The Changeless, The Changing
The Changeable in Medicine

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"A doctor gazes at his patient and sees himself; joined they are one pilgrim in search of health."

Richard Selzer, M.D.

Prophecy is attractive only if the date of fulfillment is far enough in the future to assure that the seer will either be in Elysium or in his dotage when that date arrives. The certainty of these alternatives for me in the year 2004 emboldens me to accept your invitation to haruspication. Even as I do so, I am reminded of a mordent comment attributed to Cato the Elder, "I cannot see how one liver-diviner can meet another without laughing in his face."

Before indulging in the conceit of clairvoyance, permit me to congratulate you on this celebration of your 125th birthday, and on the dedication of Botterell Hall. The only certain prophecy I can make is that the renown and achievements of this medical faculty will continue to flourish well into the twenty-first century.

Prophecy has always attracted men because it feeds the hope that if we can know the future, we can perhaps also change it to our advantage. The future, we know all too well, always intermingles change with the unchangeable. The most sophisticated seer is the one who can distinguish the changeless from the changing and changeable.

It is precisely this difficult distinction I wish to make with reference to the future of the central phenomenon of medicine - the personal relationship between one person in need of healing and another who professes to heal. This is the reality that makes medicine what it is regardless of the historic scientific, social, political or economic milieu within which it might be practised.

I will examine the healing relationship under two aspects - a philosophical aspect, which defines its unchangeable essence and origin, and a scientific aspect which is, in fact, changing and is changeable. Philosophy tells us what is permanent in medical transactions, science what is changing and changeable.

My thesis is this: there is a fundamental need grounded in the human condition that impels those who deem themselves ill to seek out those others who profess to heal. The nature of that need and the obligations it imposes are changeless and inseparable from being a physician. What the healer brings to that relationship, the techniques he uses, the attitudes he adopts, have changed in the past, are changing profoundly now, and we are subject to conscious shaping in the future. Our challenge in the next quarter-century is how to exploit the benefits of medical science without frustrating the fundamental human need that is the ultimate justification of medicine.

To propound this thesis I wish to examine three issues: first, the origins and nature of the healing relationship; second, the changing nature of our approach to that relationship, and finally, what might be done to shape the future of medicine to deter the erosion of the personal elements in healing.

1. Origin and Nature of the Healing Relationship

Medicine and its entire apparatus exist because humans fall ill and need other humans to assist them in being healed or to live with their illness. Illness itself is an assault on our humanity, on the things we associate with being human; illness takes from us the control of our own destiny, not in distant public realms, as governments do, but in the most intimate realms of our personal lives. It robs us of our self determinancy and self-identity with an inescapable directness.

When we become ill, our bodies dominate our lives and become the centre of our attention. Our other interests are subordinated to its demands. Limited by pain, disability
and worry, we lack the knowledge and skill needed to become whole again. We must place ourselves in the power of other persons and institutions, strangers to us and our families. These strangers demand access to our most intimate secrets. They subject us to multiple examinations, then define what is good for us. We must adapt, and reconstruct our lives according to their advice or perhaps prepare for death. Even when the symptoms or illness are trivial, these assaults on our humanity remind us of our mortality.

The ill person seeks to be healed: to be made whole again, to regain his or her own concept of a satisfactory life. It is to the physician, as a professed healer, that we turn to assist us in making our humanity whole again; to repair or reverse the bodily defect and to do so in a way that recognizes the uniqueness of our own experience of illness. In a democratic society we expect that our conception of what is worthwhile will be taken seriously into account, that our good is sought, and that we will be treated with a recognition of the vulnerability illness imposes upon our existence as free men and women.

Medicine is most characteristically medicine when it brings all its science, art and morality to bear on the moment of clinical decision; when the physician advises the patient what is good for him or her. The choice of what "ought" to be done is the central act of medicine and this act is moral in nature—a right and good healing action for this patient.

