stability in the uncertain world of sickness.

With good reason much has been made of the need for physicians to maintain their knowledge through constant educational effort, because it is so evident that patients are threatened by physicians' ignorance. Good physicians admit their ignorance and call for help. It is true, but not self-evident, that over-referral is as bad as under-referral because it may reflect either pandering or fear. Recognizing that a constant accompaniment of medical practice is fear that damage will be done to a patient through one's actions leads to the next category. Patients are also endangered by failure of the physician's nerve. This is something that most laypersons are fortunate not to know about. Whether it is not overdiagnosing serious illness, starting or stopping treatment too soon, holding to a disputed diagnosis or course of action, or simply not turning and running when things get too bad, it takes nerve to care for the sick, and nerve requires self-discipline (both to be present and not to be converted to

gun-slinging). When doctors get old, the thing that probably goes first is not knowledge but nerve. Psychiatrists see suicide looming in every depression; surgeons feel cancer in every lump of fat in a breast; internists suspect myocardial infarctions with every ache in a sternoclavicular joint.

Self-discipline is necessary not only for thoroughness, but for the maintenance of knowledge, constancy to patients, and nerve—all components of the trustworthy doctor. When to these are added attributes of altruism and humanness required to work with patients, it is obvious that technical competence is only the necessary beginning of a clinician. Perhaps in their best exemplification these virtues are unteachable. Perhaps in the same way it is not education that creates a Picasso. But just as even the unartistic can be taught to draw sufficiently to render a figure on paper, the basic attributes of these virtues are, I believe, both teachable and evaluable. Before someone denies the possibility, it seems reasonable to ask who tried to do the teaching, how much time and money, and how many people were committed to the task.

THE RETURN TO IDEALS

It does not require much observation to realize that these values are not central to the training programs of modern medical centers. But the history of the period of medicine through which Walsh McDermott lived his professional life suggests the strong beginnings of change. The great physicians of the 1920s embodied within themselves the ideals of their profession as they reached towards science to provide a solid intellectual basis for medicine. Individuality lost its warrant as science seemed to provide equality to all in the quest for nature's secrets and in the treatment of disease. Science became central to medicine and provided the values embodied in schools of medicine. In concert with the surrounding society, the importance of the individual person and of ethical issues have grown in medicine over the last decade. Once again the qualities of the individual physician have assumed importance, but they are now ineluctably married to science and technology. As so often throughout his career, McDermott saw this development sooner than most others and helped lay a systematic basis for a return to ideals of physicianship in medicine.

ENDNOTES

- ¹Daniel Webster Catell, *The Physician Himself* (Baltimore, MD: Lord Baltimore Press, 1922).
- ²Alfred North Whitehead, *Science and the Modern World* (New York: Free Press, 1925) p. 103ff. See also Hans Jonas *The Imperative of Responsibility*, (Chicago, 1925) p. 209.
- ³University of Chicago Press, 1984, p. 209.
- ⁴Alvin Feinstein, "An Additional Basic Science for Clinical Medicine: IV The Development of Climetrics," *Annals of Internal Medicine* 99 (6) (Dec. 1983), pp. 843-848.
- ⁵Rene C. Fox, "Training for Uncertainty," in *The Student Physician*, ed. Robert K. Merton, George G. Reader, and Patricia L. Kendall (Cambridge, MA: Harvard University Press, 1957), pp. 207-241.
- ⁶Walsh McDermott, "Evaluating the Physician and His Technology," *Daedalus* 106 (1977), pp. 135-157.
- ⁷Russell L. Cecil, *A Text-book of Medicine* (Philadelphia, PA: W.B. Saunders, 1927).
- ⁸Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), p. 338ff.
- ⁹Eric Cassell, "The Conflict Between the House Staff and Attending Physicians," *Bulletin of the New York Academy of Medicine* 60 (3) (April 1984), pp. 297-308.
- ¹⁰See the Introduction of Cassell, *Talking to Patients. Volume II: Clinical Technique* (Cambridge, MA: M.I.T. Press, 1985); also Mack Lipkin Jr., Timothy E. Quill, and Rudolph L. Napodano, "The Medical Interview: A Core Curriculum for Residents in Internal Medicine," *Annals of Internal Medicine* 100 (1984) pp. 277-284.
- ¹¹David Mechanic, "The Public Perception of Medicine," *New England Journal of Medicine* 312 (1985) pp. 181-183.
- ¹²Pedro Lain Entralgo, *Doctor and Patient* (New York: McGraw Hill, 1969).
- ¹³Jim McIntosh, *Communication and Awareness on a Cancer Ward* (New York: Prodist 1977).
- ¹⁴Henry Beecher, "Ethics and Clinical Research," *New England Journal of Medicine* 274 (1966), pp. 1354-1360.
- ¹⁵Entralgo, "What Does the Word Good Mean in Good Patients?" in *Changing Values in Medicine*, ed. Cassell and Mark Siegler (University Publications of America, 1985).
- ¹⁶James Childress, "Rights and Responsibilities of Patients," in *Changing Values in Medicine*, op. cit.
- ¹⁷Cassell, "The Function of Medicine," *Hastings Center Reports* 7 (1977), pp. 16-19.
- ¹⁸Willard Gaylin, "Introduction to Autonomy-Paternalism-Community: A Symposium," *Hastings Center Report* 14 (1984), p. 5.
- ¹⁹William May, *The Physician's Covenant* (Philadelphia: The Westminster Press, 1983).
- ²⁰Albert R. Jonsen, Siegler and William J. Winslade, *Clinical Ethics* (New York: Macmillan, 1982).
- ²¹Stephen Toulmin, "How Medicine Saved the Life of Philosophy," *Perspectives in Biology and Medicine* 24 (1982), pp. 736-750.

- ²¹McDermott, "Medicine: The Public's Good and One's Own," *Perspectives in Biology and Medicine* 21 (1978), pp. 167-187.
- ²²Charles Bosk, *Forge and Remembrance*, (Chicago, IL: University of Chicago Press, 1979).
- ²³McDermott, "Education and General Medical Care," *Annals of Internal Medicine* 96 (1982), pp. 512-517.
- ²⁴Cassell, *The Healer's Art* (Cambridge, MA: M.I.T. Press, 1985), p. 35ff.
- ²⁵Jonas, *The Imperative of Responsibility*, op. cit., chapter 4.
- ²⁶McDermott, "Education and General Medical Care," op. cit.

