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PREFACE

This is the second report from the fellows of the Institute on Human Values in Medicine. This group of thirteen fellows was selected by the Institute Board in April of 1975 and held fellowships in the years 1975 and 1976. In Part I of the Report, their individual projects are described; while some papers prepared by the fellows are included in Part II.

One of the most rewarding and successful elements in the Institute program has been the mini-fellowships. The emphasis has been on small grants to faculty members and, occasionally, students, to encourage their interest in the humanities in medicine. Their applications have been competitively assessed from a large pool of qualified applicants. In addition to the reports by the fellows contained in this volume, the fellows reported to each other, and to the Institute Board, at a conference held in February of 1976.

The reports presented by the fellows show how they are engaged in substantial human values work both within the nation's medical schools and in projects related to the development of human values concerns in medicine. By April of 1977 the Institute had funded seventy-seven fellows. Further Institute Reports shall detail the work done by those engaged in the more recent projects.

E. D. Pellegrino, M.D.,
Director of the Institute
As part of its series of publications on human values activities in health professional education the Institute on Human Values in Medicine presents reports of the work of its fellows. These reports not only contain important papers prepared by the fellows, but also their reflections on the human values work which they experience during their fellowship tenure.

The reports contained in Part I of this publication follow a similar pattern because they were written in response to questions provided by the Institute. In order to aid the reader, these questions are given below:

1. What did you do during the tenure of your fellowship, and how does this compare with what you had planned to do when you applied?

2. Has your understanding of your subject developed as a result of your work under your fellowship? If so, in what way?

3. What effect, if any, will your fellowship work have upon your teaching or any other professional activity?

4. Will you offer any new courses as a result of work done during the fellowship period? If so, please describe them briefly.

5. If you completed an article, book, or monograph, what are your publication plans?

6. Expressed roughly in percentages totalling 100 per cent, what proportions of the fellowship period did you spend at your own campus, at other institutions or locations in the U.S., at other institutions or locations abroad?

7. Did your institution contribute any funds for travel, supplies, research assistance, or any other such ancillary purpose, to help you with your work under the fellowship? If so, please indicate amounts.

8. To what extent will you be able to apply (and perhaps extend) your fellowship work upon returning to your regular position? What assistance, if any, will you receive for this time from your institution or from other sources (including released time, research or secretarial assistance, etc., as well as grant assistance)?
9. What is the possibility that your professional activities and leadership at your institution will result in a program (as opposed to occasional courses) of teaching about human values in relation to medicine and the other health professions?

As a further assistance to the reader a brief index will be found at the end of this volume. I would like to thank the fellows for their cooperation in preparing their reports, Mrs. Helen Eddy for copy editing and proofing, and Mrs. Lucille Weber and Mrs. Edna Boulden for their work in production of the manuscript. The art work for the cover was done by Gene Harris.

Thomas K. McElhinney, Ph.D
Director of Programs
Institute on Human Values in Medicine
PART I

1975-1976 FELLOWS
ROLF W. AHLERS

Rolf W. Ahlers, Ph.D, is Reynolds Professor of Philosophy and Religion, and Chairman of the Philosophy Department at Russell Sage College in Troy, New York. His fellowship involved clinical training at the Albany Medical Center, Albany, New York, from 1 January to 31 July 1976.

THE OUTLINE OF THE PROGRAM

The program of study sponsored by the Institute has taken form in the context of the Program of Humanities and Bioethics in the Department of Preventive and Community Medicine of the Albany Medical College. It consists of two major activities: The first is that of study and participation in the Departments of Psychiatry and Pediatrics of the Albany Medical College. The second thrust is realized in my being appointed "Fellow" of the College to teach a course on Medical Ethics. A third portion of my proposal was to strengthen concern and programs in medical ethics in the Capital District of New York State. I will elaborate on the developments of this third aim toward the end of this outline.

A. On the Locked Psychiatric Ward E2 at AMC

The vast majority of my activity was spent in the Department of Psychiatry of the Albany Medical College and was one of the most fascinating experiences of my life. I participated daily in the major staff meetings of the Department of Psychiatry, as well as in small group therapy sessions, mainly with Dr. Fred Grunberg, Chief of Services of the Inpatient ward of the Department of Psychiatry. Dr. Grunberg was primarily instrumental in my activity on his ward. Several observations can be made here that will be clarified in greater detail later.

One is that the criteria for determining "illness" or "health" are very uncertain in psychiatry. Drug abuse as well as alcoholism is considered as illness or at least as a result of illness (e.g., emotional imbalance). During my activities on the E-2 ward two patients were admitted, one an alcoholic and the other a drug pusher who was himself an addict. The latter was moved out as soon as possible and placed into a detoxification program. But the alcoholic was in the program for several weeks. This uncertainty about criteria for defining illness emerged constantly. For example, a person who behaves illegally -- e.g., exposing himself publicly, dragging young nurses to bed with him in the
nursing home where he was kept -- was considered ill. Due to his diabetes he is impotent and probably compensates with such sexually aberrant behavior. But is this a sign of mental illness? A controversy erupted on the E-2 ward because of this case. The fact that I was present certainly stimulated staff debate of such issues. In addition, the way in which the staff of E-2 works together as a unit, having at least two major meetings a day, which all are expected to attend, facilitates having ethical debates take place in that group, more intense than would normally be the case in my absence.

My second observation is this: Since psychiatric health and illness is much more a social phenomenon than is the case in other fields of medicine, the staff on E-2 at AMC works much more as a unit than I found, for example, in pediatrics or on other wards. The interaction among the staff serves a very concrete purpose: to solve the serious problems emerging in the community of patients and with the individual patients themselves. But this interaction has another purpose: to be a model of sanity for patients. On the one hand, I was struck by the gravity and seriousness of the staff, by their commitment to the patients. And on the other, I was struck by their good humor and lightheartedness even under situations of severe stress. Personally, it was obvious, on first glance, that here was ill health to a greater or lesser degree. More serious deliberation of the issue has problematized this issue. But it is very difficult for me to agree with the positions of Thomas Szasz and others who think with him that psychiatric wards in the United States "manufacture madness."

The reason for this seriousness, good humor, and commitment to themselves and to patients among the staff must be sought, I believe, in the fact that in psychiatry it is not as easy to keep the subject doing the scientific reflection removed from the object of reflection, as is the case in the other disciplines within medicine. The therapist introduces himself much more actively here than in the pediatrics or internal medicine. Especially in borderline cases, where a high degree of instability or a condition of "depersonalization" might be observed, the diagnostic process is always measured by the greater stability of the diagnosing subject. Certainly, textbook information about health and illness is always general and hence abstract and might not be the exact criterion to measure this particular case under consideration.

This fact that the psychotherapist constantly interacts personally (and not only as a removed or "objective" scientific subject) both with staff and patients itself has a strong psychotherapeutic effect. If there is one question that arose in my mind during my week on E-2 ward, it is the question whether the staff's willingness to keep these avenues of communication with patients open was at least in some cases not abandoned too soon. I found myself cutting off such avenues very readily in some cases. There were cases where I could observe even at first glance obvious "illness," and the scheme of healthy, scientific subject standing over against ill, observed object was quickly established without the patient's having a chance to get out of that trap. I even now question whether
part of that willingness to establish that scheme in mind was not
produced by my frustration in communicating and being effective
as a therapist. Most recently, I found myself doing this with a
twenty-six-year-old female patient. (One of the case studies pre-
sent in my paper. See Part II (below.)

B. In the Birth Defect Institute at AMC

My work with the Department of Pediatrics was far less ex-
tensive, but in no way less enlightening. I was able to partici-
pate in counseling sessions with Dr. Ian Porter, Chairman of the
Department of Pediatrics at AMC and with Dr. Mark Degnan, both in
Pediatric Genetics. One main issue emerged here very quickly --
the social dimension of disease -- but just as significant became
the other issues -- responsibility was rarely focused on the ab-
stract "society" or "future generations." The basic questions
were always: What is the chance of my children having the disease
or being carriers? What can we do if disease strikes us, or our
children? I cannot recall one single session in which the abstract
notion of responsibility to future generations was raised. Is this
in itself irresponsible? So many public decisions are made on the
basis of precisely such abstract considerations; decisions relating
to population policy, fetal research, pollution of water and air,
urban planning, etc. Here always "society" in abstraction, possibly
even society of the future, is the object of consideration and we
consider it legitimate to reflect ethically in this way. It is
possibly symptomatic that in the many counseling sessions that I
experienced, it rarely occurred to me that it might be wrong to
leave decisions up to this individual family even if their decision
could lead to a greater "deterioration of the genetic pool," as is
so often stated in scholarly publications. It is not appropriate
to cite the values of the Nazis in order to justify the probably
predominating concern with the freedom of choice of the patient who
is being counseled. I think that leading geneticists' abstract con-
siderations (such as Joshua Lederberg and H. J. Miller) are impor-
tant to raise, but arguments by geneticists such as Dobzhansky and
sociologists such as Sorensen and theologians such as Ramsey are
convincing that the rate of "contamination" is rather slow and the
possibility of a problematic and possibly dangerous interference in
the development of mankind's genetic makeup might very well outweigh
the dangers that we have created by the advance of medicine itself.

In the context of these reflections it becomes significant to
observe how much the dignity and well-being of the patient and his
immediate family were consistently the object of Dr. Porter and Dr.
Degnan. I was touched by the pastoral dimension of their concern.
Great sensitivity and tenderness prevailed. A three-week-old baby
with Down's syndrome was fondled for the medical purposes, to de-
terminate a precise diagnosis, but it was much more than that. Great
sympathy for the parents and great love for this particular baby
flowed into the procedure. Babies were not only scientifically
analyzed, but also cuddled, and throughout, the purpose of the
counseling session was to provide an open future with hope and
also with realistic attitudes for the contingent problems at hand.
That has been traditionally the function of priest, who also laid
on hands and relieved burdens of worry and guilt, but I have
always considered this pastoral dimension of the medical profession altogether proper.

Throughout this experience I learned much factual data that is of inestimable value for my own teaching.

C. Conferences Organized During Grant Tenure

1. In January of 1976 I organized, together with Dr. Robert Baker of Union College, Schenectady, and Canan Rue Moore of the Program of Humanities and Bioethics, a three week long conference on "Ethics in Medicine and Technology." It was a good conference, which furthered the concern in medical ethics in the Albany area, one of the concerns voiced in my grant proposal to the Institute.

2. A second conference was organized by Dr. William Rockwood of Russell Sage College and me in May, 1976. This two-day affair was in many ways an improvement over the rather long January conference insofar as the small group discussions introduced here brought about much more group participation.

D. Course on Biomedical Ethics at AMC

1. I continued to participate energetically during the Spring term of 1976 in an "Ethics Discussion Group" at the Albany Medical Center which I helped reconvene in the Fall of 1973, after it had not met for a year or more. As a member of the steering committee during the 1975-1976 academic year, I had a part in guiding the activities of this group, largely directed toward faculty.

2. I also continued to participate in a group organized by Dr. Caroline Whitbeck in Philosophy at State University of New York at Albany, called the "Seminar in Society and the Health Sciences."

3. As a result of my activities in medicine and human values in the Capital District of New York State, I was invited to participate in a panel discussion on Michael Roemer's film Dying, both of which were aired over WMHTV, Channel 17, our local educational TV channel. It was a live airing, with the possibility of phone calls into the studio. Participation by viewers and by the studio audience was intense; and by reports from those who saw the program, it was excellent. The panel had that feeling also.

4. Teaching Seminar in Ethics at the Capital District Psychiatric Center, Albany

The out-patient clinic of the CDPC at Albany experienced an "ethical" irregularity with one resident in psychiatry. Dr. Hassenfeld, the director of the CDPC out-patient clinic, took this occasion to have a teaching seminar in ethics, surrounding such issues
as confidentiality and responsibility of psychiatric staff. He invited me to participate in this seminar as a consultant in ethics.

5. Future Activities

I have written two new grant proposals in the hope of continuing this work, but even without such outside help, the interest in the issues already raised certainly gained momentum. I believe the support given to me by the Institute helped give momentum to a developmental thrust, and I and the forces interested in these issues are much indebted to the Institute for this work made possible by its grant.
Howard A. Brody, M.D., Ph.D. Candidate in Philosophy, was funded for a year of study at Michigan State University from June 1975 to June 1976. He is currently completing his graduate work in philosophy under a second Institute fellowship.

1. Activities: I spent my year as a student working toward the M.D. and the Ph.D. in philosophy of medicine, following the program outlined in my application materials of December, 1974. Six months were devoted to each of my medicine and philosophy programs. As of June 1, I had completed all but six weeks work toward the M.D. and had completed all three comprehensive examinations required by the Department of Philosophy. I had also worked farther on the outline of my proposed dissertation and had completed a draft of one chapter. Work remaining toward the Ph.D. involves completion of a comprehensive exam to be developed by the Department of Human Development, and completion of the dissertation (June, 1977).

The generous support of the Institute has allowed me to participate also in activities important to the medical humanities, although not specifically related to my Ph.D. work. These include the following:

A. I participated in both the annual meeting of the Society for Health and Human Values and the Institute's Fellows Conference, both of which were very useful and stimulating.

B. I have served as a member of an ad hoc committee to develop a conceptual framework for "Future Directions in Health Care," under the sponsorship of the Rockefeller Foundation, The University of California-San Francisco Health Policy Program, and the Blue Cross Association. The committee met initially in February and will meet again in July to consider a working paper. I also consulted with the Health Policy Program regarding the preparation of the working paper.

C. I have continued to coordinate monthly medical ethics conferences at two Lansing hospitals, and have become involved in the preparation of a videotape on one case of particular ethical interest.

D. I served as a member of a committee on the ethics of bone marrow transplantation, which prepared a report for a national conference on bone marrow transplantation.
held at Michigan State in May, 1976.

E. I have helped conduct courses in medical humanities taught by Dr. James Potchen, Department of Radiology.

F. I gave a guest presentation on medical ethics at the NSU Upper Peninsula Medical Education pilot program in Escanaba, and consulted with the director on an ongoing medical ethics program for the students there.

2. Understanding: My interim fellowship report of January 5 included a prospectus outlining my proposed dissertation topic and research. My plan for the dissertation is essentially unchanged since then, although I have subsequently completed basic literature searches on the placebo effect in clinical medicine and expect to begin work next year on the major portion of the topic, i.e., the placebo effect in relation to the mind-body problem as a philosophical issue.

My understanding of medical ethics and the medical humanities in general has also been enhanced a good deal by the supplementary activities listed above.

3. Teaching: Pursuing my Ph.D. in conjunction with my M.D. has helped prepare me to offer courses in medical ethics and in philosophy of medicine in a way that will demonstrate the methodology of philosophical inquiry while maintaining a practical, clinical orientation and appealing to the interests of a medical audience. I have now had some teaching experience both in medical ethics and in the medical humanities more broadly defined, both at NSU and at Galveston.

4. I personally have not offered, nor do I intend to offer, any new courses this year or next; however, I continue to present myself as a resource for a number of ongoing courses and conferences. This has included guest lectures in courses taught outside of the medical school.

5. Publications: While my thesis project has not progressed anywhere near the publication stage, I have prepared several items over the past year. These include "Ethical Issues in Screening for Abnormal Child Rearing Practices" (with Betty Gaiss), Pediatric Annals, March, 1976; to be reprinted in forthcoming book on child abuse edited by R. E. Helfer and H. Kempe; and "The Physician-Patient Relationship: Legal and Ethical Aspects," to be published this year in the Journal of Legal Medicine. I have also had some very preliminary discussion with David Sobel on collaborating with him on a chapter on holistic medicine for his forthcoming book, Ways of Health. (Editor's note: Howard Brody published.)

6. Location: Essentially, 100 percent of my fellowship period was spent at my home institution, barring only one- or two-day conferences.
7. **Support:** No support funds were supplied by the institution other than general office facilities.

8. Upon completion of my academic program in June, 1977, I plan to enter three years of residency training in family practice. The extent to which I will be able to pursue teaching or research in the medical humanities depends on the situation at the particular residency program for which I am accepted. At any rate, following that, I intend to seek a position in a medical school family practice department in which I can offer courses of the sort described in #3 above while also seeing patients on a part-time basis. I think that my program to date, as supported by the Institute, has prepared me in the best way possible to pursue these career plans.

9. The medical ethics and medical humanities interest groups in the medical school at Michigan State remain informal, although I have made good progress in identifying those persons who are interested and who have expertise in the relevant areas. I hope in the next year to build on this informal base, possibly with the consultation of Institute members if available.

Editor's note: Howard Brody has been the only Institute Fellow to receive a second grant. He completed his Ph.D. comprehensives in June, 1976 and received his M.D. degree in August, 1976. He completes his current Fellowship in June of 1977.
VAIRGINIA G. DRACHMAN

Virginia G. Drachman, Ph.D., held an Institute fellowship from July 1975 to June 1976, during which time she completed her doctoral studies in history at the Buffalo campus of the State University of New York. Her dissertation was "The Attitudes and Practices of Male and Female Physicians Toward Women Patients: An Investigation of the Relation of Feminism to Medical Care in Late 19th Century America." Dr. Drachman is presently studying at the University of California in Los Angeles. She will soon begin duties as an Assistant Professor of History at Tufts University.

I was awarded a fellowship from the Institute on Human Values in Medicine to complete my doctoral dissertation, "Women Doctors and the Women's Medical Movement: Feminism and Medicine 1850 - 1895." For my research, I relied on a variety of manuscript materials in various archives around the country. I spent the first six months of my fellowship year researching these materials. My traveling and living expenses were supported by my fellowship from the Institute. Without it, I would have been unable to pursue my research as fully and as expeditiously as I would have liked. During the remaining six months, I wrote up my research and completed my dissertation so that by the end of the fellowship year I received my Ph.D. in History. I have recently completed a paper based on portions of my dissertation which I plan to submit to the Journal of Medicine and Philosophy's upcoming issue on women. During the fellowship year, I was also the recipient of a fellowship from the Division of Medical Sciences at the Smithsonian's Museum of History and Technology, and so throughout the year, I traveled to Washington, D.C., on a regular basis to do research on their collection of obstetrical and gynecological instruments.

My experiences during the fellowship year have had a large impact on my academic interests and the direction in which I am presently moving. I began my research as a historian of women interested in the history of health-related issues relevant to women's lives. I am now moving in two different but related directions. Let me discuss each briefly.

Using the history of women doctors and women's health as a starting point, I am now moving more into the general area of medical history. I am coming to it as a social historian and my approach does not conform with the traditional "famous men in medicine" approach. Rather, I see medical history as an ideal area to examine the economics, politics, and culture of American society. I have designed a course in the Social History of Medicine and Public Health which I am offer-
ing this year in the School of Public Health at the University of California at Los Angeles, (see enclosed syllabus). The course proceeds from the basic assumption that medicine reflects society and that attitudes of physicians toward their patients and toward medical problems affect the medical care they prescribe. Based on this premise, the course examines issues such as medical attitudes toward Afro-Americans in the Antebellum South, toward women in Victorian America, toward the working classes during nineteenth century urbanization and industrialization, etc. The course has been well received. Part of its appeal, I believe, relates to the important implications it has for understanding contemporary health-related issues.

I am also venturing out of history and beginning to look at some of the social questions related to contemporary health issues. More specifically, during my fellowship year, it became clear to me that in order for me to do thorough medical history, I needed to have some basic understanding of the science of medicine as well as of present health care issues. Part of the work I am doing this year as a Post-doctoral Scholar in the School of Public Health at UCLA includes taking medical courses. These courses are designed for people who do not intend to be physicians but are working in medically related areas. The medicine I am learning is helping me to pursue my research. It is my intention to bring my investigation of women doctors and women's health up to the present. The medicine I am learning will be invaluable in helping me to interpret patient records throughout my research as well as to analyze medical problems. I am also finding the medical background helpful as I begin to branch out into contemporary issues related to women's health. I am particularly interested in the changing trends in birth control use and their implications for the relationships between men and women.

As a historian in the School of Public Health, I am in a unique position. I bring new ideas to those working in public health, and they offer new perspectives to me. The give and take makes for an exciting interchange of ideas. My teaching is perhaps the best example of this dynamic at work. There are students in my class from the school of public health, the department of history, and the medical school. The exchange of ideas is always exciting and enlightening, particularly as students begin to understand each other's perspectives.

I intend to continue to teach medical history to historians and to people in medicine. My future goal is to work in a university program consciously designed to attract students in both the humanities and the medical sciences and which will encourage an environment of communication between them.
A HISTORY OF PUBLIC HEALTH
AND SOCIAL MEDICINE

This course will present a historical analysis of the ideas, attitudes, and institutions of social medicine and public health. This semester it will focus in particular on the ways politics, economics, and culture have influenced our approach to "health" and "disease." It will cover the late eighteenth century through the early decades of the twentieth century. The focus will be on the nineteenth century. We will cover the following areas:

1. Historiography of medicine
2. The medical setting: medicine as a science and as a profession
3. The impact of social ideas on medicine
   a. Afro-Americans in the Antebellum South
   b. The Victorian lady
4. The popular health movement
   a. Health reformers
   b. Regular and sectarian medicine
5. The public health movement
6. Attempts at disease control
   a. Cholera
   b. Venereal disease
7. The changing role of the hospital in the nineteenth century
8. The birth control movement

Course requirements:
- a short paper (3-5 pages) based on the readings for one of the weekly topics
- a final research project on a topic of the student's choice, which will rely primarily on the use of primary materials.
Readings

We will read some of the following in entirety and portions of others.