We cannot deal with the question of what is good for this patient if we equate it with a merely scientific, expedient, economical or socially useful decision. The very uniqueness of the experience of illness always frustrates such oversimplification. Merely to apply science, economics, psychology, is to be a scientist, economist, or psychologist, but not to be a physician. We become physicians only in the moment of clinical truth, when everything we know converges on the good of this unique person who trusts us to heal him or her—not society, not science, not the family, not future generations.

Three crucial elements of the healing relationship, therefore, confer upon it a special quality among human relationships. These are: the fact of illness, the act of medicine, and the act of profession of the healer. They constitute the foundation of medical moral obligation. I have developed this theme elsewhere and I wish only to underscore the importance of the interaction of these three elements as the determining principles of the nature of the medical transaction.

What we have is a vulnerable and afflicted person in need of healing (the fact of illness), confronting another person who promises to heal in the best interests of the patient (the act of profession), and the expectation of a decision and an action that is right and good for this patient (the act of medicine). This triad of personal relationships is intrinsic to all medical and healing interactions. No foreseeable expansion of medical technology can alter it since it is grounded in the nature of being human. It is the unchanging element in any predictions we may make about the future of medicine and the profession.

II. What is Changing and is Changeable

Over the centuries, physicians and other healers have responded with differing attitudes, capabilities, techniques and organizations to the unchanging need of the sick person. These responses have been shaped by cultural and social forces characteristic of each era. The way the fact of illness is interpreted, the implications of the promise inherent in the act of profession, and the modalities that comprise the act of medicine are alterable and have been altered. This is graphically illustrated by the ways in which our approach to the healing relationship has been altered in the years since the medical school at Queen's was founded. Unquestionably, the most potent influence during this period has been the ascendancy of the epistemology and methodology of experimental science to clinical events. This is most dramatically evident in the recent history of therapeutics.

One hundred and twenty-five years ago, when this medical school was founded, disease was still regarded as a disturbance in the balance of the whole body's economy—a view held in common by both physicians and patients. Health was restored by restoring the balance of input and output of food, urine, sweat or phlegm. The idea of health as a balance still prevailed and was analogous to the insonomia, eukrasia, and sophrosyne of the Greeks. Restoration of balance was sought by inducing some physiological effect—sweating, vomiting, urination, purgation—to assist the body to recover its balance. Medicine was conceived as a means of restoration of the balance of the whole organism. Distinctions between organic and non-organic symptoms were vague at best; the ideas of specific cure, or of localized disease amenable to radical and specific cure were not fully developed as yet.

But even as your school was being born, the ideas that were profoundly to transform this holistic view of medicine were gaining strength. Thomas Sydenham (1626-1684), two centuries before, had posed the first challenge to disease as a whole body phenomenon by seeking a nosology based in discrete clinical entities which embraced cases with similar signs and symptoms. "It is necessary," he said, "that all diseases be reduced to species." Each species was conceived to have its own natural history with its own specific remedy whose effectiveness could be objectively measured against the natural history of the entity. Sydenham and his successors, Boissier de Sauvages (1707-1767) and Linnaeus (1707-1778) focused on proximate discrete causes rather than general theories of disease.

Not quite a century later, after Sydenham, Morgagni (1682-1771) published his great Treatise showing that clinical illness and symptoms could be localized in specific lesions in specific organs. The idea of the diseases organ was extended to the diseased tissue by Bichat and then by Virchow who localized disease in cells. Today we seek discrete causes of disease in sub-cellular, organelles, in disordered molecular structures and even in the altered quantum states atoms.

In the nineteenth century, the physicians' approach to therapeutics as a restoration of the whole body economy was seriously compromised by the concept of the discrete
localized disease process. Further erosion took place as the Paracelsian notion of a specific therapy for each specific disease assumed reality. First came the isolation and chemical identification of the active principles of botanicals long used empirically in therapeutics. This was followed by the synthesis of specific therapeutic chemical agents like the salicylates, chloral hydrate, and chloroform, and toward the end of the century by the use of specific immunizing agents and antitoxins. In the twentieth century, and continuing to this day, medicine has been the beneficiary of an ever-expanding number of specific and radical therapeutic agents - sulphonamides, antibiotics, hormones, vitamins, pharmacological antagonists, and we are now well into the era of synthesis of specific polypeptides, the uses of enzymes, and even genetic recombination.

These two ideas of disease localization and specific therapeutic agents directed to the discrete disease locus have radically transformed the physician's approach to the healing relationship. These ideas have transformed our concepts of medicine, and physicians and will transform them even more profoundly by the year 2004. Let us look at some of these transformations briefly.

1. We now no longer think of restoring the whole body economy or measuring therapeutic success by restoring the balance of bodily input and output of sweat or urine, let us say. Instead we hunt out the diseased part and we seek to eradicate it by drug or operation - not heal the whole body.

2. We have become specialists - not complete physicians. We master an organ, a system, a specific diagnostic technique or therapeutic modality. We tend to identify medicine with its technical armamentarium. Each specialist frankly admits that the whole body is not his domain. We even demand that the generalist, the family physician, be a specialist in generalities! Each of these uses an arcane language, less and less open to our colleagues in other specialties, isolating us from each other and placing formidable barriers between ourselves and our patients.

3. To make our powerful technical knowledge available to larger numbers of people we institutionalize and bureaucratize. We ourselves become bureaucrats, interposing auxiliaries - receptionists, nurses, admitting and business offices - between ourselves and the patient. The patient's unique experience of illness becomes routinized and standardized. The patient's record, shared by a legion of healthy humans, becomes the patient's card of identity - not a person. We feel satisfied if we do our part in the team.

4. The whole of medicine becomes identified with the specific and radical cure of localized disease. The care of patients, helping them to cope with minor or chronic illness, is the domain of nurses, social workers, family, friends, and clergy.

5. We develop the scientific stance of objectivity - standing back, simplifying, analyzing, reducing the variables so our observation will be valid. In the process we leave out all those identifying things most important for the patient: job, family, social status, aspirations. What we see and feel is a legitimate disease and the proper domain of medicine. The subjective the psycho-social, and emotional elements in human illness tend to be devalued in any scientific model of this kind.

6. We are easily seduced into meddlesome medicine, into an excessive zeal for our procedure and our regimen. We co-operate too easily in the patient's search for the quick pharmacological fix, and add to the 1.5 billion prescriptions written each year in the United States. Or, we seek still another consultation, hoping for a lucky hit - a specific disease location, and a magic bullet to wipe it out.

7. We begin to believe that medicine is so technical that the patient could never understand it, and so we justify our paternalism and in doing so, usurp the patient's moral right to choose among alternatives, to exert his/her moral agency. The physician is no longer mediator in a generally accepted value system. We know little about patient and family; often the patient is a stranger. The physician's bond with the patient is fashioned from his special knowledge, not his engagement with the patient as a person.

8. The dominance of reductionism in disease quality and therapeutics even expresses itself in the physician's ethic. The emphasis has become increasingly placed upon scientific competence, and the exhortations to service - compassion, to the dignity of the person - are being systematically diminished. We need only compare the concerns in the original American Medical Association's codes of ethics with the very spare recent statements of that code. The craftsman's ethic, which was the ethic of the early Greek physician before being ennobled by infusions of stoicism, philosophy and Christianity and the other Western religions, seems to be returning.

9. Finally, specialization, discreteness of diagnostic and therapeutic tasks, engenders a commodity approach to the healing transaction. The profession attaches specific fees to specific acts, especially to many procedures that comprise so much of modern medicine. Legal and commercial considerations have been superimposed upon a human relationship in which service to others in need is the ultimate justifying principle. It is interesting to note that the Federal Trade Commission in the United States perceives medicine as a commercial enterprise and that it interprets medical ethics as a self-serving mechanism, not as originally intended as a safeguard for the patient. Whether the Federal Trade Commission is right or not, it is highly significant that such a notion should even have surfaced.