Ashton, James. The book of Nature: Containing Information for Young People who think of Getting Married, on the Philosophy of Procreation and Sexual Intercourse, showing how to prevent Conception..., N.U. 1861.


Moore, Elizabeth. "Maternity and Infant Care in a Rural County in Kansas." Bureau Publication #2, Washington, D.C.

Paradise, Viola I. "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana," Bureau Publication #34, Washington, D.C.


Priscilla Dillingham Kissick holds a Masters of Nursing degree and serves as a Supervisor for the Community Nursing Service of Philadelphia, Pennsylvania. Her fellowship, 15 April to 15 July 1975, included study at hospices in England and in Geel, Belgium.

As a student (October, 1974) at St. Christopher's Hospice in London, I found that the most interesting and creative advancements in the care of terminal illness in the United Kingdom had transcended the boundaries of even so new a concept as St. Christopher's. Dr. Saunders had made the treatment of physical, psychological, social, and spiritual pain a legitimate concern of current medical practices. The need to institutionalize patients in order to obtain appropriate care was no longer essential.

The initial problems of providing relief of physical pain to those suffering in death had been worked through by the Hospice phenomenon. Health care professionals and their allied volunteers were ready to move forward to new, yet in many ways quite old, areas -- home care, day care, and the first hospice under the auspice of National Health Service.

Visiting and studying these programs was the purpose of my Fellowship. The subsequent piecing together of those aspects which might be most beneficial to staff and patients of the Philadelphia Community Nursing Services became my long-range goal.

St. Christopher's

Care, in the basic hospice program, is relief of pain in all its dimensions. The word "hospice," a place of refuge for travelers, derives from the days of the Crusaders who would take rest therein during their pilgrimage. For St. Christopher's and the people who work there, it is important that the hospice live up to its medieval ancestry and provide rest to the pilgrims passing through life. The contemporary version is unique, largely due to creative simplicity, providing the patient relief of pain and freedom to live out life in his unique fashion.

On an initial visit to St. Christopher's one would not guess that each of these patients is terminally ill. Space, in both its architectural and human dimensions, is electric with life. Color, plants, tex-

Note: Observations based on full-time enrollment in the St. Christopher's Hospice Training Program (October 1974), patient follow-up, and a Human Values in Medicine Fellowship (March-July 1975).
tures, sunlight, paintings, and people create an environment far removed from the usual deathbed image. These ingredients, so meticulously planned, now are established in each of the death and dying programs. The variations from the St. Christopher's model are one of degree; each with the blessing, both timid and robust, of Dr. Saunders, who is unquestionably the patron saint of each and every hospice in the United Kingdom.

St. Luke's Nursing Home - Sheffield - Day Care Center

St. Luke's Nursing Home in Sheffield has been able to incorporate most of the features of St. Christopher's while building not only a handsome primary building but also a newly opened day-care wing. Their hospice program varies from St. Christopher's only by degree. The patient/nurse ratio at St. Luke's is 1:1 (St. Christopher's, 1:25) -- 75 percent professionally trained, 25 percent aides (goal of 50-50). The drug program, basic narcotics mixture, is the same as St. Christopher's. However, in the "North Country" there is less belief in the potentiating effect of chlorpromazines on narcotics, and generally less use of psychotropic drugs. The staff rationale is "People in the provinces are less neurotic than in London."

St. Luke's is the first hospice to incorporate a day-care program. The wing is designed to accommodate a census of fifty patients per week (ten each day). The patient population is mainly postdischarge and waiting list patients. The program included pain assessment and evaluation; physical therapy, which the staff feels has not been adequately serviced in previous programs; occupational therapy (concentrating on Activities of Daily Living, ADL); special showers and bathtubs; and lastly, one of the most essential ingredients, a properly fitted beauty salon. The program is designed to provide the maximum flexibility and ability to respond to needs. The lack of rules and regulations is startling. It is amazing to observe a facility function without the anticipated institutional-protective rules. When the prevailing ethic is, "How can we be most individualistic and unregulated?" nurses are found in the most fascinating places -- taking patients to Lourdes on a holiday, talking to patients, playing chess, crying with patients, visiting the theater, or as I once saw, a male divinity student teaching a patient to waltz in a wheelchair!

St. Luke's has a solid hospice program with experimental day care and a bereavement program run totally by volunteers, the equal of which I have not been elsewhere. They demonstrate that volunteer programs can be professional. Once a week, Sister, Matron, social worker, and volunteers meet to discuss individual patients, deaths that week, and to evaluate the status of the family, its needs, and its ability to cope. The volunteers carry out the visiting and bereavement counseling, as decided by the group. Part of the success of this process is that all volunteers are included with hospice staff at daily rounds. All hospices have extremely active volunteer programs, but Sheffield includes the volunteers most intimately and professionally in the program. A significant number of volunteers, male and female, are recruited as a result of personal involvement with relatives and friends at St. Luke's.
St. Joseph's Hospice and Home Care Program

St. Joseph's presents a very different image from the sophisticated facilities found at St. Christopher's and St. Luke's. Parts of the building date back more than one hundred years and remain a fine example of 1870's architecture. It recently had a "major renovation" when the sign was changed from "St. Joseph's Home for Dying" to "St. Joseph's Hospice."

St. Joseph's is physically comparable to institutions I have known in the U.S.A. -- very drab, unattractive, overcrowded, lacking in aesthetic aspects of form and beauty. The physical setting, however, has not interfered with the institution's ability to influence markedly the concepts and practices of "care for the dying." It was here that Dr. Saunders began the work that has changed treatment for the terminally ill. She had said to me that St. Joseph's remains the place of real action.

I spent four days here as a student, but was unable to do more than define some of it's components. How St. Joseph's works as an integrated whole remains an enigma to me! It does have an unique Home Care Program with an eccentric young physician: there are nursing sisters (nuns) in habit; the aides are predominantly newly arrived from Ireland with their unique accents and approach to people. Of the 150 beds, 100 are terminal -- almost three times the census of St. Christopher's.

My first clinical contact at St. Joseph's will remain an unique experience. Each of my student group was directed to chat with one patient; mine was a man in his early 60's. I sat with him and soon said, "You look so sad" whereupon he told me of the conflicts he now must work through as he lived out his short life span. Many a time I have said to a patient, "You look sad, glad, etc." but never has this statement evoked the pouring out of such anger, frustration, and despair.

This patient sat in the midst of a six-bed ward crying huge sobs with an absolute stranger holding him in her arms. Thus do unique experiences seem to tell the story of St. Joseph's and sister institutions.

Christ Church Hospice and Home Care Program

Christ Church is the only hospice run within the National Health Service. The funds to build it were raised independently, but now the NHS has accepted responsibility for the program expenses. It is similar to all the other hospices. The questions as to how one can provide care to the terminally ill within the operational restrictions of the NHS will be answered at Christ Church, it is hoped. At the time I visited, there had been no problems. Their Home Care Program was staffed by three young nurses of varying experience and background. This hospice has yet to provide more than consultation and evaluation, but the program might evolve to offer home nursing services.

St. Christopher's Home Care Program

The St. Christopher's Home Care Program was the climax of my observations. It was here that I was best able to compare the service we have been providing in the Philadelphia Community Nursing Services with that at St. Christopher's.
The core of St. Christopher's Home Care Program is housed in a wing recently added to the hospice; it is staffed with four nurses and one secretary. A weekly pain control clinic is held in this Home Care wing staffed by the medical doctor who is partially responsible medically for the eighty-nine Home Care patients. These patients have the services of their general practitioner, the Home Care physician, 24-hour on-call nursing services, and also the reassurance that a hospice bed will be available if need arises.

The Home Care nurses function mainly for consultative assessment and in a coordinating role. The personal care that may be needed is provided primarily by the National Health Service District Nurses.

The Home Care nurses have a great understanding of pain control, and they do total assessment of patients on home visits. The knowledge that the nurse can quickly get a physician and also a hospice bed provides an admirable level of security. The nurses in the Home Care Program were above average professionals.

Geel Family Care Research Project

On May 16-17, I journeyed to Geel, Belgium, to attend the International Symposium on Family Care for the Mentally Ill, jointly sponsored by Columbia University and the Catholic University of Leuven. For centuries, Geel has pioneered in family care of the mentally ill. This multiyear interdisciplinary and collaborative research project aims to identify the factors which initiate and sustain community-based family care as an alternative to institutionalization.

The proceedings of the conference will be published. Full exploitation of the relevance of these many doctoral dissertations to the home and foster family alternatives for the dying must be deferred until the complete record is available for analysis. However, it can be said in passing that the community's economic, social, cultural, psychological, and related variables are apparently more important for family care programs than the disease circumstances or patient needs.

Conclusions

The Home Care Programs all seem to deal with situations less stressful than those which I have known in the United States. The benefits of the National Health Service and the welfare state provide the nursing of terminal illness in the home as a choice for the patient. Underlying all of this is a well organized support system of human services.

My experience in the United Kingdom has led me to the following questions for my Community Nursing Services environment:

1. Can a generalized Home Care Nursing Service without the United Kingdom level of support services provide adequate care for the terminally ill?

2. We have been, and will continue to, service those patients with no alternative system of care and the occasional "I want to die at home" patient. But could we provide services of a quality to equal those in
England?

3. Will the United States physician provide any support to nurses attempting to carry out their functions with the patients at home?

4. Can a voluntary generalized nursing agency provide at-home terminal care without reaching a deficit budget in the delivery process?

During the weeks and months ahead, I will be trying to answer these and other questions. I am preparing to present to the Supervisors of the Community Nursing Services the highlights of my United Kingdom experience and assess their commitment to city-wide action.

Within West Philadelphia I am giving several in-service sessions for twelve Home Health Aides who administer the bulk of terminal ongoing home-nursing care. I am visiting with Public Health Nurses for cooperative visits to patients where the nurse may feel my experience will aid them in their practice. I am carrying a small sample of patients to determine how satisfied I am with the care I am able to provide.

The Human Values in Medicine Fellowship provided me with a unique and rich experience. I eagerly await the evaluation of my colleagues and peers as to the value of the contribution I might make.
Laurence B. McCullough, Ph.D., spent a month as an Institute fellow in October of 1975. He worked on the theme of the moral status of pain and suffering at the University of Texas Medical Branch in Galveston. Dr. McCullough is presently Assistant Professor and Head, Medical Humanities, at the new Texas A&M School of Medicine.

I devoted my time on the fellowship to a study of the moral status of pain and suffering. In particular, I focused on claims regarding pain and suffering as justifications for allowing patients to die or even to hasten their death. The study was limited to a consideration of patients afflicted with incurable and terminal disease.

Before I undertook the project I was not aware of two things of which I am now more than well aware. First, there is not a well-developed body of literature on the subject. Hence, I have been somewhat at a loss as to how to proceed and have, for the most part, had to find my own way. Second, reflection on the moral status of pain and suffering has led me to realize that the issues involved are a good deal more complex than I had at first thought they were. For instance, it is not at all clear just how we use the terms "pain" and "suffering" and what we mean when using them. Is pain always disliked, for example? If it is, then there may be a solid (though as yet still not fully understood) connection between pain and its moral status. It may be, by its very nature, evil. But is it mere physical evil -- which is dislikable -- or is it morally evil? How are we to distinguish moral and physical evil? If, on the other hand, there is no connection between pain and its being disliked, a fortiori, there should be none between pain and physical evil, the dislikable in itself. If this is the case, then it is not always the case that pain is morally evil and, hence, to be avoided or eliminated, even if this were to mean the taking of life. Similar questions can be raised about the nature of suffering. In short, claims about pain and suffering, when examined closely, reveal themselves to be shorthand terms for a variety of different claims. These latter claims need still to be sorted out.

Necessarily, then, I am still at the stage of determining what the questions are. The next stage will be to set out the best framework for dealing with these questions. Finally, claims about pain and suffering, once sorted out, must be connected with the general issue of the right to die. The latter two parts of the project are still before me. I expect to be occupied with these tasks for the next few months. This study will, I expect, result in a manuscript that I shall submit for publication.

While my project per se does not relate to teaching plans I have,
the opportunity to be associated with the Institute for the Medical Humanities has been invaluable in planning the courses which I shall give at the new College of Medicine at Texas A&M University, beginning in the fall of 1976. My planning has been helped immeasurably by conversation with Drs. Engelhardt, Burns, and Bean, of the Institute senior staff.
John F. Monagle, Ph.D., is Director of Human Values in Medicine at St. Vincent's Hospital and Medical Center in Toledo, Ohio. He also serves as Associate Clinical Professor of Bioethics in the Department of Community Medicine at the Medical College of Ohio. He spent the period of 1 June to 11 July 1975 studying nontherapeutic research on children at the University of California Medical Center in San Francisco.

1. The purpose of my fellowship was to research the available ethical-legal information at the University of California Medical Center, San Francisco, regarding "Nontherapeutic Experimentation on Children."

Albert Jonsen, S.J., Ph.D. (bioethicist), extended me a warm welcome and the Administrative Assistant for Academic Affairs, Ms. Erica Heath, allowed me to use all available information concerned with the court case of James Nielsen, J.D., vs. Regents of University of California.

My proposed plan was fulfilled beyond expectations.

2. The understanding of my subject was greatly enhanced and there was a substantial change in my ethical thinking. My direction changed to a more realistic consideration of the necessity for concern regarding the common good without violation of the rights of normal children.

There is needed consideration for the concern of children by further clarifications between bioethicists and pediatricians -- perhaps the establishment of an ombudsman corps to represent the experimental subject in larger institutions doing human experimentations.

3. The understanding of my subject will help greatly in my teaching and consulting activities at St. Vincent Hospital and Medical Center as well as at the Medical College of Ohio, Toledo. The scope of my presentation in this area has been directionally broadened to a more meaningful consideration of the common good and its promotion.

Future writings in the area of nontherapeutic research will include such considerations. I will encourage nursing and medical students to explore the area of social needs in medicine and the sacrifice necessary by healthy control subjects to help the less fortunate.

4. No new course will be offered, but the area of nontherapeutic research will be greatly amplified and clarified by the results of my fellowship program.
5. When time permits, I will publish an article entitled, "Nontherapeutic Research: Concern for My Children's Children."

6. I spent the entire period of the Fellowship at an institution other than my own.

7. St. Vincent Hospital and Medical Center contributed $500.00 for research purposes.

8. I will be allowed time for further research in this area together with library and secretarial assistance for publication purposes.

9. A program in human values as well as an office for consultation has been established and implemented at this Medical Center.

My sincere gratitude to the Institute for the fellowship grant.
ANTHONY R. OLIVER-SMITH

Anthony R. Oliver-Smith, Ph.D., is a social/cultural anthropologist at the University of Florida in Gainesville. He is also an Assistant Curator of Ethnology at the Florida State Museum. His original grant, from 15 June to 15 September 1975 permitted time doing field work in Yungay, Peru, and analysis of findings in Gainesville. A supplemental grant to assist in transcription costs was subsequently awarded. Dr. Oliver-Smith also served as a member of the Institute's Humanistic Dimensions in the Social Sciences in Medical Education Dialogue.

1. The majority of the tenure of my fellowship was spent conducting field research in individual patterns of adaptation to disaster and culture change in the highlands of Peru. The tenure of my fellowship extended from June 15 to September 15 of 1975. I spent from June 15 to July 8 in Gainesville, Florida, designing the research instrument to be used in the field and making other preparations for the trip to Peru. From July 9 to September 4, I was in Peru, either in the Callejon de Huaylas or in Lima, conducting research with the victims of the 1970 earthquake-avalanche disaster of Yungay. I returned to the United States on September 4 to begin the analysis of the data collected in the field. With the exception of the unforeseen necessity of several trips to Lima from Yungay, the tenure of my fellowship went according to plan.

2. My understanding of the research topic has developed considerably as a result of my fellowship, particularly from a methodological and ethical standpoint. My original intention in the research was to conduct structured interviews with survivors of the 1970 earthquake-avalanche disaster of Yungay, Peru, in order to determine the relationship between individual adaptation and sociocultural change. A number of basic conclusions regarding the research have been reached, at least from a preliminary preanalysis impressionist standpoint. First, the character of the community rehabilitation system seems to affect the nature of individual adaptation to personal circumstances of the tragedy. The individual's adaptive strategies and his success at coping with the situation seem often to be closely linked to his involvement in those efforts of community reconstruction going on around him. Indeed, access to meaningful employment, often in reconstruction, regardless of its relation to predisaster employment patterns, seems to be a key factor in individual coping patterns. This pattern would tend to parallel Adams', Hamburg's and other researchers' conclusions that a healthy concern with and response to the material tasks of life are key elements in a successful adaption to the stress of long-term disability or terminal illness in individuals.

However, at this extremely preliminary point in the analysis stage of the project, the primary concerns deal not so much with the actual content of the research as with its methodological and ethical aspects.
The experience of conducting the initial interviews has convinced me that structured interviews of the type often employed by psychological and anthropological researchers are not only inadequate research tools for this kind of project but also may involve ethical compromises for the investigator if extreme care is not taken. It was due to this realization after the first half-dozen interviews that I felt obliged to alter the methodology and research instrument in order to continue with the project. The formal questionnaire was abandoned in favor of a more loosely structured approach that would allow the interviewee to tell the investigator as much or as little as he pleased on certain topics. Particular care was taken to avoid direct questions that dealt with the painful losses and episodes in the subject's experience in the disaster. There is an ethical reason for this avoidance.

An investigator does not have a direct therapeutic relationship with his subject. His goal is information, not therapy. So long as he is not working toward helping his subject, he is certainly under a moral obligation to avoid causing him any harm or pain. When the subjects of research are victims of a catastrophic tragedy, direct, impersonal interviews querying the subject on the nature of his loss and pain as well as his efforts, possibly unsuccessful, toward rehabilitation in the aftermath may bring to the surface emotions and recollections that cause the subject considerable anguish. This is not the role of the researcher, particularly when he has had a long-term, friendly relationship with his subjects, as I have had with the Yugainos. Perhaps, it is here that we find a major ethical dilemma that is, in a sense, a product of certain methodological differences between psychology and anthropology. Because of his traditional participant-observation methodology, the anthropologist often finds himself in the position of studying his friends, people to whom he not only has a professional responsibility, but also a relationship based on friendship and other cultural values. The M.D. or psychiatric practitioner can justify causing his patient considerable pain on the grounds that his intent is therapeutic. The anthropologist, functioning professionally as well as often on a more basic human level as friend, has no right to cause or renew pain in his subjects for the sake of research and with no therapeutic intent. Most importantly, the investigator, like the M.D., in undertaking research or treatment with people under severe long-term stress, acquires a heavy obligation to his subjects and ultimately to science to provide as clear a meaning as possible to the subject's experience of the research or treatment. Both M.D. and scientific researcher on this level have pierced the shell of objectivity and have obligations to subjects that extend beyond professional ethics into moral considerations based on shared experience and common humanity.

3. The experience of the fellowship and the realizations mentioned in part 2 of this report have further sensitized me to the difficulties involved in human research in general and in areas of human affliction, specifically. However, my interest in this particular form of research has not diminished due to the methodological and ethical problems that I encountered. On the contrary, I feel that methodological refinements for research in these areas of human adaptation can be devised that will eliminate many of these difficulties. In particular, I feel that research of this kind, if properly conducted, can lead not only to important material on human behavior under stress, but also will provide further illuminating ethical perspectives for social scientists and medical personnel alike.
From my own personal standpoint I feel that my understanding of certain ethical questions in anthropology, and social science in general, has been vastly broadened by the problems encountered during the fellowship period. I fully intend to integrate this increased understanding of the obligations of the professional to his subject or patient into my own teaching and writing.

4. Dr. John Adams, Dr. Dennis Owen, and I intend to offer a course on human adaptation to long-term stress in the spring quarter of the present academic year (1975-1976). Dr. Adams is a psychiatrist who has specialized in patterns of coping and adaptation of individuals to terminal illness and long-term disability. Dr. Owen will examine the issues of human suffering from a theological and philosophical perspective. I intend to integrate the research data and conclusions from my fellowship into the course framework from an anthropological and cross-cultural perspective. The course will be open to all students. There are possibilities at the moment that the course will become part of the NEH program on the humanities and the professions that has recently begun here at the University of Florida.

5. At present I am preparing a report on current research to be presented at the annual meetings of the American Anthropological Association on December 2-6, 1976, in San Francisco. Dr. Adams and I intend to prepare a number of articles on the results of the research supported by the fellowship.

6. Approximately one third of the fellowship period was spent at my own campus. Approximately two thirds of the fellowship period was spent in Peru.

7. The University of Florida contributed film, tapes, and stationery to the project. A precise dollar amount is unavailable, but a rough estimation would place the amount in the area of $200.00.

8. At present, the results of the fellowship research are being analyzed here at the University of Florida. Additional assistance for the transcription of taped interviews in the form of salary for at least two graduate students is requested of the Institute for Human Values in Medicine in order to facilitate the analysis of the collected materials. The University of Florida will also contribute to this effort in the form of funds for typewriters, tape recorders, and stationery.