No one would deny the enormous advantages of the concepts of disease localization and specific radical therapy. They have given us the golden age of medicine, and made medicine a most powerful force in enhancing human existence. But these virtues carry with them their own defects. They have generated tension between what public and patient seek, and what the profession wishes to provide. Patients are no longer willing to make an act of total faith in the doctor's judgment; they call instead for regulation of the profession, for a bill of rights, they demand
informed consent and legal redress, a voice in certification and licensure, and the right to make their own decisions in the medical moral dilemmas of medical progress — life prolongation, abortion.

Medicine today has seriously broached the order of nature. It will widen the breach unquestionably. What is unresolved is how to use its capabilities humanely — to enhance the quality of individual and social life, to enhance humankind to fulfill all the potentialities of its nature.

Our central questions then are questions of value, purpose and meaning — the eternal philosophical and moral questions — now given an unprecedented urgency because there are so many things we can do. These questions will always be short of ultimate resolution but they arise now with special force. They are philosophical questions; they arise in scientific advances but are unresolved solely by the method of science.

The challenge before the profession in the next quarter-century, and well beyond that, is to preserve the human character of the healing relationship while securing the fullness of benefits that science and organization can offer to all patients.

III. Shaping the future — active futurology

We may take an active or passive view of futurology. In the one case it is an exercise in predicting events we cannot control; in another, it is an estimate of probable events we can change by anticipating them. I prefer the latter view because we do, in fact, create the future by what we do in the present. Given the erosive tendencies I have outlined, what might we do to preserve the changeless elements to serve the fundamental human need that generates medicine in the first place?

I would like to offer three suggestions for an active futurology: First is to encourage the optimal development of the generalist; second, to reconstruct medical ethics on a sounder philosophy of the healing relationship; third, to modify medical education so that moral concerns become as crucial as scientific skills.

a) Optimal development of the generalist.

Specialism is as old as medicine and it is found in primitive and ancient, as well as modern medicine. It will assuredly expand in the future as medical knowledge increases beyond even its present advanced state. Its growth is not to be gainsaid because too many urgent problems are optimally treated by those who confine their efforts to organ systems, therapeutic modalities or diagnostic techniques.

The more specialization grows, the more immediate is the need for the generalist to guard the unchanging need for personal care of the sick. The specialist is not absolved of this obligation entirely but he necessarily exercises it over a narrow range. The task must fall to the generalist, internist and family physician who have the greatest potential and, I might add, the gravest obligation, to safeguard the person of the patient. (6) I will, however, refer to the generalist to signify the function essential to safeguarding the person of the patient.

The authentic generalist will neglect no significant feature of the patient's life situation — at home, in the family, at the job, in society. The person of the patient is defined in multiple roles and relationships. His cure or care — the selection of the best decision for him — depend on taking cognizance of those personal relationships as well as the "disease" from which they are often indistinguishable.

Neglect of the personal dimensions of illness is never justifiable but it is a little more tolerable when the treatment is radical and specific. It is less so when the disease is chronic and cannot be cured but only contained, like diabetes, arthritis, or heart disease. Impersonal care is least of all tolerable when the disorder is incurable, or is psycho-social or emotional in origin. Then the required modalities of treatment are helping the person to cope, adapt, and realign his expectations of life, through education, relief of anxiety, counselling of family and employer — in short, caring in place of curing.

The disorders requiring care are most often the ones bequeathed especially to the family physician. It is the family physician who must help the patient restructure his life in the face of some physical or emotional impediment insusceptible to medication or operation. It is peculiarly the task of the family physician to preserve the personal character of the experience of illness. If they do not, the need is so fundamentally in those who are ill that it will be met by other health professionals, or by the many "alternatives" to the medical model now so fashionable — chiropractic, naturopathy, acupuncture, spiritualism, psychosurgery, astrology, to mention a few already in serious contention.

To protect the person of the patient, the generalist must inevitably generate some tension with institutions and specialists. He must stand against those physicians who justify their scientific, bureaucratic or commercial stances. The patient must be guarded, too, against the confusion that comes with too many instructions from too many people: he must intervene against institutional routines that submerge the uniqueness of this illness for this patient; he must intervene against any measures, however efficient, at that moment when they ignore the human needs they are presumed to serve.

Even more sensitive is the need to assure that medical decisions are morally arrived at, free of manipulation and coercion and with maximum opportunity to choose among alternatives. This means the generalist will be called upon to play the role of auditor and critic of the specialist's advice. The sick person needs help in understanding the nature, costs and benefits of proposed therapeutic regimens, especially those of marginal benefit. The patient must finally determine whether the risks and costs are "worthwhile" in terms of his conception of health and the good life.

As critic and auditor of specialists, the generalist must concentrate on being an advocate of the patient's good as seen by the patient and based in his more intimate knowledge of the patient's life situation. He would be foolish to criticize the technical expertise of the specialist but he does have an obligation to assure the competence of the specialists he uses for his patients. He must know his surgeon's
norbidity and mortality statistics, not those of the best medical centres; he must weigh the experience of the specialist near at home to the one at a distance. He stands as a buffer against the specialist's enthusiasm for his technique or regimen and the subtle compulsion to do what we know how to do.

This role of critic and auditor will not be welcomed by all generalists. It must be exercised with utmost care, with respect for the specialist's recommendations, without moralizing and with closest consultation with the specialist. Done clumsily, it becomes an incitement to malpractice; done carefully, it serves the interests of both the patient and the specialist. Its motivation must always be the vulnerable state of the ill person and his need for help before the complexity and inherently dehumanizing character of organized and technologically based medical care.

The physician is not the only healer obliged to safeguard the personal quality of medical care. Nurses, allied health workers, social workers—all who enter a personal healing relationship with the patient—are ipso facto involved. The depersonalizing trends I have described will place ever heavier burdens upon them as well. Physicians are being challenged to encourage other health workers, to remove the obstacle of professional jealousy and to share their relationships with the patient more fully with the other health professions. New complexities in the legal and ethical order will be generated thereby but the collective obligations of all health workers cannot be denied because of those complexities.

All health workers must appreciate, too, that now and in the years ahead the real or perceived depersonalization of medical care can drive patients to seek "alternative" models of care. Promises of a "wholistic" approach and fear of overuse of technological medicine can draw them to chiropractors, acupuncturists, herbalists or psychosurgeons. The human needs of those who are ill are so fundamental that they will be filled, even at the risk of scientific incompetence.

The generalist, because of the promise he makes in declaring himself a generalist, will carry the major responsibility in the future, aided by the specialist in a limited way and by his colleagues in other health professions in a more intensive way than the specialists. This will create tensions within the profession, putting generalist and specialist in an adversarial position at times for the good of the patient. But these are necessary tensions and it is the obligation of all the health professions to see that those tensions are creative of better personal care and not destructive. This end can, in my opinion, be achieved only if we re-examine the moral foundations of the health professions and restructure our ethical codes—and this is my second suggestion for re-shaping the immediate future of medicine.

b) A code for the health professions.

There are several characteristics of professional moral codes that militate against the degree of responsiveness required to meet the patient's personal needs in illness. Historically, these codes have been created by the profession, for the profession, and have intermingled the etiquette of interprofessional relationships with the ethical obligations owed those who are to be served. Each profession has developed its code in isolation from the others. None of the codes has been derived from an explicitly reasoned philosophical position about the nature of the healing relationship. Lately, the oldest of the codes, that of the American Medical Association, has become sparser in content, has emphasized scientific competence and muted the obligations to service and caring.