9. The University of Florida is the recipient of an NEH grant for precisely the purpose of teaching about human values in relation to, not only the health professions, but also law, business, engineering, and the other professions. I am at present and intend in the future to be as fully involved in this program as possible as it relates to the medical and health professions.
ROBERT D. REECE

Robert D. Reece, Ph.D., is the Program Director of the Department of Medicine in Society at the Wright State University School of Medicine in Dayton, Ohio. He holds a joint appointment as Associate Professor of Medical Ethics in the Medical School and Associate Professor of Religion in the University. In Fall, 1975, and Spring, 1976, Dr. Reece spent time at the University of Florida in Gainesville and at the University of Texas in Galveston.

INTRODUCTION

My application for an Institute fellowship stated two goals, both directly related to my current position as chairman of the Department of Medicine in Society in the Wright State University School of Medicine. The first goal involved a comparison of programs in the medical humanities and social sciences, addressing the following questions: (1) What philosophies lie behind medical humanities programs? (2) What organizational structures, curricular designs, and teaching methods are developed consistent with these philosophies? (3) What difficulties, political and educational, have such programs encountered?

My second goal was to gain a general understanding of the world of health care professionals. I wanted to examine how physicians perceive their own functions and responsibilities in the delivery of health care and how they handle problems in which value questions and ethical issues are prominent.

SITES AND SUPPORT OF FELLOWSHIP

During the period of my fellowship I spent two weeks each looking at medical humanities/social sciences programs at two rather different institutions: the University of Florida College of Medicine and the University of Texas Medical Branch. The fellowship was executed solely in these two institutions. Wright State University School of Medicine has agreed to fund one third of my fellowship expenses. Because of rising costs and low estimates in one or two areas, the actual expenses of the fellowship somewhat exceeded the proposed budget. The difference was covered by Wright State University.

SUMMARY OF ACTIVITIES

In seeking to achieve the first goal stated above, an examination of medical humanities/social sciences programs, I interviewed faculty and administrative personnel who were responsible for the development
and implementation of the programs. I also talked with faculty and administrators who had varying degrees of interest in the program but who were not directly involved. I also spoke with several students to assess the program from the student's point of view.

I attended every class that could be construed as being related to the medical humanities programs of the two institutions. This included classes for premed and other undergraduate students, classes for allied health professionals at the undergraduate and the graduate level, classes and teaching rounds for medical students, and sessions for residents. I also observed the variety of physical settings in which the programs were implemented.

I pursued the second part of my study, focusing on the experience of the physician in his medical context and the value issues which physicians encounter in practice, by accompanying physicians and observing them in their rounds in a pediatric ward and the emergency room of the university hospital, in family practice clinics, and in rural and inner-city clinics. The only departure from my proposal was my failure to accomplish in any systematic fashion my intention of examining the problem of informed consent in a clinical setting. That expectation proved unrealistic in the time available.

**COMPARISON OF THE TWO PROGRAMS**

The programs that I examined share much of the same basic philosophy, but represent rather divergent organizational and curricular patterns. The chart below demonstrates many of the main points of contrast between the two schools:

<table>
<thead>
<tr>
<th>UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE</th>
<th>UNIVERSITY OF TEXAS MEDICAL RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Definition</strong></td>
<td></td>
</tr>
<tr>
<td>Broadly defined: Humanities and Social Sciences. Courses involve lawyers, historians, sociologists, philosophers, anthropologists, economists, and religion and English faculty</td>
<td>Intensive; Medical Humanities, Emphasis in depth upon history of medicine, philosophy of medicine, and law and medicine.</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td></td>
</tr>
<tr>
<td>Division within the Department of Community Health and Family Medicine</td>
<td>The Institute for the Medical Humanities is a relatively independent institution attached to the School of Medicine</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td></td>
</tr>
<tr>
<td>Medical School: Budget of the Department of Community Health and Family Medicine</td>
<td>Endowed chairs. Line item faculty salary in Department of Preventative Medicine and Community Health</td>
</tr>
</tbody>
</table>
University: National Endowment for the Humanities Grant

Independent funds through the Institute for the Medical Humanities, especially National Endowment for the Humanities funding

Access to Students

Through the Department of Community Health and Family Medicine

Through the Department of Preventative Medicine and Community Health

Students

Baccalaureate students and allied health students, medical students, and residents

Allied health students, medical students, and residents

Curricular Involvement

Leadership in required first-year department course. Less structured involvement in department's clinical rotation. Electives in last year

Required course in first year in medical ethics. Responsibility for law and medicine course in the second year. Participation by invitation in clerkship sessions. Electives in the fourth year

Location

On the main university campus

Separated from the main university campus

The most notable contrasts one can observe in this table are the differences in organizational structure -- a division within a clinical department versus a relatively independent institution -- and broad versus intensive definition of the program's scope.

DISCUSSION

The ultimate purpose of the comparison and assessment of the two programs that I examined was to determine what issues I needed to address as the director of a new program in a new medical school. The following observations reflect my tentative conclusions concerning the philosophy and structure of medical humanities/social sciences programs. Although these observations grow out of my thinking in connection with my fellowship, they are not intended either as a description or as an evaluation of the programs at the two institutions that I visited.

1. Identification of Areas of Responsibility

A developing program in medical humanities/social sciences must be clearly defined both in terms of its fundamental purpose and the range of its activities. One fundamental issue is whether the affective or cognitive dimensions of experience are to be featured most prominently. Although the distinction between affective and cognitive domains may be
somewhat artificial, it is important to delineate whether the program is intended primarily to affect the attitudes of students or to provide certain kinds of knowledge and perspective and to help students develop skills in using this knowledge and perspective to understand the context of medical practice.

Moreover, program goals need to be defined in such a manner that it is clear how faculty shall demonstrate their competence and can be recognized as holding appropriate credentials for the position, given the importance of credentials within the field of medicine. For example, if the program is defined in terms of the application of traditional humanities/social sciences disciplines to medical education, faculty should hold terminal degrees in those disciplines. Furthermore, since the objective is to bring an outside perspective to the study of medicine, it is important that a faculty member maintain an identity that has some independence of the school of medicine, by teaching, publishing, or participating in other ways in the academic life of a parent discipline.

The polar extremes to be avoided in delineating the scope of a program are definitions of competence that are so narrow that the faculty is not able to interact with medical faculty and students in a variety of settings and across a spectrum of issues, on the one hand, and a philosophy that is so broad that the program becomes a catch-all for all subjects that do not naturally fit into some other traditional medical school department, on the other hand.

There is also a need to determine the extent and limit of the audience that the program will serve. The potential responsibility is extensive, if the program is designed to serve not only the medical school student but also the postgraduate physician in both residency training and in continuing education. There is, moreover, the challenge of developing programs for undergraduate premedical students and for a number of health care professional students, including nurses, medical technicians, physical therapists, occupational therapists, and others. Accompanying these opportunities is the danger of diffuseness, superficiality, and lack of clear focus if the program attempts to cover too broad a spectrum with limited resources. Experience seems to dictate that one should establish and consolidate a base of activities before expanding to a new area.

2. Organizational Structure and Location

The effective operation of a medical humanities program and its long-term survival in the medical setting are enhanced if the program can be located organizationally where some visibility and security can be provided. Visibility is significant in communicating to faculty and students alike that the area is one that is taken seriously. The ability of a program to make an impact upon the process of medical education is increased if it has a position of organizational strength from which to operate. The survival of a program and its ability to resist the changing whims of medical education suggest that a program be located organizationally in a manner designed to protect it from frivolous attack.
To suggest that organizational status is important is not to deny that there have been effective social sciences and humanities involvements in medical schools on a purely ad hoc or informal basis. Likewise, individual humanities or social science faculty have frequently been located within existing departments as part of the general program of that department, particularly in departments of psychiatry. However, appropriate organizational status within the medical school organization will help to lend legitimacy and credibility to a developing program. Three kinds of organizational structures have emerged in the more prominent humanities and social sciences programs in medical schools in this country:

A. A division within an established clinical department, for example, the Division of Social Sciences and Humanities in the Department of Community Health and Family Medicine at the University of Florida.

B. An independent Institute, possible with endowed chairs, associated with a medical school, as at the University of Texas Medical Branch.

C. A department of medical humanities or humanities and social sciences, as at the Pennsylvania State University College of Medicine at Hershey. Wright State University is among the institutions that have adopted this structure.

Whatever the organizational structure, one of the burdensome yet necessary dimensions of the development of a medical humanities program is the willingness of the program personnel to assume a responsible role in the larger organization by being involved in a variety of administrative and committee tasks. Such activities help to educate humanities scholars to the nature and process of medical education. Moreover, each involvement provides the humanities faculty with visibility and the opportunity to interpret to colleagues the program's goals and philosophy. Administrative and committee responsibility is part of the price for establishing a medical humanities program. The danger, of course, is that the administrative tasks become so overwhelming that they undermine the teaching program that lies at the core of the medical humanities/social sciences program.

3. Clinical Interaction

Regardless of where a medical humanities program is placed within the organizational chart of the institution and regardless of the location of its primary teaching responsibility, the task of finding avenues for clinical contact and adapting clinical examples for teaching purposes is crucial for the success for the humanities program. Humanities and social sciences faculty need to contribute to clinical teaching and they need to develop skills in uncovering and explicating the value and social dimensions of clinical cases, which seldom are immediately obvious to the casual observer.

Some argue that this clinical contact is achieved most readily if the social sciences and humanities program is located in a clinical department. Although the opportunity for communication may be enhanced
by such an organization, close personal relationships of humanities faculty with clinicians are probably at least as important as organizational structure for these purposes. However it is accomplished, it is critical that students be aware of the clinical basis and applicability of the medical humanities/social sciences curriculum.

4. Personnel

Despite the importance attached to the issues discussed above, the wise selection of personnel is probably the most critical factor in the development of medical humanities and social sciences programs. Faculty members must have clearly defined areas of competence and a desire to maintain the integrity of their own professional specialty. However, their area of expertise must not be so narrow as to conflict with the broader goals of medical education. Moreover, they must endorse the concept of "applied" humanities and social sciences and perceive their function as that of enabling students to employ concepts in very practical settings. Medical humanities faculty are clearly not attempting to educate specialists in the humanities; they must recognize that medical education is professional education and is quite different both in format and content from educational settings with which humanists are most familiar. Humanists should recognize that medical students are much more practical in their orientation than are traditional liberal arts students. Faculty members in a medical humanities/social sciences program ought to enjoy the challenge of employing their expertise in professional education rather than feeling that their disciplines are being diluted. Thus, they need to be tolerant of the ambiguous nature of their task and flexible in adjusting to a different kind of setting. The ability to work with a diverse group of people and a spirit of cooperation are also important personal characteristics for an effective faculty member of a medical humanities program.

5. The Teaching Task

One of the common observations of those experienced in medical education is the distinctiveness of the task of medical education as a form of professional education. Curriculum time in a medical school is a scarce commodity. Consequently, themes that would be developed in a leisurely manner, perhaps using the Socratic method in a liberal arts curriculum, must be streamlined and presented directly and concisely. Scheduling of classes and allocation of time to specific topics do not fit the three-credit-hour course pattern to which most humanities/social sciences faculty have become accustomed.

One of the fundamental challenges to humanities and social sciences faculty is to accommodate themselves to the scarcity of time, without lapsing totally into a lecture mode that undermines student participation. Since every hour of student instruction is seen as precious, faculty must invest considerable effort in developing each hour of the course. If the goal of a program is to help students develop perspectives and ways of thinking about issues rather than primarily providing factual knowledge, particular ingenuity is required in developing a cur-
riculum that can achieve these goals with maximum efficiency. An educational format needs to be designed that can enable students to discover and test ways of thinking without allowing unfocused and wandering discussions. In light of this, social sciences and humanities faculty need to be much more concerned with educational process than is often the case in a liberal arts college. A variety of modes of education and the use of various media need to be considered in developing an efficient and effective teaching program.

The challenge to the ingenuity of liberal arts faculty is intensified when the teaching arena is moved into the clinical setting. Teaching in such an environment becomes much more informal and even more abbreviated. Faculty need to be prepared to respond immediately to a particular case encountered in clinical rounds. It is to be hoped that a base of knowledge and terminology has been laid early in the educational process that will enable the faculty to make a point briefly and meaningfully in the same fashion to which clinicians are accustomed. A liberal arts faculty member in such a situation, however, is obviously out of his natural habitat. Here the need for flexibility and the ability to deal with ambiguity most clearly manifests itself. Even the classroom setting in clinical education is strange to a liberal arts faculty. Some faculty members, for example, have expressed dismay in trying to teach a class during a noon-conference in which students are engaged in eating lunch while the teaching session is in progress. Such a setting is so common for clinicians, however, particularly in residency education, that they simply fail to understand why social sciences and humanities faculty find this any problem at all.

Another key issue in the development of a teaching program involves the comparative virtues of continuity versus variety. There are both advantages and disadvantages with a course that utilizes a number of different faculty appearing as guests on particular topics. The advantage is that students will not become bored with a single face and with a single approach to a problem. Moreover, they can benefit from the teaching of people who are expert in each of the areas under consideration. The disadvantage is the potential lack of continuity and lack of identification with a particular faculty member who can pursue a line of thought through several different kinds of experiences.

6. Impact on Clinical Faculty

Perhaps the greatest challenge to medical humanities and social sciences faculty is to influence the clinical faculty directly or indirectly. If the perspectives, approaches, and attitudes that the humanities and social sciences faculty are attempting to promote in students are not embodied in the conduct of the physicians who provide role models for the medical students, then the effectiveness of medical humanities and social sciences programs is severely hampered. If medical humanities faculty can assist the physicians who are professors and preceptors to reshape their own self-awareness, then the long-term effects of a medical humanities program are assured.
Since the whole purpose of my fellowship was directly related to the development of the medical humanities/social sciences program in my institution, it seems appropriate to include a brief description of that emerging program. The Department of Medicine in Society at Wright State University School of Medicine is the organizational unit of a newly-developed school of medicine charged with introducing the perspective of humanities and social sciences into the medical curriculum. The school will admit its charter class in September 1976, with the Department of Medicine in Society as a fundamental component of the curriculum. The Department attempts to integrate two distinct academic traditions. The first area is the humanities, specifically medical ethics and humanistic perspective of medicine and medical arts. The second tradition comes from the social sciences and emphasizes medical sociology and anthropology. Other areas integrated by the Department will be law and medicine, philosophy of medicine, and the history of medicine. In addition, community and societal concerns such as the organization and delivery of health care services in medical economics are within the scope of the department.

The Department of Medicine in Society will have primary contact in the first two years of medical education and will cooperate with clinical departments during the last two years. The department will have a total of eighty-eight contact hours during the first two-year period, with the additional opportunity of encountering students in two-week selective periods which will follow each core curriculum quarter. The program of the Department of Medicine in Society is described in greater detail in Human Values Teaching Program for Health Professionals. (Philadelphia: Institute for Human Values in Medicine, 1976) Thomas K. McElhinney, Ed.

CONCLUSION

My goals for the fellowship involved increasing my understanding of the philosophies and implementation of medical humanities/social sciences programs and introducing me experientially to the physician's world. The experience has proved invaluable as we have proceeded to build an integrated humanities/social sciences program in a new medical school. The intensive examination which the fellowship period made possible has been supplemented by shorter trips and visits by consultants, several of which have also been funded by the Institute. This extensive experience has contributed significantly to the development of the Department of Medicine in Society and its programs.
DENNIS F. SAVER

Dennis F. Saver had completed his second year at the Medical College of Pennsylvania in Philadelphia when he spent the summer of 1975 visiting several medical schools. He is presently nearing the end of his undergraduate medical studies.

I, II, and III

My Fellowship activities fell into two unequal-sized parts, consistent with my proposal. In the major segment I studied two medical-philosophical problems for three weeks each. Secondarily, I visited a number of different medical schools that have human values teaching programs. The former pair of studies provided several "global" benefits: a substantial base for further learning, sharpened ability to separate and distinguish some of the philosophical elements in a given situation, and better understanding of the roles and requirements of interrelating philosophy and medicine. The second part of my Fellowship gave me valuable exposure to a spectrum of teaching programs, their environments, and the manifold talents of their instructors. I was led to new and sometimes unexpected thoughts about human values in medical education. I will describe first each topic study and then the set of site visits.

During three weeks at the Department of Community Medicine and Family Practice of the University of Florida College of Medicine in Gainesville, I studied (1) philosophical approaches to death via imaginative literature and (2) clinicians' approaches to a patient's death. Dr. Ronald A. Carson supervised this study and met with me four times a week for lengthy discussions. Death is a common and notoriously disturbing part of medical practice. It also has been long a focus of philosophic thought. However, disciplinary concerns have been divergent -- medicine, with how and why the mechanics of the body cease functioning, and philosophy, with the fate of consciousness.

There has been little consideration of the social role that physicians play in the death of the individual in either discipline, but this topic has been explored by a third discipline: literature. The importance of the physician's role is apparent in the mounting public interest in "death with dignity" and joint decision-making by physician and patient. A host of medico-philosophical issues are involved: What philosophical positions are useful/acceptable/reasonable for the patient and physician not only as individuals, but as members of a community?
What are the responsibilities and obligations of a physician to a patient, and also of the profession to the public?

Dr. Carson and I developed a bibliography (see Appendix) that served as source material for our discussions of how physicians face death, how the circumstances of dying can alter reactions to death, what some historical concepts such as "in the fullness of time" might mean today, and what the relationship of the physician to the dying patient should be. Literary works about death such as The Plague and The Death of Ivan Illych were rich tapestries, weaving together many facets of experience simultaneously. They were valuable for reflecting not only the existentialist viewpoint but also elements of Socratic, Stoic, Christian, and rationalist positions. However, the person-to-person interactions of physician and patient occupied the foreground in these works, and thus were important resources in my analysis of respective social roles.

As my time in Gainesville came to a close, I began to draw together my thoughts on several questions. How have philosophers through the ages thought of death and how much can their viewpoints (or some eclectic mixture thereof) inform the present? What purpose, if any, do Westerners now ascribe to death? Are physicians' views apart from or a part of the larger society? What sorts of ideas and practices might a physician find useful in dealing with dying patients? I started to work on these questions through two separate essays, whose unfinished forms I have attended to sporadically since leaving Dr. Carson's tutelage.

While in Gainesville, I spoke with the chairman and a number of faculty in the Department of Community Health and Family Medicine about the effect of the teaching program in human values on the medical students and their subsequent behavior with patients. During one day I visited the Department's rural clinic in Mayo, Florida, and learned a great deal about how it was established and what roles it plays in the community, as well as a little about the "folk medicine" that continues to exist alongside it.

The second three-week project was carried out at the University of Texas Medical Branch (UTMB), Galveston's Institute for Medical Humanities, with Dr. H.T. Engelhardt, Jr. Dr. Engelhardt has made significant contributions toward a philosophic understanding of disease, and this is the area I chose for study. After embarking on some background reading, I decided to concern myself particularly with the distinction between "illness" and "disease." This project turned out to be unexpectedly difficult to dissect out cleanly, yet I was in the best place to attempt the task. My hour-a-day meetings with Dr. Engelhardt and occasional discussions with other members of the Institute were of incalculable aid to my understanding the readings and to making my own thoughts coherent. I was able to read extensively, thanks to Dr. Engelhardt's well organized files and UTMB's superb library (see Appendix).

The subtleties of this subject matter often led me to confusion and tangential paths. I became acutely aware that my lack of training
in philosophical models was an obstacle not easily overcome. Philosophical distinctions among concepts or the implications of a line of reasoning are infrequently intuitively obvious, but need exploration through a disciplined pattern of thought. I think of this pattern as having two elements: a generic method of approach, and a repertoire of theoretical models upon which to draw. In the former I became more practiced, but my inventory of the latter was not significantly enlarged. Much lengthier and more detailed study of philosophy would be required to accomplish this.

My work with Dr. Engelhardt culminated in presenting a paper at an Institute seminar. In this paper I reviewed several historical concepts of what constitutes a disease and some modern revisions of disease theory. I then attempted to distinguish illness as a self-designated "lay phenomenon" from disease as a "medical phenomenon." This led to consideration of how these determinations are culturally bound and therefore changeable, how they have an inseparable element of value, and how they play a legitimizing role in medical diagnosis. The decision to legitimize depends upon the medical training and experience of the practitioner, and so the encounter of the physician with unfamiliar "illness" can be problematic. I argue that such problems are on the increase. In the last section of the paper I explore forms of the patient's self-concern and how these concerns relate to physicians' classical functions of providing diagnosis, prognosis, and therapy. What obligations does a physician have to a patient within this framework? This paper was presented in second draft at the seminar, and is now in the midst of revision.

While at UTMB I profited from various activities of the Institute, including other seminars, classes for medical students taught by Dr. Burns and Dr. Engelhardt, and the general spirit of energy and productivity. On several occasions I was also able to talk with Dr. Lorraine Hunt about the special workshop on humanism in medicine that she was teaching for faculty and housestaff at UTMB.

In the second segment of my fellowship I explored a number of human values teaching programs in medical schools. My intent was to gain an understanding of the strong points, weaknesses, and organization of the program with an eye toward application of such knowledge to the Medical College of Pennsylvania (MCP) where I am now a student. Course evaluations, students' opinions, and reflections of the program's faculty were all to serve as grist for the mill. I had more success with this last source than the preceding two, as the timing of my visit usually coincided with student vacation periods. Course evaluations were not always available or did not give definitive information on the questions in which I was primarily interested: Has the course newly enabled the student to perceive value issues in medicine? Has it changed his/her ideas? Does it make a difference in his/her approach to the rest of medical school? What elements, if any, are incorporated into students' patterns of thinking and behavior? Especially, how are value concerns integrated into clinical situations? In other words, while I felt that studying the role of human values in medicine while a
medical student is a priori an activity of intrinsic worth, I did not know what changes it would work. A case for instituting such teaching at MCP would be strengthened by positive outcome measures from other programs.

I sought answers in a variety of institutional styles. Drs. Burns and Engelhardt at UTMB and E. A. Vastyan at Hershey have separate, well-staffed departments in their respective schools. Dr. Robert Hudson at the University of Kansas and Dr. Glenn Pratt at the Medical College of Virginia have long-standing histories and respected places as almost "solo practitioners" of human values teaching at their schools. At the University of Florida in Gainesville, Dr. Carson is part of a relatively new program in the College of Medicine, and is embarking on a monumental joint teaching effort in collaboration with four other professional colleges of the university. Dr. Robert Hudson at the University of Colorado was in the midst of teaching the first human values-type course at the medical center, for students in the Pediatric Nurse Associate school. The commitment of the parent institutions to the human values teaching programs ranged from firm to tenuous. Universally there was opposition from at least some quarters of the medical school. Students reacted in diverse ways to the courses, and to the same course.

I talked for a half day with each of the above-named instructors. This time was very productive in educating me in the local history of their program--its political survival and growth--and in answering questions such as how many students participate, what number seek more exposure, at what time in medical school these activities occur. We also engaged in some very interesting speculation about the questions that are not precisely answerable, a category which included many of queries previously listed. Behavior is difficult to quantify, controlled studies are unlikely because there is a significant element of self-selection among medical students who pursue human values courses in medical school, and the identification of value problems is far easier than their solution in actual clinical settings. Even though measures fine enough to assess changes in patient care and physician outlook are not currently available, the mistake should not be made of substituting whatever indications are available (i.e., accepting mere indications for more than their real worth).

Despite their differences in form, style, and content, a unifying thread did run through the teaching programs I visited. Simply stated, a program's success seemed to depend not on its organization but upon the personal credibility established by its faculty and the respect that came to be granted to them as individuals. It was first necessary to pass quarantine--there would be no crusades or inquisitions instigated by these "ethics people," nor did they make others feel defensive. It was essential for non-MD faculty to learn something about clinical medicine and the environment in which clinical decision-making takes place. Over time, as the individual instructor in the human values program came to be trusted, his/her ideas came to be trusted as well. In most cases, it is not clear whether, should the founding spirit(s) leave the institution, the baton of success would be passed on to his/her replacement.
At the time of application, I had planned for the fellowship to help prepare me to teach a course, which I was thinking of petitioning to do as a senior student. Similarly, I thought that I would gain expertise in the teaching of human values, which would translate into suggestions for a program at MCP. Both of these proposals have been somewhat obviated by the unfolding of "the MCP Bioethics Story." The Dean appointed a Director of Bioethics (physician) and an Associate Director (a social worker/theologian) who are beginning by offering two electives for freshmen students. It is much more appropriate to support this effort than to work independently of it.

As one of my goals, I had naively expected to gain competency in the subtle and complex discipline of philosophy during six weeks. To do this well would require starting at a basic level in philosophy per se and progressing step by step to a solid understanding of various theoretical models over a much longer period of time. I nonetheless did make a start in the long-range project, and also sharpened my skills of disciplined thought. A minor objective, which did not progress well, was augmenting my ability to write clearly and facilely. There has been slow improvement in the former, but little progress in the latter even though I modified my fellowship proposal to allow part-time work in the fall on the papers I had painfully started during the summer. Each precious written word has flowed forth like water from a stone. Despite sixty or seventy hours in obeisance before my typewriter and countless resolutions to conclude the work, the status quo has been little altered. I think that this lack of productivity is due in part to some of the unexpected consequences of the fellowship.

My fellowship had several results that were not originally envisioned. In retrospect, the contact with my fellowship preceptors and the faculty of the teaching programs I visited was extremely valuable. Just as I believe that much of clinical medicine is taught through role models, so I believe the case is similar with human values in medicine. It was an unforeseen benefit that I met people who as role-models were not only instructive but worthy of emulation.

The other unexpected consequence of the fellowship was a change in my approach to medical school and my role as an advocate of human values teaching at MCP. One of my major hopes in visiting teaching programs went largely unfulfilled: to discover how human value issues can be raised usefully on clinical teaching rounds by students. Holding high office and demonstrating great diplomacy are probably requirements. A junior medical student is hard put to qualify for the attempt. One problem is the same sort of before-mentioned ad hominem situation that perils credibility of the faculty of human values teaching programs. Clinical instructors must already consider a student to be competent, reasonable, and intelligent before the student raises a delicate value issue, or the issue is likely to be dismissed with negative associations.

Though the reasoning is fallacious, the practical import of its frequent occurrence must be considered. More bad than good may be done by well-meaning efforts. I do not believe it is either possible or advisable to fulfill the varied, sometimes contradictory, and sometimes questionable expectations of each medical school instructor. Nonetheless, to learn the clinical and didactic teaching of junior basic
clerkships to my own satisfaction and agitate significantly for human value concerns (which are viewed with disinterest) would require for me more hours per day than the twenty-four currently allocated.

Most of my proposed goals were accomplished during the fellowship period. To review, these were:

--investigating in some depth two topics concerning the relations between medicine and philosophy, in a semitutorial fashion
--having my first experience of an extended period of time devoted solely to reading and thinking about human value issues in medicine (an opportunity not available in the MCP curriculum)
--studying the integration of human values teaching into several medical schools; the problems, successes, and potential applicability to MCP
--developing sources to draw upon for later consultation, and possible use in a speakers program

In addition, I began work on three papers which I will revise as time permits. I also met many people with whom I had extremely valuable discussions and whose role models will remain important examples for me. Some of my evaluative questions about human values teaching programs in medical schools, my expectations of learning philosophy per se, and my desire to write with facility met with only partial success. The fellowship led to a critical self-evaluation and a shift in emphasis in my approach to the junior year of medical school.

IV

I will offer no courses as a direct result of the fellowship work.

V

Three papers are in various stages of revision and will be forwarded to the Society upon completion.

VI

Approximately 15 percent of the Fellowship tenure was spent on my own campus. The remainder was spent at other institutions in the United States as described above.
APPENDIX

BIBLIOGRAPHY

I. APPROACHES TO DEATH (University of Florida College of Medicine, Gainesville)


______. "Death and the Physician," Commentary, June, 1969, pp. 73-79.


Bibliography, Part I (cont.)


Skillman, J. J. "Ethical Dilemmas in the Care of the Critically Ill," The Lancet 14 September, 1974, pp. 634-642.


II. ILLNESS AND DISEASE (UTMB, Galveston)


Broussais, F. J. V. De L'Irritation et de la Polie. Paris: Melle Delaunay, 1828. Ch. 1 (pp. 1-5) and Ch. 3 (pp 58-79).


Engelhardt, H. T. "Human Well-being and Medicine: Some Basic Value Judgments in the Biomedical Sciences," manuscript.


Bibliography, Part II (cont.)


I. The Fellowship granted me provided for one month's study under Dr. Edmund D. Pellegrino at Yale. I had planned to explore the possibility of a philosophy of medicine with him. Three emphases were originally planned: (A) the process of clinical decision-making (using philosophical epistemology); (B) discovering whether there is a difference between a medical and a human relationship between physician and patient; (C) the centrality of the body for a philosophy of man and a philosophy of medicine.

Noting only the changes mentioned in II, below, this task was accomplished without major shifts in emphasis. Dr. Pellegrino and I met several times a week for three-hour periods on a formal basis. We also met informally at other times. During these periods we focused on the central issues in a philosophy of medicine from a conceptual standpoint. In essence we attempted a philosophical dialogue (in the Platonic sense) on the nature of medicine and how it might differ from other arts and sciences. This search for a definition was fruitful, not only due to the joy of discovery, but also because it was necessary before moving to a philosophy of medicine to establish that medicine could be considered a unified discipline in its own right. Dr. Pellegrino was extremely generous in his time devoted to the topic and to me. During these sessions we tried to grapple with concepts without reference to what others might have said or written. Our own original thinking was our goal.

While this process was taking place, I read or reread and consulted the books and articles listed in the Bibliography. Beyond the fact that Dr. Pellegrino was at Yale, it was a good place to conduct research. I brought with me all the writings of Merleau-Ponty. The Yale Library, particularly the History of Medicine Library, and Dr. Pellegrino's own personal library provided more than ample resources. Tabulating the insights from the readings with our discussions revealed the following:
A. Apart from Lain-Entralgo, Scott Buchanan, and Michel Foucault, there existed little or no explicit attempt to formulate a philosophy of medicine in this century. When we discovered this for ourselves, Dr. Pellegrino suggested that we write a book together on the topic.

B. Readings articulating explanatory theory and casual evaluation in the history of medicine and related disciplines revealed a central problem: how the clinical judgment of relating universal scientific knowledge to particular individuals was possible.

C. The writings of Hippocrates, Plato, Aristotle, Galen, Pietro D'Abano, Harvey, Bernard, Strauss, and Merleau-Ponty, as well as those mentioned in A, above, led us to confirm our own decision that the uniqueness of medicine was tied to its working in and through the body.

From these three discoveries we developed outlines and plans for a book on the philosophy of medicine, taking as the starting point the uniqueness of medicine as a clinical relationship.

II. The understanding of the subject considerably deepened with the opportunity—rare, I might add—to discuss and digest philosophical concepts with a professional like Dr. Pellegrino. The genesis of this mutual interaction led to the proposal that a jointly written book might be considered. Following this proposal, the study and outlines produced during the summer fell into place, almost as if they implied such a volume. The resulting paper documentation prepared during the one-month period exemplifies this genesis:

A. Summary Reports on Our Mutual Discussions
B. An Outline of Study
C. Card File from the Readings
D. An Outline for a Proposed Book (revised twice)
E. A Conceptual Schematic for the Book (one page)
F. A Summary of Chapter Contents (4 pages)
G. A Chapter Outline for the Book (1 page)
H. A Report on the Readings (30 pages, incomplete)
I. A Synopsis for Publishers (20 pages, incomplete)

Thus, the direction of writing a book emerged from both discussion and reading, and was not contemplated until after two weeks of the fellowship tenure.

During our discussions we touched upon two very important topics that need more exploration between the humanities and the health sciences. The first was an accusation made by Foucault and by MacIntyre that Aristotle did not provide for a science of individuals. By this was implied that either medicine is such a science, or that philosophy of medicine must be a philosophy of science of individuals. This accusation seems untrue considering Aristotle's statements on the genera-
tion of animals and his highly developed concept of tragic insight. Secondly, we found attempts to consider medicine an applied science rather than a relationship between human beings. A fruitful research project could ensure a better basis for medical ethics, a meta-ethical basis, if the concept of "applied science" for medicine were thoroughly analyzed.

III. Some parts of this question have already been answered. The major result of the fellowship tenure has been a personal synthesis of several concerns: hermeneutics or theories of interpretation, cultural studies, medical ethics, and religious studies. The concept of a philosophy of medicine allows for a synthesis of insights from these philosophical areas which better relate to the plans and courses of the program I have inaugurated and presently coordinate at a medical center. Please refer to IV and V for specifics.

IV. The Program on Human Values and Ethics at the University of Tennessee Center for the Health Sciences will offer seventeen new courses for students in the following Colleges: Medicine, Nursing, Allied Health, Graduate School of Basic Medical Sciences, Dentistry, Pharmacy, and the Graduate School of Social Work. These courses are for three hours credit on an elective basis. We have already offered one during the summer quarter, and another two during the fall quarter of 1975. One of these was "The History and Philosophy of Medicine." The Fellowship tenure greatly enhanced this team-taught course.

Additional courses planned from the experience of the summer were "Decision-Making," which analyzed from a philosophical perspective the clinical decisions made by the students, and "The Body," an interdisciplinary study of the body from the perspectives of art, music and dance, literature, philosophy, psychology as a complement to the physiological studies of the students.

V. Following the summer fellowship tenure, the plans for the book developed and more revisions took place. We produced:

A. A revised book outline
B. A narrative summary of the book by Chapter Outline
C. A completed synopsis for publishers
D. Task definition (incomplete)
E. A request for further travel support to confer in person on more difficult areas of joint-authorship

A and B were submitted to Yale University Press with some expression of interest. The publishers, of course, will want to see the entire manuscript before making any decisions, and that is our present goal. (C is attached as a report to the fellows. (See Part II, below.) It includes a bibliography.)

Following the book, we plan to co-author articles that might develop one or another topic of the book. Additionally, I plan to do some research into the relationship between the Aristotelian concept
of tragic insight and the possibility of a science of individuals.

VI. The fellowship tenure was spent entirely at Yale University under the tutelage of Dr. Pellegrino. Follow-up from the tenure has taken place at our home institutions.

VII. UTCHS contributed one half of one month's salary and full benefits for one month (social security, insurance, etc.) to the fellowship tenure. Projected further support will appear in manuscript typing and time for research.
Robert F. Thompson, Ph.D., specializes in African and Afro-American art. He is an Associate Professor of Art at Yale University and for 1975-1976 served as a Master at Calhoun College. Dr. Thompson has produced two exhibitions of African arts, a number of articles, and two books.

1. The Tenure of the Fellowship; Comparison with Original Plan Submitted

I had planned to concentrate primarily on the Yoruba (southwestern Nigeria) cult of Osanyin and to use the materials on the interaction of healing and art as a base for further investigation of tie-ins and continuities and contrasts in New World black herbalism arts. What I have come up with is a broader and more general text, which I spent the spring and summer of 1976 writing up for Harper and Row. It follows the same African/Afro-American trend of historical interest but with respect to a description of several cults in Africa rather than an intensive survey of a single aspect of an African religion. I now have, and have almost completed shaping for publication in a book, evidence on the Ngbe cult of Calahar, Nigeria, and its splendid recrudescence in the West Indies, the use of the grave as a kind of "medicine" for the continuity of the lineage or the family among the Yombe (with plenty of supporting evidence for the practice of similarly decorated graves in the black south of the USA), in addition to data about the cult of Osanyin, Yoruba lord of herbalism. I am writing up these materials in a book tentatively titled The Transatlantic Tradition: Towards the History of African and Afro-American Art. But such was the wealth of data garnered on this voyage that I have enough material to begin, almost immediately after completion of the Harper and Row book, another volume specializing in the more purely Yoruba herabalism and art interactions; and this one Mouton and a Dutch circle of iconographers wants by June, 1977. So I will be very busy.

Let me recount, in a kind of informal running-diary manner, how events reshaped my proposal. In the summer of 1975 President Gowon was suddenly deposed in Nigeria and an awkward interregnum-like period ensued. My contacts in the field warned me to stay put for several months to wait and see. Accordingly, as against the possibility that Nigeria might erupt again in war, I immediately began a contingency alternate plan, starting on this side of the Atlantic, of amassing data on a medicinal-art interlock among black Americans, which I already had sufficient data to prove probably stemmed from Bas-Zaire. I did this in case I had to select a new country (which fortunately was not necessary and also led to the broadening of the scope of my book). Accordingly, until I left for Nigeria in the early fall, I traveled to Louisiana, Georgia, and South Carolina photographing old traditional
black graves decked out with medicine bottles, vases, motion-glyphs (as I call them) such as miniature airplanes, bicycle handlebars, glasses, or shoes (the actual pair of the deceased). I worked intensely the region around Edgefield, South Carolina, and Augusta, Georgia, and I worked the area about Awendaw, South Carolina, and the city of Charleston itself. In New Orleans, I concentrated on the McDonoughville old black cemetery in Algiers, across the river from the city proper, where I found an enormous amount of data—specifically, there I met what I was later to meet in a survey of Delaware and Maryland graves which I also worked before leaving for Nigeria in November—the presence of lengths of iron pipe as a bi-lingual statement next to conventional headstones, again plenty of seashells ("medicine" for guiding the spirit to the "land of demise," for as one Georgia informant put it, the sea brought us from Africa, the sea shall return our spirit, and that is why we blacks must put seashells on our graves).

And everywhere, in Louisiana, Georgia, South Carolina, Maryland, Delaware—and as far north as the Sandy Ground cemetery on Staten Island (founded c. 1830 by runaway blacks from Snow Hill, Maryland, who made their living there oysterng about New York harbor till pollution destroyed their livelihood in 1911), I found the same code: overturned, deliberately upside-down vessels, broken crockery, often pierced (medicine: to kill the object and send it with the deceased to the other world). Simultaneously, I interviewed as many knowledgeable Bakongo in the U.S. as I could discover and twice journeyed to Cambridge, Massachusetts, to sit with the great Mu-Kongo scholar, Fu-Kiau Bunseki who told me that baluka, "to die" in Ki-Kongo, literally referred to upside-downing, hence the ancient Kongo custom of placing inverted basins on graves as a kind of material hieroglyph of death. He told me that if I did have to switch entirely to Kongo that I would also meet graves with further "medicine for mediation" that would startle me with their closeness to traditional old black (Kongo-influenced) graves in the South. For instance, he claimed that the use of hollow stalks, whose ability to survive the annual slash-and-burn fires causes them to be viewed as emblems of persistence, probably explained the cryptic lengths of pipe (as hollow permanent burn-proof stalk-equivalent) on black graves. He told me of graves with mirrors (as medicine of double vision, of the reflective boundary of two worlds) embedded in them. That I had seen dramatically instanced at Sunbury, Georgia, where not only mirror fragments but even the mirror-equivalent (and splendid motion-glyph, suggesting mediation into the other realm)—the headlight of an old Model-T Ford embedded in the top of a handmade concrete tombstone. In sum, had Nigeria erupted into war I had conjured up an alternate program to fall back on, the idea being that I would apply to Zaire and study the originating impulses in Bas-Zaire between the capital, Kinshasa, and the sea. But I was overwhelmed with what I came up with and determined, as you can well imagine, that the evidence was far too fascinating (and useful for blacks in search of important links to their past) not to write up and incorporate for others to build upon as soon as possible.

In the process of adding this wing of Kongo-Carolina, Kongo-New Orleans data to my book, one of the more fascinating continuities I
came across involved the ancient Kongo custom of koma nlongo—literally, "nailing the oath" whereby, in order to ratify and make morally binding an oath (say, two parties swear to forgive and stop feuding), nails or wedges are driven into an image, the idea being that the pain of the act enrages the soul within the object, which stays permanently enraged and is only prevented from acting in a mystically dangerous way against the two parties so long as they keep their word. Compare what I learned in the vicinity of Waycross, Georgia: viz., if a black lady is troubled by an alcoholically inclined or wayward husband and wishes, as a drastic court of last resort, to frighten him into behavior of more suitable substance, she repairs—quite publicly, so as to ensure gossip networks carrying the news back to him—to the grave of a respected elder and literally strikes the foot- and head-stones as if to drive them, like nails, deeper into the earth to alert and anger the spirit within, calling upon this spirit to aid her in making her husband "shape up or else." I was led to believe that this method often works, so awesome are its implications. Nailing the image would appear to have been transmuted into nailing the stones among American blacks.

Finally, in the process of this extra research I was startled to discover that blacks used Ki-Kongo, the language of Bas-Zaire, as a virtual lingua franca in New Orleans in the early nineteenth century when they were confronted with first Spanish, then French, then English. The lingua franca was called gumbo. Since "jazz" was born in New Orleans, it struck me that many of its enigmatic and famous words, "funky," "boogie," plus words of special parlance among New Orleans healers, the whisky-plus-grave earth charm. To be for luck in gambling and the use of goofer dust (from a grave) for frightening people into better behavior might be connected with Kongo. This is what I came up with: lu-Fu(n)ki: body odor; bungi, "devil"; tobe, grave earth plus palm wine—lucky in hunting; kufwa, "corpse." By November I knew I had material for a whole new series of articles, or for (what I have decided to do) a long chapter added to my Harper book.

In late November, when I arrived in Lagos, I found the country in chaos; traffic jams snarled the city for five hours daily; Yorubaland was tense and I was challenged by police roadblocks and so forth. I decided to bypass the towns I had originally planned on working in and to go to where I was told things were quiet—Calabar, capital of the southeast state, where fortunately I had extra entree into the rather deep cult of Ngbe (leopard and healing), which also satisfied my perennial criteria of applicability to New World black cultures and civilizations. But before I went to Calabar I traveled deep into forest and farming areas of Yorubaland and worked with healers and was reinitiated into the cult of the river (Eyinle) and was taught a fascinating bit of lore about the use of leaves as ideographs: viz., each leaf in a medicinal vessel is selected not only for its actual proven use in healing but also for the puns in its name suggesting different objects used to appease dangerously psychotic elderly women ("witches") and to cause their powers of mystic destruction to function so that everyone can benefit. For example, aaju leaf puns on shaaju, "take mercy on"; agogo leaf puns on the healing agogo bell as well as the phrase agogo igun, beak of the vulture, one of the terrifying images of witchcraft.
Most important and to the point, however, was the fact that I was able to straighten out the knotty problems of symbolism linking the Yoruba-influenced 'para-medical' healers of Puerto Rican New York with the Yoruba proper. For example, I was taught in initiation why there is a bird on the staff New York healers have and a bird on those healers use in Nigeria. I was given by one priest-herbalist rich lore on the Nigerian use of inverted mortars (having an entirely different symbolism from that obtaining among Bakongo re inverted basins), which I could then beam at Afro-Cuban and Afro-Puerto Rican New York practices where mortars are also inverted in honor of the same god. The reason: eons ago in the rainy season inverted mortars collected water, and thunder hurled down if landing in the resultant pools, was dampened and ruined. Hence it is considered insulting to the thundersgod to leave a mortar right-side-up; hence the Atlantic custom wherever the thundersgod and his associated healing herbs are honored.