These traits of the codes of the health professions singly and as a whole are inimical to the fulfillment of the unchanging, human need of those who are ill: to be treated not only competently but in a way that respects their personal identity and uniqueness. I have outlined elsewhere my conviction that we need a reconstruction of the moral foundations of medical ethics, one that is based in the nature of the healing relationship. Suffice it to say in this essay that a reconstructed total foundation and professional code must have several characteristics: First, it must recognize that the healing relationship occurs between a vulnerable human, a person seeking help in the state of illness which is an assault on his whole being. The ill person is dependent upon another—the healer—who professes, that is to say, promises, to be competent and to use that competence for the patient's good. The relationship is, of necessity, one of inequality, for the patient can never be as fully informed, knowledgeable, as free to choose alternatives, or as "in charge" as the physician. The patient brings his whole person to another person because his very humanity has been wounded by illness, not just his liver or spleen. It is out of the intricate phenomenological inter-relationships between the patient's experience of illness, and the promise the physician makes to heal that illness, that the moral obligations must be derived.

What is more, any new professional code must recognize the moral obligations common to all healers and the fact that increasingly the complexities of modern therapeutics demand co-operative healing actions. We need a basic code of ethics that defines the obligations of all healers as healers. Only then can we specify the obligations health professionals owe each other when they act in concert.

Finally, any morally defensible code must today be derived in consultation and co-operation with those whose good the code is intended to serve: the patient's and the public for whom the profession has spoken in the past with an authority no longer acceptable in a democratic society. This does not mean that the professions must become mere instruments succumbing to the lowest or even the average comprehension of what medicine is and can be. It does mean that the voices of those whose needs give rise to the social significance of the service professions must be heard and taken into account. It is perhaps the most difficult challenge for a profession like medicine which for several millennia has combined technical with moral authority.

The need to re-examine, reconstruct and refurbish the moral codes of the health professions requires dimensions of education that have not been adequately developed in the past. This brings me to the third, and last, of my suggestions for an active medical futurology, medical
c) Two aspects of medical education in the next 25 years.

My colleagues on this program have carefully outlined the recent history and future needs in medical education. I wish only to make two observations that are pertinent to the major theme of my essay. The first relates to the need for a different education of specialists and generalists, and the second, to the importance of humanities and ethics in the education of all health professionals.

Again, I hope you will forgive me if I refer to themes I have developed extensively elsewhere and to which I can allude here only very briefly.

I believe the forces tending to depersonalization — especially the need to scientize and organize medical care — will sharply divide the prime obligations of specialists and generalists and place them in adversarial positions. Some will suggest that this dichotomy must be healed entirely and that this is a prime task for medical education. I do not subscribe to this view. Rather, I believe it important to distinguish clearly between the differing functions of specialists and generalists because the differing needs of patients call for a certain construction tension between them.

It seems more realistic to prepare each — specialist and generalist — to perform his part of medical care optimally and thus fulfill the expectation and right of patients to both technical and specialized care and care that is also personalized and interacted. The specialist who presumes to be a generalist is as doomed to failure as the generalist who sees himself as summarizing all the specialists by knowing a little about each.

Specialism and generalism require different attitudes of mind; they offer different satisfactions and attract different peoples; they require different emphases and kinds of basic and clinical education. This is not the place to detail these differences. I wish here only to suggest to my educator colleagues that a task for the immediate future is to look at these differences realistically in the light of patient needs — the unchanging fundamental of medical care. We must not gloss over them in a romantic effort at professional amity that might sacrifice the very heart of the act of profession we make when we offer help to one who is ill.

The last point I wish to make is that education in the humanities and ethics is as essential to being a complete physician as are the basic and clinical sciences. This assertion, like my last one, deserves better justification than I can give it here. Again I apologize for introducing such a controversial claim without adequate validation. Permit me a brief statement of justification.

If medical progress produces new moral dilemmas, if the values of patients are at issue in medical decisions, if the profession needs to reconstruct the bases of its professional codes, then physicians need some of the formal skills of ethical discourse and knowledge of ethical principles to manage their relationship with patients in morally defensible ways. This means that medical students need a more formal and continuing exposure to ethics as a discipline in medical schools during the residency and in continuing education.

In many medical schools in the United States and in Canada courses in medical ethics are today enjoying a resurgence.