In Calabar town I was most extraordinarily lucky; I was initiated right into a royal wing of the Ngbe society; was taught dance steps, invocations, manners of making libations to the ancestors and to God and much more lore about the costumes which the local Ngbe masqueraders wear and which were also brought in slavery to the New World. The real break-through was in bells--one bell for a warrior, so that in time of war he can hold his hip-bell in his hand and walk warily and silently into hostile territory, many bells if the mask is female since females stand for peace; and the merry tinkling of myriad crotals and so forth is a continuous demonstration of peace and well-being. This may sound like a small detail indeed until it is appreciated that the attachment of one or several bells to further enigmatic healing instruments immediately "sexes" them; and this straightened out whole pockets of recondite lore the meaning of which had escaped me. The bell data (plus associated feather data--a circlet of rich plumes=women healers and leaders) I have been able to use as a kind of rosetta stone to unlock and classify whole congeries of Afro-Cuban masks and drums, for the feathered drums of Cuban blacks are one of the phenomena of the West Indies and they stem directly from the feathered drums of Calabar.

Most dramatic of all, was my being swept into the parade of the noblemen of the city, with the thrilling prerogative of dancing with the king to the shrines of Big Qua Town in Calabar and my being allowed, in secret, in the middle of the night, to open old notebooks of the first elders who could write in Western style (they have their own pictographic script, connected with incantations, healing, the ultimate voyage into the dead, all sorts of things which they call, as American blacks do, "heavy"). At this point I was so excited with the privilege of opening these old musty books and actually, as a brother, being allowed to copy down the incantations, canoe history (which lineage came in which canoe, when to found which town) and, best of all, the secret nsibidi signs glossed in Efik, Efut, and English, that I had acute indigestion (literally) for days. I was simply being force-fed too much information.

In sum, a splendid, powerful chapter of its own, about Calabar, and the black men sworn into the Mason-like brotherhood of Ngbe both there and its branches in the New World, sprang into life during my residence in Calabar in December. In January I did some more gap-filling Yoruba
work. But as I drove through former Biafra and noted tension and outright xenophobia, I was aware that I was lucky to have done the work at all and when I talked to our Embassy personnel I warned them that what I saw in the provinces (on the streets, as opposed to inside the shrines where I did the bulk of my work) indicated something terrible was about to happen. It did happen. Only weeks after I returned President Muritala Musa Mohammed was assassinated. The future of Nigeria is a question mark. I feel fortunate to have entered, done work, and returned home without incident.

2. My understanding of my subject has vastly broadened. I see that comparatist cultural portraiture is the only way to convey meaningfully (and with the sort of informed vigor that will attract students and enlighten ordinary readers) the transatlantic continuities of black culture. The main change in my work is that from here on out, for at least the next five books (God give me the breath) that I envision, I will simply write one specialized tome after another on the deeper aspects of what I have learned—a book on Kongo/Carolina, a book on Calabar/Havana/Nueva York, and a book on the New York Latin music scene and its relation to the herbalistic cults of African origin that many of its key protagonists secretly participate in. Continually my interest will be to show the function of black art as an instrument of healing (even if the "disease" to be cured is simply lack of confidence or inter-personal strife) and ethics (teaching proper behavior through lyrics and canonic motion). I also want to do another book on the icons of the Yoruba and have opened up new contacts and struck fresh areas of investigation on this recent fellowship. The humanities and the health professions could investigate more closely than has been done the seething cult world of which the Puerto Rican dance bands of New York, Philadelphia, et al, are but "fronts." The dance halls lead to the botanicas, the botanicas lead to Yoruba beads and remedies, these lead to Nigerian and cognate cultures. The task is endless.

3. I will open a brand-new seminar in the spring of 1977 in which I will teach the new data. I did the same last year and with the fresh insights into Caribbean/Old World continuities was able to shape a Foreign Area Training Fellowship program for another promising graduate student (Ms. Judith Bettleheim) and have the pleasure of watching her win this fellowship. She is in Jamaica now, studying dancers, healers, and the relation of their lore to West Africa. News of the data reached the organizers of the Triennial Conference on African Art, to be held this April (1977) in Washington and I have been asked to chair a paper on the black diaspora and art which I will do and give a lecture based on some of the aforementioned material.

4. I will teach new seminars on Yoruba/New World icons, Calabar/New World and Kongo/New World continuities. Specialized and intensive, these new seminars will be planned to map the areas charted by my fieldwork and to send out graduate students to test and deepen the lore I have brought in. I am also redesigning my undergraduate lecture course (trial modification was effected in the spring of 1976) to incorporate the new information on Calabar masking, Yoruba Osanyin healing symbol-ism, and so forth.
5. I have been writing up since the moment I returned in January, 1976, a full-length book for Harper and Row, with a chapter on Calabar/New World, a chapter on Kongo/Carolina and the rest of the Deep South, and a chapter on Yoruba icons and Cuba and Latin New York, and another chapter on Yoruba-Fon icons/Haiti.

6. time spent-- at Yale roughly 40%
   in Deep South 10%
   in Nigeria 50%

7. Yes.

8. I was immediately able to apply my fellowship work in May/June, 1976, with the luck of being asked to give lectures in Kinshasa, Zaire; during the course of this work I was able to lay the groundwork for continuous liaison between my research and colleagues at the National Museum of Zaire. The latter were enthusiastic about my Kongo/Carolina work and even went so far as to lend me for private use a Toyota land-rover so that I was able to go into the interior, to Yombe country, and photograph some 350 graves in assorted styles, all of which overlapped in one way or another graves in the traditional black South.

   For some reason, people still assume traditional culture is fragile and going under everywhere. Yet books like The Unmeltable Ethnics (Novak) and other close studies are showing the fallacy of such reasoning. Healers and their lore are at the vanguard of this refusal not to be different. The use of the grave as a kind of mystic "medicine" is one of the most dramatic refusals of black Southerners to give up their moral and paramedical lore that I know of. The problem is that what is one man's search to be loyal to his ancestors, in a way fragmentarily remembered, is another man's "superstition." But the medicated graves of the black south are one of the untapped histories of black continuity in this nation. Folklorists have known for over a hundred years that black graves were different, with their deposits of pipe, crockery, and so forth and I even discovered a fine poem by Wallace Stevens in point, Like Decorations in a Nigger Graveyard, but now I have the data to show why medicine bottles are upturned and inserted in the grave mound and so forth. The luck of testing in the field the Zaire component to the extra work done before leaving for Nigeria will keep me busy, as I have said, for some time.

9. It is possible that I might mount a program of study, intensive and focused on so-called "Latin New York" but I rather doubt it, frankly. My task is to write books, and someone would have to man the program, and in a clash between desk-work per se, and fieldwork-plus-writing-and-teaching-the-fieldwork, there is no question of which performance I think (and know from experience) I am best suited for. Also, in being selected Master of Calhoun College for this academic year, I will have paid the university certain dues in that direction already.
John P. Tokarz, M.D., is a Resident in Family and Community Medicine at the Hershey Medical Center of Pennsylvania State University. The survey, which he conducted during his April-July 1975 fellowship tenure, is briefly reported on below, and more fully discussed in Part II.

Introduction

The preparation for and the practice of medicine offer unique opportunities for human interaction and growth. During my fellowship I began studying and exploring the problems of ethics and human values in primary care as preparation for teaching family medicine and practicing as a humanistic family physician. My primary focus was on methods of increasing the health practitioner's awareness of the human dimension of medicine that is concerned with the patient not only as a biological entity but also as a person whose medical problems can best be understood within the context of his feelings, his will, his values, and his life as an individual.

An important part of the art of medicine involves skills and knowledge of intrapersonal dynamics, emotions, ethics, and human values. I refer to these areas as the human dimension of medicine. It is within this dimension that health professionals and patients recognize themselves as colleagues, collaborating to promote health, growth, and fulfillment. In this dimension, health is recognized as a conscious equilibrium of interdependent relationships of body, mind, emotions, and spirit. Within this dimension exists the power to transcend the reductionism inherent in the disease model of medicine and to utilize the full healing potential of personal interaction of whole human beings.

As a result of my experiences during this fellowship, I have become aware that in order to deal with the problems of ethics and human values in medicine, the health practitioner must have experiential knowledge of these problems. Books and lectures, while a necessary complement to experience, are simply not enough in themselves to enable a health practitioner to deal adequately with the problems of humanistic medicine. I have learned that experiential involvement means medical school faculty, preceptors, residents, and students stimulating one another to develop a humanistic attitude toward their patients and their profession. This includes an awareness of their responsibility as physicians and an attitude of respect for the patient as a person. This further involves recognition of the physician's own personal problems and needs.
Objectives

My general objective was to explore many different approaches toward education in the human dimension of medicine. One of the specific objectives of this fellowship was to begin to define for myself the concept of humanistic medicine. To this end, I sought to define in operational terms a humanistic physician. I also sought to identify and describe common and difficult problems in the human dimension of medicine. Because primary care offers the widest and most comprehensive interaction between health professionals and patients and, thus, the greatest opportunities and challenges to practice the human dimension of medicine, I chose to focus in this area. A more limited objective was to study the interaction between awareness and behavior that characterizes didactic and experiential education. I looked at medical education in general and education for primary care in particular. I studied the parallels and differences between education at the undergraduate, residency, and continuing (faculty and practicing physicians) levels. I explored education in the human dimension of medicine, both as it affects the quality of patient care and the level of fulfillment of the practitioner.

Methods

My learning methods included directed reading, attending conferences, observing teachers in action, teaching, and planning and leading workshops on curriculum reform. I also initiated two empirical studies: (1) A case study of the experience of faculty at the Pennsylvania State Medical School at Hershey in teaching the human dimension of medicine through courses offered in the departments of Behavioral Sciences, Humanities, and Family and Community Medicine; and (2) a questionnaire survey documenting the frequency with which practicing physicians are presented with certain problems in the human dimension of medicine and the relative difficulty they have in dealing with these problems.

Experiences and Observations

I began my fellowship in the Spring of 1975, working with Dave C. Thomasma, Ph.D. (co-ordinator), and James Shaw, Ph.D. (professor), of the Human Values and Ethics Program at the University of Tennessee Center for Health Sciences (UTCHS). Directed readings (see my article in Part II for bibliography) in the areas of primary care, medical ethics, and human values in medicine were complemented by active participation in the several seminars, courses, and discussion groups sponsored by the Human Values and Ethics Program. Through these I gained an appreciation for the relative effectiveness of various approaches toward education in this area. The programs included quarterly lectures series on human values in medicine; a series of ethical grand rounds, co-sponsored by the College of Medicine, which dealt with patient management problems created by ethical issues; a Tuesday noon lecture series, sponsored by the University of Interfaith Center; a series on historical perspectives on medicine and culture, sponsored by the Student Activity Center; a seminar on coping with death and dying, presented by Elisabeth Kubler-Ross, M.D.; and a weekly seminar on life, health, and values.
I accompanied Dr. Shaw on interdisciplinary teaching rounds where questions of human values were discussed that pertained to each patient seen on the General Medical Ward of a V.A. Hospital. The stimulation of a philosopher raising difficult and pertinent ethical issues to be discussed informally by clinical attendings, house staff, students, and chaplains developed a consciousness of the human dimension of medicine well integrated with the more traditional concerns of teaching rounds. This format proved to be much too time-consuming for consideration as a prototype of education of large numbers of students, yet was a very effective method of faculty development. The influence of this experience upon the faculty involved should have beneficial effect for their students and patients throughout their careers.

I was instrumental in the redesign of the practice profile interview guide used in evaluating family medicine practices for suitability as perceptorship sites. I wanted to discover the physician's perception of problems in ethics and human values that relate to primary care. While utilizing this guideline to interview practicing physicians in their offices as well as during a conference exploring these issues, I gathered the information that led to the development of the questionnaire project described below. As an instructor in the nurse practitioner program at the primary care center of the University of Tennessee, I learned how difficult it can be to deal with the problems presented by ethical and human value considerations in primary care. I also experienced the frustrations inherent in effectively teaching health practitioners how to deal with these problems. The rapidly evolving physician assistant programs present a useful model for studying many of the problems and possibilities of medical education in general. Because these programs involve fairly small numbers of students (15 to 30) in a compressed curriculum (usually about four months of classroom training and eight to twelve months of clinical experience), the effect of changes in the design of curricula and learning experiences can be evaluated much more rapidly than in more traditional educational programs. Thus, the feedback loop so essential to the continuous improvement in educational programs has a much shorter lag time, allowing for more flexibility and more rapid evolution. The lessons learned in a relatively short period of time with small numbers of students can then be translated into improvements in more cumbersome systems.

For example, in the nurse practitioner program the instructors observed that a high level of anxiety was interfering with effective learning. A series of brief workshops utilizing principles of group dynamics helped to focus the students' attention on their problem areas and to generate from their brainstorming suggestions for redesigning their educational program to deal with their problems. One major source of anxiety proved to be the difficulty the students had in developing realistic expectations toward their learning experiences and for their own future performances. Directed talk sessions with faculty advisers and early exposure to practicing physician assistants in a patient-care setting were useful in aiding the students to develop more realistic professional and personal expectations and thus alleviate counterproductive anxiety. These methods, developed and tested in the
physician assistant program over a period of a few months, were then available for modification by the faculty counselors and curriculum designers responsible for the education of other health practitioners.

The most effective education in the human dimension of medicine takes place through extensive experience with a good role model in a clinical setting. At the University of Tennessee I developed guidelines for an elective for students to investigate in a preceptorship setting what characteristics of a practicing physician make him or her a good role model in terms of reinforcing the growing, humanistic, student physician. This elective, undertaken with proper enthusiasm, could be one of the most valuable learning experiences available to student physicians interested in the human dimension of primary care.

While senior adviser to the Medical Education Committee of the American Medical Students Association, I planned and coordinated an organizational meeting to explore how AMSA could stimulate the growth of effective medical education for humanistic primary care. The meeting was held at the Hershey Medical Center of the Pennsylvania State University, a school with an international reputation for major innovations in medical education. A task group of medical students from around the country came to study how this school (HMC) deals with the three problem areas identified by the committee as most crucial to medical students and their future patients. These three areas are (1) evaluation of teaching effectiveness, (2) humanization of medical care, and (3) teaching for and delivery of primary care. This committee also agreed to investigate the possibility of publishing an annotated bibliography for medical students interested in stimulating effective education for humanistic primary care, based on my bibliographies. During a subsequent AMSA conference in New York City, this project was once again approved, and funding is being sought. During this latter conference, I helped to organize a workshop in which medical students discussed their ideas for effecting the changes in their own institutions necessary to stimulate such education.

At the Hershey Medical Center I worked with Donald Kennedy, Ph.D., the director of research in Family and Community Medicine and a member of the Department of Behavioral Science. With his guidance and the help of E. A. Vastyan, B.D., professor and chairman of the Department of Behavioral Science, I designed and began work on two specific research projects. The first of these was a case study of the experience of the faculty at Hershey in effective education in the human dimension of medicine. A summary of this study is included in this fellowship report (Part II).

The second project was a documentation of the frequency with which family physicians perceive problems with different areas in the human dimension of medicine and the relative difficulty of dealing with these problems. Included in this fellowship report (in Part II) are a copy of the questionnaire itself, the introductory letter explaining it, and a compilation of preliminary findings based on responses of over four hundred practicing family physicians in the state of Pennsylvania. (Further data generated by this project, as well as the complete text of the Hershey case study, are available from the author.)
The experiences afforded me through this fellowship have significantly enriched my appreciation of the relationship between medicine and the humanities, and the synergistic energy generated by interdisciplinary work. Occurring during a six-month period between the end of medical school and the beginning of my residency, this fellowship was particularly valuable for me on a personal level. I needed the time to reflect upon the intense and often frustrating experience of undergraduate medical education while I was preparing to enter an even more intense training period. As a result of my experiences in this fellowship, I have changed my approach toward understanding the human dimension of medicine from didactic methods of study and reflection to an emphasis on experiential involvement. Although didactic methods are useful in increasing the awareness of concepts and problems in the human dimension of medicine, it is only when they are complemented by conscious experience that true learning takes place.

The only true measure of the effectiveness of education is the behavior of students and practitioners. The most effective educational experiences are those in which the student has real personal responsibility. In medical education, this takes place at the clinical level: on the floors of the hospital, in the clinic, and in the offices of private practitioners. The most effective education in the human dimension of medicine takes place in an extended preceptorship experience with excellent role models. In a primary care setting, this process can be facilitated by incorporating in the selection process a mechanism to identify preceptors who behave in a desired fashion toward patients. The bulk of medical education, however, takes place in medical centers where the role models are a self-selected group of clinicians who often value academic and research aspects of medical practice above more humanistic concerns. It is the clinical faculty, then, who could profit most from experiences designed to heighten their awareness of the human dimensions of medicine and their pivotal role in shaping the behavior of future practitioners.

Residents' behavior is even more influential on the behavior of medical students. Students and residents spend a significant amount of time together, shoulder to shoulder, caring for the real problems of individual patients. A resident who is comfortable in identifying and dealing with significant problems of ethics of human values in medicine can have a significant, positive effect on the behavior and attitudes of students and clinical faculty alike. Residents are in a very crucial phase of their professional development. The attitudes and actions that they learn at this stage profoundly affect their future behavior as physicians. Mechanisms must be developed to enable residents, students, and faculty to actively help one another become aware of and deal with the problems in ethics and human values intrinsic in the daily activities of teaching, learning, and patient care.

One method of significant value has been a weekly personal growth session for residents and faculty, facilitated by someone skilled both in personal dynamics and in dealing with problems of ethics and human values. Since beginning my residency in Family Medicine at the Hershey
Medical Center, I have been able actively to participate in a weekly session with five other first-year residents and six faculty members in the Department of Family and Community Medicine, facilitated by Mr. Vastyan, the chairman of the Department of Humanities. The participants have repeatedly expressed their excitement and satisfaction with these excursions into encounter and self-discovery, both verbally and by their consistent involvement. This active exploration of the human dimension of medicine enjoys the best attendance of all the optional conferences of the department. This format has proved to be a valuable method of recognizing and dealing with common personal and human value problems that present themselves in medical practice, teaching, and everyday life. Beyond the primary benefit to the individuals involved, however, are the secondary dividends enjoyed by the patients and students of these individuals who have learned to function with more facility in this dimension.

During my fellowship period I began to collect data sufficient for three potential publications. One of these is a case study of the Hershey experience, another is the questionnaire project with practicing physicians, and the third is an annotated bibliography of books and articles relating to problems of human values in primary care.

I spent approximately 40 percent of my time at the campus of the University of Tennessee Center for Health Sciences, 40 percent at Hershey Medical Center, and 20 percent at other institutions or locations in the United States. During my fellowship period, the University of Tennessee provided approximately $2,000 for my work. The Penn State Medical Center at Hershey provided approximately $2,000, as well as printing fees and professional assistance; and the Pennsylvania Academy of Family Practitioners provided approximately $300 worth of postage and processing.

During my residency I have been able to continue work in this area with assistance from the Penn State Medical Center, including released time for conferences, research and secretarial assistance, and the opportunity to teach both medical students and physicians' assistants and be involved in curricula development.

In conclusion, I would like to emphasize that this fellowship has afforded me very valuable experience in which to begin learning about the problems of ethics and human values in primary care and possible approaches toward educating health practitioners to deal with them effectively. I would like to thank the many people who made this experience possible.
Albert Van Helden, Ph.D., is Associate Professor of History at Rice University in Houston, Texas. Dr. Van Helden spent time in studying the History of Medicine in order to prepare an undergraduate course. His study was carried out in England and at the University of Texas Medical Center in Galveston.

In April, 1975, I was awarded a grant by the Institute on Human Values in Medicine in order to prepare myself to teach an introductory undergraduate course in the history of medicine at Rice University. The period of the grant was from 1 July to 31 December, 1975, and the work was to be pursued at the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston, Texas. Due to the curtailment of activities during July and August at this institute, it was subsequently decided, with agreement from the Institute on Human Values in Medicine, that work on this project would be carried on in London, England, in July and August, and that my residence at UTMB would be from 1 September to 31 December, 1975.

In London I consulted with Dr. A. Rupert Hall, Professor of History of Science and Technology, Imperial College, University of London, and Dr. William F. Bynum, Head of the Subdepartment of the History of Medicine, University College, University of London. During this period I concentrated on the basic background in the history of biology. Abundant sources were available in the departmental libraries at Imperial College and University College, as well as in the British Library (British Museum), the Wellcome Historical Medical Library, and the Warburg Institute.

During my tenure at the Institute for the Medical Humanities at Galveston, I worked closely with Dr. Chester R. Burns (History of Medicine), Dr. James P. Morris (History of Medicine), and Dr. H. Tristram Engelhardt (Philosophy of Medicine). I attended the following courses:

1. The History of Public Health. Instructor, J. P. Morris. This is a three-hour, lecture-discussion course, taught to graduate students in epidemiology. I acted as student and consultant and also lectured several times.

2. Topics in the Humanities, designed for baccalaureate health professional students at UTMB. Instructor, C. R. Burns. The course was a three-hour seminar-discussion course, involving twelve students (six nurses, six occupational therapist), several graduate students working on their Ph.D. in the philosophy of medicine at the Institute for the Medical Humanities, and a research assistant. The two main topics dealt with this semester were "Resolving Problems in the
Care of Terminally Ill Patients," and "Child Rearing in America: Historical and Philosophical Considerations."

While "The History of Public Health" was related to my personal aims in an obvious way (and was as such extremely useful), "Topics in the Humanities" was important in my program in a more subtle, but equally important, way. It made me sensitive to medical issues themselves and opened conceptual doors that are already proving to be extremely important in my teaching.

During my residence in Galveston I gained expertise in the history of medicine per se (as distinct from the general history of biology) and laid the foundations for the course taught in the spring of 1976 at Rice. For this, the Moody Medical Library was ideally suited with its excellent collections of monographs and periodicals in the history of medicine and related subjects.

The following are preliminary observations made during my tenure at Galveston and the first two weeks of teaching the history of medicine at Rice University:

It can be argued that in the demanding professional training in medical school, a full-fledged course (or courses) in medical history makes intellectual demands that few medical students are willing to meet, even though they feel that the subject is inherently interesting and in some sense important, or even relevant. In numerous conversations with medical students at UTMB, Baylor School of Medicine, and the University of Texas Medical School in Houston, I have found this to be the predominant attitude. Medical students will go to occasional lectures on the history of medicine, but see the subject as at best an appendage to the core curriculum. They agree that if medical history is to be part of a physician's education it can best be learned at the undergraduate level. Teaching medical history at the undergraduate level, however, presents these several problems:

A. Expertise. A small university such as Rice cannot justify hiring a professional historian of medicine to teach that subject alone. More likely, such an institution will hire a historian of science willing to teach other subjects such as the history of technology and the history of medicine. Yet, the history of medicine requires special expertise not easily gained in a historian's training. Very few institutions (e.g., the University of Wisconsin, The Johns Hopkins University, and Yale University) offer graduate training in both the history of science and the history of medicine. Lacking expertise in the history of medicine, I had to take leave of absence in order to prepare myself to teach this subject.

B. The Students. The history of medicine is an important part of both intellectual history and social history. As such it has a legitimate place in any general history program. Since there are few required courses and few prerequisite courses in the humanities at Rice University, the history of medicine can be taught only as an
elective. For this reason students with a variety of majors enroll in it. About half the students in this course are premed majors. Obviously, then, such a course cannot be tailored to one specific segment of the undergraduate student body, and this puts restraints on the teacher's expectations of students' expertise. Short of allowing only junior and senior premed majors to take the course (a policy frowned upon by the Rice administration), not much can be done about this. Yet, the varied backgrounds and levels of expertise of the students in the course are also important factors in stimulating discussion: students in the course appear to be learning from one another.

Some of the pressure of medical school appears, however, to have worked itself back into undergraduate education. Premed students at Rice are concentrating heavily on scientific subjects and are extremely "grade-conscious." Since few of these students have taken humanities courses before, and many have never written a term paper, they feel they are in unfair competition with students whose major subjects have required them to write numerous papers. It is not that premed students are unwilling to do the work; indeed my impression at this point is that they are working much harder in the course than other students. It is rather the uncertainty of a paper. No matter how they work, they might get a poor grade on the paper and therefore get a poor grade in the course. (To premed students any grade below "A" is a "poor grade," for obvious reasons.) In my course I require a ten-page paper (30 per cent of grade) besides a midterm (20 per cent of grade) and a final examination (50 per cent of grade). It is apparent that many premed majors decided not to take the course after being told of this requirement. Obviously the fact that this particular course requirement drives away the students who potentially stand to gain most from the course raises serious questions as to the role of term papers in such a course.

C. Readings. Thus far the single biggest problem in teaching this course has been finding suitable readings. In a small group one can have recourse to the many excellent articles. However this is impossible in a larger introductory course. Large-scale reproduction of articles is costly and, in many cases, requires permission from the holder of the copyright. This latter procedure is long and complicated in the case of numerous articles. The course readings, therefore, have to be in paperback books, and here the choice is disappointingly small. For example, after reading Robert Hudson's endorsement of Sigerist's Great Doctors (Clio Medica, 1975, 10:157), I was disappointed to learn that it is out of print. I ended up with Singer and Underwood's Short History of Medicine as a core text, even though I disagree with their "Whig" notions. The present reading list has numerous shortcomings, and I hope that I will be able to improve it with the help of the students in this course.

CONCLUSION

Although medical history was not entirely terra incognita to me,
my expertise in the subject was not sufficient to allow me to teach it. Yet, my colleagues at Rice and I agreed that it would be a very valuable addition to the Rice curriculum. The fellowship granted me by the Institute on Human Values in Medicine allowed me to prepare myself to teach the history of medicine, but it also gave me a welcome opportunity to expand my personal intellectual horizons. My tenure at the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston was an extremely stimulating intellectual experience. I am profoundly grateful to the Institute on Human Values in Medicine for giving me this opportunity.
HISTORY 370
Spring, 1976

Instructor: A. Van Helden

Required Reading


All readings are on reserve under this course number. Items 1, 5, 7, 8, 9, 10, 12 can be bought in the Rice Campus Store.
Course Outline by Weeks

Primitive Medicine.
Egypt, Mesopotamia, India, China.
Greek Medicine.
Graeco-Roman Medicine.
Islamic and Medieval European Medicine.
The Scientific Revolution.
Film, Discussion.
EXAMINATION
18th-Century Medicine.
19th-Century Biology.
19th-Century Scientific Medicine.
20th-Century Scientific Medicine.
Social Medicine 1700-1850.
Social Medicine 1850-Present.
Psychiatry. (PAPERS DUE APRIL 14)
Medical Education and Professionalization.
FINAL EXAMINATION
PART II

PAPERS PREPARED IN CONJUNCTION
WITH INSTITUTE FELLOWSHIPS
I find the relation between therapist and patient in psychiatry to be unique among the disciplines in medicine. This uniqueness can be characterized by two major observations: First, the object of the therapist's activity is the diagnosis of the illness, as in other branches of medicine; but unlike other branches, this illness is being objectivized by introducing the subject of the therapist into the diagnostic process. In other branches of medicine the therapist has (hopefully) a close personal relation to the "person" of the patient in order to make progress in defining the person-alien disease that is to be separated from the person by therapy. In psychiatry the line separating "disease" and "personhood" is liquid insofar as the personality of the patient is diseased. This illness affects the person to a greater or lesser degree. The philosophical issues of autonomy and personality, and the theological issues of guilt and redemption, closely relating to autonomy and personhood, gain focus through this fluidity of identification and alienation between therapist and patient. I would like to illustrate this by several case studies.

A thirty-nine year old woman was admitted to E-2, the locked psychiatric ward of the Albany Medical Center. She had a history of paranoid schizophrenia, dating back twenty years. The reason for her admission was that she put a match to her hair trying to burn out the "radio" in her head. A few years ago she attempted to do the same, and only recently she obtained an axe to "cut out the radio in my head." Her long periodic hospitalizations, ranging from a few months to several years in duration, made a diagnosis fairly easy. This woman lived by herself, within blocks of residences of her two younger brothers and her mother. She had held jobs off and on, but never for longer than a few months. Since my special interest is the use of religious language by psychiatric patients, I became interested in this patient because she felt "directed" by others. Her "radio" had the ability not only to cause others to talk to her, but even to listen to her thoughts so that there was never a private moment. She felt constantly observed. People, i.e., the "voices", were out to "get" her, and this delusion, which was mainly auditory in nature, spilled over into apperception of physical presence. She heard voices not only in her radio, but also in the attic and in the basement and even within the closet of her room. The attempt to silence the voices had physical manifestations insofar as she wanted at least to close the door of the closet within which strangers trying to direct her had hidden. But just as it appeared to her altogether impossible to silence the voices, so also she could not close the closet door. In conversation with her she stretched out her hand, tightly clasping the imaginary door-knob, to illustrate how strenuous it was to close the closet door.

Other directedness and self-alienation are hidden theological issues, but they become especially relevant when their phenomenological
description is religious in nature. The patient heard a "cross, on which she was going to be nailed and tortured, being banged together in the basement. In addition to the nailing, the torture was to consist in burning skin off her face with a red-hot iron. This image was taken by me to indicate another aspect of her twenty-year-long struggle to find her self-identity. Another religious symbol employed was that of the devil and, as can almost be expected, sex was closely related. The patient had feelings of guilt at having had sex with the devil. She could pinpoint the time (by a day and year near the interview time) and she indicated that this had happened once before a few years ago. She explained how now the devil was within her, a vivid expression of a lack of self-identity. How much the theological issues of her religious delusion were a part of the psychological problem of lack of self-identity gained even more significance when the "voices" talking to her were identified as certain band leaders such as "Al Capone" and other public personalities (such as radio announcers). From conversation with her it became apparent that she listened almost constantly to popular AM radio shows - she did not work and was at home literally twenty-four hours a day, seven days a week, even her shopping being done by her younger brothers. The "band leader," trying to program her behavior, appeared in other names but was always the same person. Twenty years ago, when the rock craze descended on the teenagers, the patient apparently had had a psychopathological proces of personality identification.

One of the most significant aspects of my conversations with the patient was a brief episode in which I asked her how old she was, which was a rhetorical question on my part--I had previously looked into her history-- in order to establish a bridge of communication. After telling me her correct age of thirty-nine, I mentioned that I was just as old, at which she stared at me with incredulity exclaiming: "That cannot be. You must be kidding!" It did not seem ridiculous to me at all. The patient was obese but looked to me to be thirty-nine even though the psychiatric resident who had admitted her thought that she looked "much older" than her thirty-nine years. At my inquiry, why it could not be that our age is identical to within two months, she exclaimed: "You look much older!"

It took a week-end for me to interpret this statement adequately, but on the Monday following, the picture was complete. During the previous conversations the patient had several times made remarks like: "What is going to happen to me? What is my future to be like? My life has hardly begun, I have hardly lived!" The patient perceived herself as a youth because, in fact, nothing had happened during the twenty years of her life, beginning with her nineteenth year, a time when for most people the most productive years of life begin. The patient remembered the termination of the most hopeful and promising part of her life with the most bleak and eventless second half of her almost forty-year-old life.

A basic anthropological issue had been raised with these observations. No doubt a "pathological" phenomenon comes to light here,
but nevertheless one that raises basic anthropological issues relevant
not only to the ill, but also to the healthy. The pathological deter-
mination of the patient's observations had been made by Karl Jaspers' 
General Psychopathology, which first appeared in German in 1913.1 For
our purposes especially the remarks about "awareness of the future, the
future vanishes"2 are of relevance. Our patient observes something
about her life that most normal people observe but fleetingly: that time
inexorably passes on, but that the person really remains in one place.
The phenomenon indicates a lack of self-development and thus lack of
synchronization with external time. Internal time stands still; there
is no internal development, while external time rushes on and on. The
body is perceived to participate in external time, because it is grow-
ing older, inexorably moving closer and closer to the grave. This
lack of synchronicity between internal time and the development of the
person is observed with great pain. Most normal people frequently muse
about time inexorably moving on and they seriously question personal
growth, but the question remains a genuine question, and is at least
tentatively answered positively. In any case, most normal people have
little chance to muse for long, because the events in which they are
inextricably tied up sweep them along, effectively denying any serjous
doubts of personal growth. The moving from horizon to new horizon3 of
new tasks, creates the web of meaningful continuity and progress in
personal growth externalized in significant participation in external
events of vocation, family, society, and politics. The schizophrenic
"split" of consciousness vanishes quickly in the normal person so that
the quite legitimate philosophical question is rapidly overcome (raised
by the Buddhist incessantly turning his prayer wheel), the question
which essentially leads Hamlet to ask his famous question: "To be or
not to be, that is the question," and which is most formally stated
in Kant's Critique of Pure Reason in the first form of the Antinomy of
Reason.4

For the normal person this question can momentarily be a very pro-
found existential question that quickly vanishes with immersion in re-
newed tasks. At most, these profound questions become an intellectual
luxury for the student of philosophy, an esthetic preoccupation for
the educated or the student of art who may look at Dali's painting of
the "clocks" or at Munch's painting The Cry. Existentially the "normal"
person does not permit such musings to seriously hamper the immanent
flow of time. But our patient experienced something expressed by
Jaspers in these words: "Another schizophrenic woman described the
painful admixture she suffered of emptiness, nonexistence, time stand-
ing still and the return of the past:

'Life is now a running conveyor-belt with nothing on it. It runs
on but is still the same...I did not know death looked like this...
I am now living in eternity...outside everything carries on...
leaves move, others go through the ward, but for me time does not
pass...when they run around in the garden and the leaves fly about
in the wind, I wish I could run too so that time might again be
on the move, but then I stay stuck...time stands still...one swings
between past and future...it is a boring, endless time. It would
be fine to start again from the beginning and find myself swinging
along with the proper time, but I can't...I get pulled back,
where to? there where it comes from, where it has been before...

it goes into the past - that is what is so elusive...time slips

into the past...the walls which used to stand firm have all fallen
down...do I know where I am, oh yes - but the elusive thing is

there is no time and how can one get hold of it? Time is in
collapse.'" (Jaspers, ibid., 86f.)

What our patient referred to with the remark that her life had

hardly begun is identified by Jaspers with the remark that there is

"proper" time and thus, conversely, "improper" time, the time marked

by being "out of things," by not being "moved" and "being stuck." Our

patient observed that the interviewer was "much older" than she herself

was (in spite of the fact that the admitting therapist had observed

that she looked older than her age) because she perceived in him a
time experience that she lacked, that time experience which V. E.
Freiherr von Gebsattel calls the "flow of immanent time."6 Edmund
Husserl has indicated7 that the "temporal horizon" of daily lived
life is obviously different from that dimension of time which Gebsattel
calls, together with Honigswald, "transeunte" time.8 The chronologically
proceeding time is an abstract and therefore fictitious time in re-
lation to my real experience. Husserl writes:

"Moving freely within the moment of experience which brings what

is present into my intuitional grasp, I can follow up these con-
nections of the reality which immediately surrounds me. I can
shift my standpoint in space and time, look this way and that,
turn temporally forwards and backwards; I can provide for myself
constantly new and more or less clear and meaningful perceptions
and representations, and images also more or less clear, in which
I make intuitable to myself whatever can possibly exist really
or supposedly in the steadfast order of space and time...There-
fore this world is not there for me as a mere world of facts and
affairs, but with the same immediacy, as a world of values, a
world of goods, a practical world."9

When our patient frettingly observed, "My life has hardly begun"

and "What will happen now?" she had left the plane of immanent flow of
time in which I engage myself as a person, pushing events into some in-
tended and meaningful future direction; and she observed from the plane
of the abstract, merely chronological flow of time the basic indiffer-
ence of each moment. One moment is not more value-laden than another,
as the healthy person experiences it, but is rather neutral, because from
the absolute perspective of total remoteness from temporal "reality"
indeed differences10 disappear and "all is vanity," as the writer of
Ecclesiastes expresses it in the Old Testament. Our patient has there-
fore in her depression indeed observed profoundly basic problems in
our time consciousness.11

Our patient complained that her life had hardly begun and that

for twenty years life had stood still. Life moved on around her. As
Dr. Fischer's patient, described by Jaspers says, life is now a running
conveyor belt with nothing on it; that is, within her there is nothing
going on, nothing moving; all events are neutral and indifferent. The
fact of a sedentary and immobile external life, which certainly charac-
terized the last twenty years of our patient, is no explanation of her
inner despair. For example, Kant never set foot outside the city
limits of Honigsberg and did not move about within the city all that much, and yet a visitor listening to Kant describe the Bridge of London in a lecture was certain that the precise detail of his description could only stem from an on-the-spot observation.

We must, rather, suspect that the situation is to be explained the other way: Because of the paranoid schizophrenia the inner development of our patient has ceased; events are no longer value-oriented; intentionality no longer characterizes the affect of the patient. All engagement within the "real world" ceases, and the natural openness of any phenomenon with which we are confronted is perceived as no opportunity for our patient to drive it onward to an intended outcome, as is the case with the normal person. Events are, in fact, perceived to be unambiguous, unchallenging.

To explain this dimension of a depressed schizophrenic, and at the same time to add a theological dimension to the anthropological observations that we are making, I would like at this point to cite a case observed by Freiherr von Gebsattel, dealing essentially with the same phenomenon of a disruption of time awareness. It is significant to observe as Hans-Georg Gadamer has done that the Christian emphasis on the dignity of contingent data is intimately related to the dimension of having an open future, to the hopefulness of any given situation. To the proper identification of given phenomena belongs this dimension of hope or futuricity, for without this dimension matters are indeed irrelevant to me. What we have before called "value" or "intentionality" gains here a special and theologically reflected significance. Von Gebsattel describes a patient who comes into his office saying:

"I have the whole day a feeling saturated by fear, which is related to time. I must constantly think that time passes away. While I now am speaking with you, I think with each word 'gone,' 'gone,' 'gone.' This condition is unbearable and causes a feeling of being hassled. I am always in a hurry. The haste begins when I awake in the morning and attaches itself to noises. When I hear a bird peep, I must think: 'That has lasted a second.' Drops of water are unbearable and get me into a rage because I must constantly think: 'Now another second has passed, now another one.' It is also impossible for me to travel by train, because the thought that I have to be at the station at 2:05 P.M. is for me just as unbearable and frightens me just as much as the thought that I need twenty minutes to get to X. If I think of a wedding the thought is unbearable because I have to think that the celebration in church will take an hour. If my sister writes that she will come in eight days on Sunday at 8:09 P.M., I cannot understand this. I cannot understand that people make plans and connect meaning to such precise indications of time and yet remain altogether calm. Therefore I feel alienated from all people, as if I do not belong to them, being altogether different from them. When people speak, I cannot understand them; that is, with my brain I can, but in another way I cannot understand them at all.
that they talk so simply and quietly and do not constantly think: Now I talk, that lasts so and so long, then I will do this, then that, and all of this will last sixty years, then I will die, then others will come along who will live also about as long and who will eat and sleep as I do then yet others will come and so on and on, without meaning, thousands of years."15

Meaninglessness and death are at the basis of the self-and world-perception of this patient and to the one we had looked at earlier. Gebsattel goes on to explain how the patient describes all her experiences as "horrible" because death is constantly envisioned as the end of any particular phenomenon, lasting only to its natural end-point in time, and also the end of her own life as the end of the sequence of all of the ending phenomena of her life. The perspective is pathological because it is past-oriented, looking only at the passing and closing of an event and not at the future and open dimension of life.

The point of special interest to us is twofold: First, all events are, in this perception, really neutral and indifferent, and secondly, related to this, the patient feels herself unattached, remote, and without commitment to them. The words "past," "future," "indifferent," and "different" are related in this way: If events are perceived as inexorably following their predetermined course, their ending is constantly anticipated, and no different outcome can possibly enlighten the horizon. There can be no frustration here, only hopelessness. Since all events are perceived in this manner, there is only an eternal recurrence of identity; never is anything different or new happening. And from the perspective of "a thousand years" hence, everything has really already passed away. Detachment, lack of differentiation, and darkness prevail in this situation. There is no sense of participation and no sense of morally constructing a universe. The reason for introducing this word "morality" here flows naturally out of our observations: The healthy person does not experience events as indifferent or neutral, inexorably approaching their natural completion without interference by an outside agent. Rather, the healthy individual understands himself as an agent within a completely open world; his own temporality, the openness within his own life, the conditions of hope and anticipation (both joyful and fearful) are merely the existential and subjective aspects of the ontological and objective "world" in which he lives and which he constructs for and around himself. Future-orientation moves from completion of one task to completion of another task. The completion of one task (or even the failure in it) leads the healthy person to tackle other things, and the "intentionality" and "value"-orientation causes him to develop reciprocity of significance between self and world. Gebsattel, in his attempts to develop a medical anthropology, can go so far as to qualify the termination of various tasks and epochs in one's life as the "dying" of such a task and epoch,16 always, however, with the characterization of such a termination being at the same time the orientation to new things. The healthy person, living within the "immanent" flow of time tied reciprocally into the flow of time of the "world" time or outward events, thus develops greater and greater segments of meaning in his own life by moving from greater and greater segments within his own
life-span closer to his own death. In this manner, death, the physical
dying of the person, can be viewed at the same time as the consummation
of life and one's life's task. Being thus driven on to an ever greater
fullness of meaning paradoxically causes for the healthy person an un-
awareness of the flow of time. Gebsattel writes: "Only when this
living relation toward the future in all our activity, only when its
meaning of becoming has been lost through the endogenous barrier, only
then can our consciousness become aware of the phases of this activity
as atoms of movement and only then can they be registered in this obses-
sive manner." (ibid,11). The loss of future implies at the same time
the loss of participation and ethical motivation to this or that thing,
to engage in this or that cause. Meaning and moral engagement are
identical, and they are created only by the perceived openness of a
situation. Seeing oneself as removed out of the significance of the
situation and experiencing it as self-contained and inevitably un-
raveling, i.e., developing by its own inherent law—the Greek notion
of fate,17 which unavoidably unravels—causes the obsessive observation
of the passing of time. If, however, one is an actor within the flow
of the event, the passing of time is not observed.