In some 80 schools in the United States, in addition to ethics, one of the humanistic disciplines — philosophy, history, literature and theology — is being taught. The aim is to reinforce and refurbish the liberal arts education in the medical setting to illustrate its importance for value decisions and for arising in both the basic and clinical sciences.

These courses are not meant to replace the traditional premedical preparation in the liberal arts, though it suggests that such preparation be strengthened.

With a good liberal arts education it is necessary to reinforce teaching in the clinical setting. There is an unfortunate incapacity of students and teachers to see its relevance for the daily work of physicians. Yet that work requires critical and reflective thinking, clarity of communication, a sense of the patient's history and location in society, and a sensitivity to human values, all of which are the proper business of the humanities, properly taught. That they are not properly taught in many universities today is another tragedy which can only be noted here.

If the generalist has the major obligations for safeguarding the person of the patient it is he who is especially needful of the closest integration of his humanistic with his scientific education. This synergy is far less important for the specialist so long as he works in co-operation with the generalist.

I see a sharp dichotimization of the education and function of specialists and generalists into two kinds of physicians — the generalist who will approach more closely the traditional concept of physician, and the specialist who will progressively become a technician.

I do not think it is wise or necessary to forestall this development because it arises in the two distinct needs of patients — one for technical expertise for a complicated disorder and the other for the making of decisions that take into account the patient as a unique person in a context of family, job and social position.

This is not the place to outline the further differences in the professional education of the physician-generalist and the physician-technician. I believe their extent and depth and the kind of basic and clinical services should be designed differently for each of them.

I have tried to look into the next 25 years and discern what will change, what is changeless and what is changeable in the central phenomenon of medicine — the healing relationship. I believe there are fundamental human needs that arise out of the nature of illness in humans which will always have to be met in the healing relationship.

This changeless substratum of needs is becoming ever more difficult to satisfy because of the scientific, bureaucratic and economic character of contemporary medicine. These are the forces changing medicine. They cannot be totally reversed without loss of benefit to patients. What is changeable, however, is the way the profession approaches the healing relationship to assure the best that science and organization can afford without depersonalizing the human relationships of patients and physicians.

I am confident that Queen's University will address the
challenges we have set before you today as successfully as you have met those of the last 125 years. May I not hope, too, that my fellow diviners and I shall have given the lie to Cato’s mordant cynicism about the risibility of haruspication?

Dr. Pellegrino is president and professor of philosophy and biology, Catholic University of America, Washington, D.C. He delivered this paper as part of a symposium marking the 125th anniversary of the faculty of medicine, Queen’s University, Kingston, October 19, 1979.

REFERENCES

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senior memberships awarded, and the first O.M.A. Centennial Award will be presented. Following the ceremonies and reception, an elegant buffet dinner will be served in a cabaret atmosphere, with music and other entertainment by Scott Walker and the Harvey Tishcoff Orchestra.

A Centennial Centre, a lounge and refreshment area for the use of delegates and their families, will be in operation throughout the meeting. Hostesses will invite you to enjoy a complimentary morning Danish and coffee, or tea. At the noon-hour on Monday, Tuesday and Wednesday, a cash bar will be set up for pre-luncheon cocktails.

All this would not be were it not for the brilliant ideas and plain hard work of the members of the Social Committee: Mrs. Joyce Robertson, Mrs. Tes MacMillan, Mrs. Ethel Myers and Mrs. Lou Pamenter, with the always able and friendly aid of Miss Pearl Ebenau. They have all been a joy. Would that all committees were as efficient.

Order forms for tickets for the Monday and Tuesday lunches, the Wednesday luncheon and dinner, and the Thursday buffet supper will be included in the March Review.

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BASIC CARDIAC LIFE SUPPORT COURSE

The Section on Emergency Medicine will be offering a Basic Cardiac Life Support Course on Monday, June 9th, 1980, during the OMA Annual Meeting at the Harbour Castle Hilton Hotel, Toronto.

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   c) Obstructed Airway Procedure

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