Future-orientation and moral engagement are therefore significant
aspects for which Christian theology can provide probably the only
sound foundation. But this thesis is not yet altogether adequately
developed. There are various kinds of "futuristic" philosophies that
do not need the label of "Christian" and that, in fact, are sometimes
outspokenly anti-Christian. Marxism is one example, and often the
Hegelian philosophy standing behind Marx is quoted as another example.
Process-philosophy might be quoted as a third kind of philosophy not
necessarily needing the label "Christian thought." In what way can the
Christian theologian make a unique contribution?

Hegel has, in fact, provided a sound argument for a stabilizing
futurism. If one danger of becoming conscious of the flow of time is
the orientation toward the past, then another danger is what Hegel
called "progress," which is without a "point of rest" and which is
"being eternally driven along." There is an unguided and a guided
futurism, according to Hegel. The ability to observe with discretion,
to differentiate appropriately, to engage morally in the immanent
flow of time adequately and not merely "here" or "there," wherever
one willfully decides—this ability is provided by the "guide."18
This is a decided philosophical argument insofar as thought finds
fault and irrationality in an "eternal progress" "without any point of
rest" and without the ability to gravitate to this or that point of
import. Is it left up to pure willfulness to "decide" what is import-
ant and what not? Can the healthy person "engage" himself wherever he
wants? Is a sign of health simply moral engagement and standing within
the future-open flow of immanent time? These are questions that cannot
be answered here, because that is not our task. But one can at
least indicate that Hegel, widely misunderstood, indicated means by
which one need to abandon neither in favor of pure willfulness and
pseudo-sophisticated "pluralism" of thought notions that do not merit
the label "philosophy," nor in favor of an absolutist interpretation
of history as divinely necessitated and directed (the popular inter-
pretation of Hegel), in which the chance and unexplainable event can-
not be perceived. To the contrary, Hegel's philosophy is probably the
only one in which the concept of absolute chance has ever been reason-
ably argued for.19

To carry our anthropological considerations one step farther, one
other case with which I have had some experience can be mentioned be-
cause it is of immediate relevance to this problem. It concerns a
twenty-five-year-old woman who was voluntarily admitted to the E-2 ward
of AMC. The reason for her admission was "bizarre behavior." She had
been living with her alcoholic aunt but became violent, insisting she
was the devil and, indeed, behaving as such. She threw chairs and
other heavy objects through the apartment in blind rage. She had a
very high level of erotic activity, masturbating during an interview.
She knelt in the middle of the street, begging God to take her obses-
sion from her. When asked during an interview what she had been doing,
a mere rhetorical question designed to get the interview going, she
answered "I have been counting the colored lights for God." When
further asked what that meant, she would not elaborate, indicating
that there is no use talking about it because we would not understand,
that she alone had been initiated and we were in the dark. The inter-
esting thing was that her "illumination" was of an evil kind and that
she suffered under it. God had put this burden on her, had cast her
into "hades," so that she is "a devil." The woman was clean and good-
looking, but upon admittance obviously rather disturbed and distrust-
ful. The load that God had put upon her was a "God-it," and God fre-
quently placed such "God-its" upon her, such as having to count the
colored lights. Her compulsive sexual behavior was another example,
as was throwing chairs. To relieve her of this compulsion, she would
pray for an "Up this it." Repetitiveness and compulsiveness are ob-
vior signs of this kind of disturbance.

Apart from the psychiatric analysis of this case the theologian
is struck by the pronounced feeling of guilt, and furthermore, by the
state of anxiety and suffering—the woman was extremely agitated,
especially in interviews, bobbing her one leg, crossed over the other
one, so much that frequently the interviewer's leg would be painfully
hit. The agitation also manifested itself in uncontrollable crying
spells, loud wailings and beating on the wall. The theologian, further-
more, was forced to wonder why the question of theodicy had to intrude
in her life. The question of theodicy was first formulated by Leibniz
and then put into very precise philosophical perspective by Kant in his
little essay Über das Misslingen aller Philosophischen Versuche in der
Theodizee of 1791.20 With this essay the aporia of the issue becomes
apparent, even though it is not "put to rest."21

The point we will try to make here is that theological reflection
on the issue of theodicy applied to psychiatric problems can be benе-

cial in our case. The basic issue, as perceived by me, was the other-
directedness of the patient. In almost classical Lutheran terms the
patient complained of being obsessed by the devil, but her "God-talk"
was obviously just as obsessive. Also, God was perceived as a power
who compels the patient to do certain things, like counting colored
lights. The patient perceived herself strikingly similar to Luther's
famous horse, ridden once by the devil and at another time by God, even though in Luther's terminology the metaphor has the intention of lib-
erating the person for genuine autonomy and personality.

In the context of the issue of theodicy, the basic problem, with which theology has been confronted even at the very beginnings of Old Testament theological reflection, is how to explain evil in the world in the context of a belief in an almighty and beneficial God who created man and world to be "good." The Old Testament participates in a feeling about the "gods" quite common in the ancient Near East. In the Gil-
gamesh Epic, as well as in the Adapa Myth, the feeling is very strongly expressed that the gods act capriciously and are very jealous of human capabilities. The Old Testament shares this feeling quite obviously, especially in the parallel Creation Epic in Gen., chs. 1 to 11. But the genius of the Old Testament rests in the fact that it made an in-
novation to the prevailing Near Eastern variants, and this innovation rests in the fact that it interpreted experiences of evil as human evil. We believe that theological insight obtained by analysis of the question of theodicy can provide a handle to the other-directed-
ness of our patient, as well as provide a final rounding out of our anthropological reflection up to this point, turning around such issues as "indifference," future directedness, and moral engagement in the internal flow of events. In the innovative Old Testament inter-
pretation of the prevalent Near Eastern question of theodicy, evil is not rationalized as God- or devil-caused, nor is it traced to an imperfect world. Rather, the concept of an omnipotent and benevolent God who has created the world ex nihilo to be "good" is asserted, whereas evil is left unexplained, which drives the interpreter, es-
pecially of Gen., chs. 1 to 11, to the acceptance of evil as man-
caused. Paradoxically, this strengthens the monotheistic notion--derived from Egypt--of God as the progenitor of the world and of man as essentially good. Gunneweg goes one step farther: This very move from a fate-ridden ancient mythology in which divine and satanic powers act capriciously to a world view in which both the divine and worldly order are well-ordered in the strict sense--which is possible only by the deposition of evil on the shoulders of man himself--this very move alone made possible also the notion of forgiveness and reconciliation. There can be no forgiveness without guilt. If man does not under-
stand himself to be the originator of evil, he can neither be held ac-
countable for evil nor can he be forgiven for his transgressions. But that implies that ultimately there can be no reconciliation; and the only alternative continues to be at best a dualistic conception of the universe in which satanic powers vie with divine powers, or at worst a pluralistic pantheon where evil strikes wherever it will. Gunneweg (ibid.) makes the interesting observation that the predominating temper of modern culture is more than analogous to the temper of ancient heroes such as Gilgamesh, Adapah or Adam. For modern man laments also the heteronomization by foreign powers (i.e., the "gods"), the aliena-
tion of true existence, and the impossibility of the use of true autonomy because tradition, ideology, and various "systems" prevent the emer-
gence of an authentic self. As antiquity not only laments the fact of other-directedness, but rather openly accuses the "gods," so also modern man feels the need to emancipate himself from the iron grip of
his own fate. Hegel has helped us to see the alienation as the "power of life," making it possible to understand the experience of being alienated as a step toward a fulfilled existence, rather than having to negate the alienated existence altogether. But the figure of Adam in the Old Testament can help us to carry this analysis a step farther. If alienation, death, and the unwhole and fragmented existence is the fertile ground for a wholesome life, then the point made by the Old Testament reinterpretation of the question of theodicy is a natural augmentation of this argument: Accepting the alienated existence as having originated in the self is the first step toward the reconciled existence.

But here we shall apply Hegel's analysis to the psychiatric problem of the feeling of compulsive obsession on the part of our patient. The central theme that we found underlying the patient's illness was the incapacity to assume responsibility for her life and behavior. All her acts were other-caused, other-directed. The context within which this compulsive other-directedness became operative was a rigid theological dualism. It can at this point be mentioned that for several years the patient had drifted around seeking ground in various religions. Several years earlier she had been in California, and had become a Buddhist. Not long ago she converted to Catholicism in a Long Island mental hospital. A year before that conversion her daughter was born. Between the stay in California and her appearance in Long Island she had apparently seen some "herbal" physician in Mexico, apparently to have an abortion. It was difficult to get data straight. Apparently sex and possibly drugs were part of her experience in California. But it was quite clear to me that her search for a religious system, culminating in a rigid interpretation of Roman Catholicism, stemmed from a basically labile personality with a pronounced identity problem.

Not willing to have my attention side-tracked to the diagnosis of "illness," which was indisputable, but which would have destroyed the possibility of dealing with the broader anthropological issues underlying her condition, the problem of theodicy became for me the central issue here. Basic presuppositions of this problem (How can you believe in a just creator-God in the face of obvious evil in the world?) were: (1) There is a just world order. Without this presupposition evil and injustice could not be observed, much less lamented. (2) There is a just God who is benevolent and has influence on the world's activities. Already the focusing of the problem of the existence of evil in the world in this way must be seen to be a result of the Judeo-Christian history of dogma; a result in the sense of the attempt to rationalize the lack of logical continuity between a just world order and a just deity on the one hand and the obvious evil on the other. For Christian teaching the problem is resolved, as mentioned above, by reference to the innovation of Old Testament thought, by tracing the origin of evil to the freedom of human action, which can decide for conformity or non-conformity with God.
The propensity of the staff on the E-2 Ward of the Albany Medical Center was to treat "God-talk" on the part of the patient as a sign of illness, which was, according to the medical model, to be extricated as a foreign element or invader into the personal autonomy of the patient. My approach, on the other hand, was different. I took seriously her search for order in her universe; I took it seriously as a sign of a search for personal autonomy. That I was correct in my diagnosis is indicated by the following developments: During one interview I simply pointed out the inconsistency in her theological thought. It was the Lenten season of 1976. The patient had a small balm branch pinned to the lapel of her suit. She had all along known me as a theologian and not as a psychiatrist. She complained of severe guilt which, when deteriorating into the bizarre signs of illness, manifested itself as a belief that she was "a devil." I pointed out that if she was serious about her faith in Christ, she must also take seriously the reason why he came to earth and was nailed to the cross, to take away our guilt and sin. If she was not willing to take Christ seriously for what he centrally stands, she was denying Christ and therefore God. Guilt and forgiveness had been placed into the center of her person. A devil did not obsess her, nor did God place on her an obsessive activity to redeem her out of devilish activity. Rather, guilt is due to sin, for which a person is accountable. Once that is accepted, the redemptive power of the Cross can become effective. I did not talk to the patient in these terse theological terms, but rather in very simple language. She asked me to pray with her, which I did, to the obvious great relief of the patient. Then she indicated immediately afterward that she wanted now to be left alone. I took that as a healthy sign.

A few days later the patient was interviewed by Dr. Seward Hiltner of Princeton Theological Seminary, who participated in a conference organized by Dr. Bill Rockwood, of Russell Sage College, and I. I had presented the Christological dimension of the issue to the patient, but Dr. Hiltner raised the theological aspect by confronting the question of theodicy slightly differently. "If you believe God to be your creator and benefactor, why do you constantly place demands on him?" Dr. Hiltner asked the patient. "You are really telling God what he must do, rather than permitting him to become operative within your life." Dr. Hiltner understood correctly that the turn to Catholicism during a critical time in the patient's life was really an attempt to expiate her feelings of guilt through what Protestants call "justification by works." He clarified to the patient the inconsistency in her theology. He pointed out that she believed wrongly. One might say that Dr. Hiltner thereby intensified her feelings of guilt. The person who does not observe the significance of the tight theoretical framework within which the patient operates and who attempts to free her from this framework will not be able to gain access to her problem, which is a real problem for all of mankind, with the only difference that in the patient it had become not a support system, but rather a system leading to mental deterioration.

Having been confronted by Dr. Hiltner, the patient burst into tears, as she had done after my conversation with her, but unlike the
previous situation, proceeded to make a confession, which, in view of the semi-public nature of the interview (there were approximately twenty people present, all from the Capital District Psychiatric Center or a few invited participants) had only so much more significance. She stated that she had committed deeds which were so atrocious that she could not tell about them, so vile that she was terribly ashamed of them. Far from being a sign of illness, we took this confession as a sign of the fact that she has assumed personal responsibility for them, confessing them in public. Furthermore, no longer was she the "devil," but rather she was the person who had committed the misdeeds. The confession was a sign of the redemptive power of reconciliation that becomes operative on the basis of assuming personal responsibility. The other-directedness had been overcome—however momentarily—and rudiments of personal autonomy had become active.

In conclusion, it can be observed that the question of good and evil behavior, of guilt and redemption, as raised by psychiatric patients, point to very human dilemmas and should not be taken simply as signs of illness that should be eliminated as a virus is eliminated from the organism. They must be taken seriously in order to cope with the diseased manifestations of these problems. In the cases of the two patients, one with whom I was personally confronted, the other written about by the psychiatrist Gebsattel, they both had elementary fears of meaninglessness that manifested itself in an ill time-perception and the constant intrusion of the hopeless vista of the morbidity of all human experience. This experience was taken seriously as a fundamental human problem that gained pathological aspects in the patients. The framework was taken seriously, as a basic anthropological issue that lent itself to theological interpretation. In the second patient whom I knew the issue of theodicy became of paramount interest and was not merely pushed aside, being interpreted as itself the illness (the tendency in contemporary psychiatry). Gebsattel reports that his patient had been completely cured after fourteen months of treatment. But the issue of cure is incidental. It is possible to employ the proper therapeutic method without affecting a cure. Gebsattel had attempted to develop a new insight into a "medical anthropology" to help modify therapeutic methods. The fact that the two patients whom I had encountered on the E-2 ward of AMC can today hardly be called "cured" does not weaken the points that I have attempted to make. The basic question remains: Of what significance is the current move to biologize illness, and in fact, all human behavior? It is highly persuasive, and yet very few therapists operate on the basis of the principles guiding this movement. In fact, using the criteria of that biological interpretation of mental illness, most of the therapy done in any case on E-2 in Albany would be incredibly naive, because it assumes at least rudiments of autonomy and personhood to be present in patients and assumes also that a psychiatric ward is or at least could be a supporting system to help patients gain their balance, if not health.

To support my contention, I must briefly recount the most recent encounter with the last patient about which I have written. A few weeks ago I met her again on the locked E-2 ward, after she had been for weeks on the open E-3 ward and, in fact, released to a local "half-way house." I greeted her with great surprise with a hand-shake as warm
as ever. She was evasive to my questions why she is back on the locked ward, and quickly wanted to terminate the conversation. She retrieved her hand out of mine slapped the back of my hand slightly and said with an air of sarcasm: "Put in a good word for me, OK?"; she then went over to a young male patient who put his arms around her waist and walked off with him.

The Chief of Service, Dr. Grunberg, told me that the patient had put aside all religion and had abandoned herself to sex. Of course this is a sign of a pathological unsteadiness of her person that is years old and probably can be traced back to her childhood. The question remains for me, however: Had the staff of the E-2 ward given her the support she needed? Could we not have paid greater heed to her repeated remarks that no one took her seriously? Now she has a fixation on sex, which is another reason. A good and appropriate reply is that one can never provide to this patient that kind of support which she needs. Lack of time, inadequate facilities and understaffing are obvious reasons for this judgment. And yet the other issue is not erased by making this observation: Personal interaction to provide an atmosphere of trust is essential, so that patients gain a health understanding of self and their environment. Not all failures can be explained away with the term "illness." This report was written to attempt to make a contribution to the issues surrounding "illness" and "health," "personality" and "autonomy."
FOOTNOTES

1 See especially pp. 82ff., of the English translation (University of Chicago Press, 1963), where Jaspers addresses himself to such phenomena as "knowledge of time," "experience of time," "handling of time," "time hurrying or slowed," "lost awareness of time," "loss of reality in the time experience," "the experience of time standing still."

2 Ibid., p. 86.

3 The concept of "horizon" as used here was introduced into phenomenological philosophy by Husserl. See Husserl, Krisis der Europäischen Wissenschaften, p. 369ff., and especially p. 382f. See Husserl-Tiana, Vol. VI, p. 267, where Husserl observes that William James's concept "fringes" helped his reflections on "horizon." Finally, Heidegger, who died on May 26 (see N. Y. Times, May 27, p. 1) and his pupil Hans Georg Gadamer picked up this concept. See Gadamer, Wahrheit und Methode, 2d ed. (Tubingen, 1965), pp. 232f. Gadamer indicates that "intentionality" and "horizon" are closely related to what Husserl called "Lebenswelt," which has ontological priority before all activity of the thinking subject. Husserl, as well as Gadamer and certainly Heidegger, wanted to avoid all psychologization of the issue. This has for us great relevance, for we believe that psychiatric observation of "illness," which was quite obvious in our patient, has philosophical and even theological relevance. Our patient has, due to a pathological development, lost grounding or footing in this ontological prior Lebenswelt, which can momentarily be an experience for healthy individuals also, but which is quickly overcome. The theologian Paul Tillich's concept "ground of Being" might be quoted as theological testimony to our issue here. Our patient had obviously lost faith in herself and the world. She was literally without future and hope, because she lost footing in the "ground of Being," and to criticize her as lacking faith would be altogether inappropriate. As Gadamer points out (Ibid., p. 288), the concept of "horizon" is constantly in flux, because living means being in movement, so that "to the one who is in movement the horizons constantly change." In our patient no such healthy mobility can be observed. She is literally at a standstill, which is also the reason why she considers herself "young." Conversely, aging and maturing can, if healthily appraised by the maturing person, be theologically interpreted as a growth in faith, which comes to completion of the maturing process at the point of death. It should be observed that this growth is constantly in touch with the Lebenswelt, which is equally perceived as growing in meaning. One final reference may be in order. Gadamer points, in my opinion perfectly legitimately, to the experience of horizons melting into one another and the contribution which Hegel's dialectic has made to this problem. See Gadamer, (Ibid, p. 336). To the issue of "horizons melting into one another" (Horizontverschmelzung), see Ibid., pp. 256, 257.
For those interested in the philosophical development of the concept "Horizon," Jürgen Habermas, at Haverford College in the fall of 1976, has taken issue with Gadamer's treatment of the concept in Zur Logik der Sozialwissenschaften, Sonderheft, Philosophische Rundschau, Feb., 1967, Beiheft 5, pp. 157ff.

4 Kritik der Reinen Vernunft, Meiner Verlag, Hamburg, 1956, p. 454ff: "The world has a beginning in time and is enclosed by boundaries in view of space. The world has no beginning and no boundaries in space and is infinite, both in view of time as well as space."


6 Ibid, p. 10.


8 Ibid, 8f.

9 Phenomenology, ibid, p. 70.

10 Hegel early introduced into his thought Schelling's concepts "difference" and "indifference." In the famous Differenzschrift of 1801, now in the authoritative Hegel edition, Felix Meiner Verlag, Hamburg, Hegel, Gesammelte Werke, Vol. 7, 1968, p. Iff. Indeed, the concept appeared even earlier in Hegel's thought, for example, in his essay entitled Die Positivität der Christlichen Religion, dating to 1795/96, published in Hegel, Werke in Zwanzig Banden, Suhrkamp Verlag, Frankfurt, Vol. 1, 104ff; reference to "Verschiedenheit" (p. 111) is made, which word of Germanic origin is displaced in later writings with the word Differenz of Latin derivation. Hegel asks himself in these early writings the question: Does not the unique, "different" event, also called the "positivity," have significance? Is only the overcoming of all uniqueness and difference to be striven for? The philosophical issue of the distinction between the general and the specific is, of course, at issue here; Hegel went beyond Plato and Schelling by indicating that reality can be viewed in clear focus only by viewing as an "identity of identity and nonidentity", expressed first in 1800 in the Systemfragment dating to that year as the "unity of the unity and the non-unity," Werke, ibid, Vol. I, p. 422. It is significant to note that that which is described with this formula is "Life." The complete formulation appears in the Differenzschrift of 1801, where it is stated in this fashion: "The Absolute itself is therefore the identity of the identity and the nonidentity; opposition and unity are in it simultaneously." Werke, ibid, Vol. II, p. 96, Gesammelte Werke, ibid, Vol. IV, p. 64. The philosophical point to be made here is that Hegel had, contrary to such neo-Marxist thinkers as Adorno and such existentialists as Kierkegaard, who both took Hegel to task for having no appreciation for contingent "positivity," the only
sound philosophy within which individual existence, unique in all of its particular and well-defined aspects, is argued for with sound reasons. And the second point to be made is that this existence takes form in the context of what Hegel earlier called "life," and what in the later formulation of 1801 calls "the Absolute." In must be stressed here that "life" (see the concept Lebenswelt mentioned in a previous note) or the "absolute" do not heteronomize or alienate unique contingency. To the contrary. Dieter Henrich has pointed out that Hegel's philosophy is the only one in which the concept "change," which can be taken as a philosophical notion embracing uniqueness, is well reasoned out. (Henrich, Hegel im Kontext, Suhrkamp Verlag, Frankfurt, 1971, p. 157ff, Hegel's Theorie über den Zufall.) Applied to our problem this means: The obsession of only seeing the abstract flow of alien time, without seeing the significance of internal time, brings with it the inability to see the significance of my unique person on the one hand and of the individual moments of existence. Only within the context of "life" or of Lebenswelt, or, to quote now Hegel's concept "absolute," does the absolutely significant momentary existence of my life-events gain relevance. Hegel does not attempt to solve the dichotomy of chance and necessity in favor of some higher harmony, as is the case with Schelling. Chance remains, rather, meaningful in itself. The schizophrenic persons which we have described have no understanding of the unique moment or, for that matter, of the uniqueness of their own life. See in this context my essay The Absolute as the Beginning in Hegel's Logic, Philosophical Forum, VI, 2/3, pp. 288-300. Lack of meaning ultimately leads to the experience that all is in vain.

11 It is instructive for the student of history to observe that this conception of history with its basic identity or neutrality of each moment was most profoundly developed by the famous historian Leopold von Ranke (1795-1886). For this historian, all data are "equidistant to God," which implies both their ultimate significance—and their neutrality and indifference. The thesis of the divine presence manifesting itself in all data has had the benefit of a historical industry the likes of which has never before been seen. For von Ranke nothing is irrelevant, not even the smallest detail. But the other side of this phenomenon is really the indifference, identity, and similarity of historical data. Ultimately only despair can characterize this view of history. See Religion in Geschichte und Gegenwart, V, 778-779, and II, 1492-1493.

12 Geschichte, RGG³, II, 1958, Tubingen, col. 1494, but see also note 10.

13 Our civilization has a continuing bias against the contingent and concrete, and in favor of the abstract and scientifically determinable. This is a sign of ill health of our culture, within which the ill health of the individual gains significance. Hegel was the first profiled thinker who systematically provided a basis of reason for two points: First, that the single, unique, empirical entity, which he called the "positivity," has not only significance, but ultimate significance. It had been Lessing who had posed the question,
not being able to answer it: What is the relation between truths of
distory and truths of reason? History just provides arbitrary data,
because truths of history merely "happen," without necessarily fitting
neatly into a reasonable context. For this same reason Aristotle ban-
ished history from scientific investigation. History depends too much
on the arbitrariness of human will and action to be scientifically cal-
culable. Hegel's preoccupation, fully developed between 1795 and
1796, with the category of the "positivity" indicates the prejudice, so
prevalent in his cultural milieu, against "positive" empirical data.
Hegel's writings of that time and throughout his later life as well
clearly betray this prejudice, which places greater trust in what Less-
ing called "truths of reason." And yet, the only reason why Hegel
went back again and again to the preoccupation with "positivity" is
because of his conviction that the realm of "positivity" cannot easily
be brushed aside. Lessing had stated that truths of reason are de-
monstrable and therefore convincing. And yet there are the truths
of history which stubbornly continue to force themselves into the at-
tentive consciousness. The second point which Hegel made was that
the historicity of Jesus Christ--making claim to be the revelation of the
realm of transhistorical reason, i.e. God-- has ultimate significance.
This historically arbitrary, underived, undeduceable occurrence there-
fore lent divine significance to the realm of "positivity" per se
Hegel's concern with this "positivity" in the essay The Positivity of
the Christian Religion Werke, Vol. I, pp. 104ff, is characterized by a
thorough Kantianism in which the realm of empirical nature is systema-
tically problematized. At the same time, however, that same essay be-
trays just as stubborn a question, whether that realm does not have
really ultimate significance after all. Hegel is opposing Kant here.
And this latter conviction is maintained even in the later periods of
his thought. The earliest formulation of Christianity being the "hinge"
around which all future history turns is written between 1793 and 1794:
Werke, I, p. 98: "But the hinge, around which turns the total hope of
our salvation is the faith in Christ as our redeemer...Against this
foundation of the Christian faith the other teachings are just so
many supporting buttresses." And in the Lectures on the Philosophy of
History, delivered once every two years beginning with 1822 and read
last during the Winter Semester 1830/31, has a very similar formulation:
"God is known as spirit only by recognizing him as the triune God.
This new principle is the hinge around which all of world history hence
turns." Werke, Vol. 12, p. 386. What we have to remember is that
Hegel understood this "new principle" as the key to an ability to
provide an adequate interpretation to historically contingent data,
called some thirty years earlier by the name "positivity." See to this
problem Gunter Rohmmoser, Emanzipation und Freiheit, Goldman Verlag,
Munchen, 1970, pp. 219, 248. See also Michael Theunissen, Hegel's
Lehre vom Absoluten Geist als Theologisch-Politischer Traktat, deGruyter
Verlag, Berlin, 1970, pp. 94, 95. And see also Hans Kung, Mensch-

14 Ibid., p. Iff, Zeitbezogenes Zwangsdenken in der Melancholie.

15 Ibid., p. 2.
Hegel speaks in his essay Spirit of Christianity of Fall/Winter 1798/99 (Werke, Vol. I, pp. 317ff) of death as the "gap" within life, or "as the deficient life in its power" (ibid. p. 343f). Life is deficient because it is disunited, fragmentary; but just this fragmentariness is also a chance for greater fulfillment. Death is the "power of life," for "life can heal its wounds, and the separated, hostile life can return into itself." (Ibid., p. 343). Disappointments, frustrations, terminations of certain goals, even the let-down that comes as an anticlimax of a successfully completed task—these are normal experiences of everyday life, and they are what Hegel refers to in this abstract philosophical language with the word "death" or "separation." Gadamer tells of suffering in the same way, Wahrheit und Methode, 2nd ed., 1965, Tubingen, pp. 208, 339. Suffering is the necessary point of transition to more appropriate self- and world-understanding. The experience of the nothing is necessary for life to bounce back with renewed vigor. Gadamer trains his thought mainly on the hermeneutical question of interpretation, but it is in no way limited to this issue. The experience of the nothing, what Hegel calls the "power of life," is necessary so that the reconstituted wholeness as something new can emerge. See Kung to this point, Menschwerdung, ibid., p. 156; also Theunissen, Hegel's Lehre, ibid., p. 17. Hegel comes back to the issue in his Phenomenology of 1807, see, e.g., pp. 29, 30 (Phenomenologie des Geistes, ed. Hoffmeister, ibid.). And Hegel has here, in the later and more mature of his writings, further specified his observations about death. Here he speaks of another kind of "death," "a death which has no inner circumference and no completion, for which which is negated here is the unfulfilled point of the absolutely free self." (Ibid., p. 418.) The dialectic of domination and repression is at issue here (see Werke, I, p. 344f) in the sense that the position of the dominating self, standing over against the dominated other, finds no way of overcoming this kind of alienation and separation. Therefore, this kind of death "is the most cold and flat death, without greater significance than slashing through a head of cabbage or swallowing water." (Phenomenologie, ibid., p. 418f). This latter passage is an obvious reference to the guillotine during this Jacobean reign of terror of the French Revolution, whose after-shocks were still felt throughout Europe at the time when the Phenomenology was written. The difference between a "good" and "right" death that is the "power of life" and one that leads nowhere but to alienation of self and others is of obvious relevance to our problem. The fact that Hegel talks in the quoted passages from the Phenomenology about "general freedom" of reason or of "absolute" freedom or about a kind of reason which is undialectically conceived can be the final source of insight to our problem: Our patients understood something about life, which is, from a certain perspective, obviously correct. Indeed, all events pass away and have their natural cycle. But this "passing," this "nothingness," is really pointless, because it is a very different nothingness from the "death" that Hegel writes about, which is the "power of life."

Hegel in the quoted passages from Werke, I, p. 341ff. constantly makes reference to the Greek notion of fate.

19 See the convincing argument in Dieter Henrich, Hegel im Kontext, Suhrkamp Verlag, Frankfurt, 1971, pp. 157-186.

20 Concerning the Failure of All Philosophical Attempts to Solve the Question of Theodicy.

21 See RGG², Article Theodizee, Vol. VI, 744, by Walter Trillhaas. That it is not put to rest, but rather provided the basic stimulus for the development of the philosophy of German Idealism, first through the pronounced "moralism" of Fichte's emphasis on the absolute I, and then through Schelling's incorporation of evil into the development of the Spirit, and through Hegel's incorporation of suffering as a positive good into his historical philosophy was exceptionally pointed out by Peter Cornehl in his excellent study Die Zukunft der Versohnung, Eschatologie und Emanzipation in der Aufklärung, bei Hegel und in der Hegelschen Schule, Vandenhoek & Ruprecht, Gottingen, 1971, see esp. p. 76f. The "problem of theodicy" is "really the actually active motive in Kantian Eschatology" (ibid., pp. 77, 76), so much so, that Kant's whole critical philosophy is really centrally structured by this problem.


25 See Romans 5:20: "Law intruded into this process to multiply lawbreaking. But where sin was thus multiplied, grace (e.g., forgiveness) immeasurably exceeded it." New Eng. Bible.

PREFACE

This document functions in two ways. First it is a report to the fellows of the Institute on Human Values and Medicine. As such it reflects the creative thinking engaged in by Drs. Pellegrino and Thomasma during the month of July, 1975, in New Haven, enabled by a fellowship from the Institute granted to Dr. Thomasma for this purpose. It is a catalog of ideas and schematics resulting from the reading and dialogue that took place at that time. The second function of the document represents a decision made during the summer to write a book together on a philosophy of medicine. The document therefore also represents a tabula incompleta from which the authors will mine a book. Others may wish to extract some nuggets from this document for more rigorous polishing and smelting.

Although the onus of drafting the report fell on Dr. Thomasma by reason of the fellowship, the document is a product of both authors. It is impossible to distinguish who first proposed a particular idea, who first proposed or decided upon an outline. The reader should not be misled by the fact that Dr. Thomasma's name appears first on this report; he or she can be assured that alphabetical order will prevail for the book. And while it is customary in co-authorships that one of the parties modestly takes the blame for errors while acknowledging the help and genius of the other, we are neither that modest nor that presumptive. We envision the outline and the subsequent book to be an initial exploration designed to stimulate continued interest in a philosophy of medicine.

We will argue that medicine is neither an applied science nor a fine art. Instead, it will be developed as an integral discipline in its own right. To be sure, it does sometimes appear to be a rigorous science or, contrariwise, an art of making good on hunches. But so does every other discipline contain this bipolarity of art and science, from mathematics to sculpture, from theoretical physics to home economics. All disciplines involve degrees of art and science.

Our development of medicine as an integral discipline is critical in that the philosophy of medicine we seek is to be a philosophy of an identifiable human activity, not a philosophy of a hodgepodge of the sciences and arts that medicine employs. We hold that medicine is not just what doctors do or what patients think it is. Instead, we will argue, it is a form of unique relationship.

We are aware that even an outline already represents a metaphilosophy, a philosophy of the philosophy of medicine. It is a metaphilosophy in that we have chosen this outline over others as an aid for
discovery and development of ideas. The guiding motives of the outline, therefore, represent an approach to philosophizing that others might not choose. We consider this approach more the result of choice than an expression of any absolute path to the truth. Rather than close discussion, we entertain the conviction that many different methods will be needed to explore the complexity of modern medicine.

Since this outline collects our original thinking as well as some ideas from readings, we have decided to present the report without footnotes and references. A bibliography is attached, however, as some authors are cited in the text of the outline. In the book, we will do justice to those from whom we derived some of our ideas.

Because we will argue that medicine is a form of relationship, a reality denied by Hume and considered the "most hazy" by Aquinas, we must caution the reader that few univocal meanings will appear in our terminology. Indeed, even the most abstract mathematics and theoretical physics involve ciphers of human interpretation, as Godel's theorem and Heisenberg's uncertainty principle attest. Employing Merleau-Ponty's description of philosophy, a philosophy of medicine would be an "algebra of medical history," a kind of symbolic magnifying glass placed over the important events and features of medicine, leaving other features to be examined with different tools. Because medicine represents that area of human action which is characteristically, but not always, true, the "algebraic" relational functions of a philosophy of medicine cannot be captured in univocal language.
INTRODUCTION

Two fundamental aspirations of mankind are health and virtue, well-being and being good. Originally these forms of human existence were identified in the practice and theory of both medicine and religion. Two important clues are furnished by this ancient conjunction, clues important for a philosophy of medicine today.

First, throughout successive developments in the West, these two forms of human aspiration have remained. As such, health and virtue are crosscultural and transhistorical values, present at the heart of human reality. Both forms presuppose a basic judgment about life: that human reality is at once fragile and perfectible.

The second clue follows from the first. Seeking health and virtue is a kind of creative interference in the given. Taunting fate and nature, medicine has all the earmarks of Aristotelian tragedy, a discovery or realization of what was not taken into account. Triggered by new realizations, reinterpretations are created about the nature of man and the world, about life and death. This special kind of tragic insight is closely related to the central problem to be developed for medical theory and practice: how science can be formed from and applied to specific and unique individuals. At stake is the nature of clinical judgment, and philosophically speaking, the nature of being human.

Pain and tragedy are, in the phrase of Gibran, "the breaking of the shelter that encloses our understanding." This statement about suffering confirms our experience. When we are truly sick, our lives virtually come to a halt. We are forced to look at ourselves as we really are; cosmetics can hide our pallor from others but not from ourselves; fierce independence cannot be reconciled with our new dependency on health care professionals, drugs, hospitals. What was once private now becomes public. An image is shattered. We can often have a tragic catharsis, an experiential discovery of what we forgot to take into account when constructing our lives. Frequently this catharsis can be a spine-chilling physiological awareness that as we have navels, so must we have graves.

D.T and E.P.

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SECTION I: NEED FOR A PHILOSOPHY OF MEDICINE

I. CHAPTER ONE: NEED

A. Introduction

Western medicine needs a philosophy of medicine to organize its geometrically expanding successes, to form an integrating principle for its splintering specialities, to offer a rational, scientific explanation of its methods, and to discover its relativity in relation to other medical systems (such as the Chinese) so that it can function universally in an expanding world community. In addition, a philosophy of medicine can critically explore the necessity and composition of a science of individuals and specificity, an area important for biological sciences and genetics, as well as clinical interactions.

A philosophy of medicine can aid philosophy itself, indeed, society as well. It can offer an empirically verifiable anthropology sorely needed as a basis for ethical, legal, political, and economic developments today. These developments involve the expanding role of medical practice, as well as of all technologized human services, in the lives of individuals. The unique act of medicine, applying theory in practice to individuals, can function as a model for the most pressing cultural issue of our time: the place of the individual in a complex mass society.

B. Probable Causes for Lack

Unlike theoretical scientists, medical practitioners are leery of philosophical speculation. Although a few medical practitioners retire to delve into the history and philosophy of their discipline, most hesitate to become embroiled in the intricacies of philosophical thought. This hesitation is mainly caused by the deleterious effects of nineteenth-century Romanticism of medicine, the lack of formal logical and philosophical training, and the utilitarian, pragmatic concerns for patients that govern their professional lives.

A critical philosophy is often seen as a menace to the essence of medical craftsmanship, making quasi-experimental decisions about human lives. This empirical method has been successful beyond imagining. Philosophical speculation is therefore seen either as a sidetrack or a frontal assault on clinical judgments. The latter have not been sufficiently distinguished from ethical judgments. Consequently, attacks on clinical judgments are mistaken for critiques of moral integrity, and vice versa. In the midst of malpractice escalation and legal guidelines, the physician is most reluctant to gain new critics.

C. Review of the Literature

We discern three areas in which philosophy has been active to a degree in relation to medicine. Philosophy in medicine seeks an understanding of medical theory and practice. Philosophy and medicine represent a catalog of mutually interesting problems.
cine seeks an understanding of medicine as a discipline, with an exploration of the underlying anthropology revealed by and through medical practice. One and only one philosophy of medicine is rare, as it would involve an anthropology commonly accepted in a culture. In other words, there is no "The" philosophy of medicine possible today as it might have been for Galen or Hippocrates or in the Middle Ages. We will attempt to be as original as possible in discovering the anthropology present in the clinical interaction of modern medicine. No claims are made that this anthropology is, in fact, the one commonly accepted in our culture, or even that it ought to be. That argument would best be left to an additional study.

1. Philosophy in Medicine

Philosophy in medicine represents a critique of theories of explanation, causes of health and disease, and the nonscientific myths that appear in the history of medicine from time to time. Generally speaking, critiques of this sort have been created for the most part by physicians themselves as they become embroiled in the issues of their day. A central theme and common concern present in this body of literature is the medical logic of discovery (including diagnosis, prognosis, and therapeusis). It is often described as being on the borderline between the logic of discovery in the theoretical sciences and the liberal arts. A review of the articulations of Hippocrates, Galen, Pietro d'Albano, Harvey, Bernard, and some contemporaries reinforces this sense.

2. Philosophy and Medicine

Literature in this area covers problems of mutual concern to philosophers and medical theories. It tends to develop from a single philosophical tradition and is largely written by philosophers, theologians, or medical theorists. Perhaps the most successfully integrated examples of this category are medical ethics, the mind/body problem, philosophy of the body, and philosophies of biology. The problems upon which philosophy focuses are of interest to medical practitioners insofar as the problems closely approximate clinical concerns. The rise of medical ethics is a good example of a concern that is asymptotic to the clinical center of medicine.

3. Philosophy of Medicine

Very little of this category has been developed in this century, despite flourishing philosophies of mathematics, physics, and biology. Von Weizsäcker points out an emerging anthropology possible from medical advances, but represents the inheritance of nineteenth-century German thinking. Buchanan employs a neo-Aristotelian metaphysics of transcendentals that appears almost ad extra in an otherwise brilliant work. Only Foucault (The Birth of the Clinic) and Lain-Entralgo (especially in La Historia Clínica and La Relación Médico-Enfermo) develop a rigorous philosophical position on the clinical relationship.
Foucault's interest is in the archaeology of the life-world from which medical advances proceed. He studies the emergence of the empirical clinical observation techniques of the eighteenth century. Lain-Entralgo employs a consistently precise historical method. From an appearance in history, he then examines the nature of the clinical act from an Aristotelian-Thomistic methodology. His work in these books deserves translation for it is quite successful. But he rarely moves beyond the definitions and modes of clinical relationships to the anthropological insights they afford.

All the authors studied, however, agree that clinical interaction is central to medicine and to its definition and function. Foucault calls the clinical interaction the material a priori of medicine. All also agree that clinical judgment is problematic for a philosophy of medicine.

The work of Wartofsky and Pellegrino is to be examined as meta-philosophy of medicine. Both offer a schematic capable of being employed to develop a philosophy of medicine. Wartofsky grounds medicine in relative social institutions; Pellegrino grounds it in an integrating anthropology.

II. CHAPTER TWO: CHARACTERISTICS OF A PHILOSOPHY OF MEDICINE

A. Cautions

1. A philosophy of medicine must be of interest to medical practitioners. Garrison is particularly strident against nonempirical theorizing.

2. It must be based on an understanding of history in order to uncover relativities and common structures of medicine.

3. It cannot be a catalog of problems. Instead, it should be based on an integrating principle. From the dialectic in the preceding chapter, it can be seen that both historically and conceptually, medicine is a relationship between physician and patient (by extension, between health-professional and patient).

4. Although it should contain a critique of this relationship, any philosophy of medicine would also involve all other forms of philosophizing. In particular, it should not stop with such a critical view of the clinical relationship, but rather move on to the implied anthropology of the medical act, which emerges from the relationship itself. In this way, external theorizing is avoided, and the philosophical insights are of value to ethics, law, economics, politics, and so on.

5. Although philosophies of the body and biology are particularly helpful, a philosophy of medicine cannot be reduced to a philosophy of an organism. Rather, it must start as a relationship between human organisms and work from that point.
6. A philosophy of medicine must examine the possibility of a science of individuals.

B. Metaphilosophical Guidelines

By "metaphilosophical" guidelines we mean a combination of motives for this work and the results of the dialectic already begun. These initial guidelines determine the structure of the philosophy of medicine we will create. Others, guided by different motives, and a different reading of medical history, would create another philosophy of medicine. In this sense, then, the guidelines are already a philosophy of the philosophy of medicine.

1. A philosophy of medicine must start with the uniqueness of medicine. Otherwise it would not be a philosophy of medicine, but a philosophy of features shared with other disciplines.

2. The uniqueness of medicine lies in the clinical interaction, where "clinical" is defined in a broad sense to cover physician-patient relationships.

3. In this relationship, results validate ideas. Objectives are more important than logical coherence. The philosophical method chosen must therefore describe important features of this interaction and come to a definition of medicine before proceeding farther.

4. Medicine differs from science as a consequence of the clinical interaction. At least two initial points of difference are obvious. Medicine does not engage objects, but human beings. The complexity of the relationship is further dictated by the need to decide. Therapy is the purpose. Hence the philosophy developed cannot be simply a philosophy of science.

5. The philosophy of medicine developed must be able to describe tensions in the relationship but not contribute to dualisms such as mind-body, patient-thing, blind faith in science-blind faith in compassion. None of these dualisms helps care of the patient as a whole.

6. After description of the clinical interaction and reflection on the distinguishing feature of medicine, an anthropology would not represent a complete philosophy of man. Instead, it would represent certain structures of human existence that make the cure effected by the clinical interaction possible.

7. The anthropology developed should be able to provide some axioms for medical ethics and guidelines for medical education.

C. Two Problems: Medicine and Philosophy

So far, we have developed insights as a result of dialectic. Now it is necessary to deal more rigorously with two problems: philosophy
is impossible to define and medicine has not been philosophically de-
fixed in the past. Hence a philosophy of medicine can degenerate into
a "non-defined of the ill-defined." Nor is the problem helped by at-
tempts to call medicine an "applied science" or a form of art, as neither
of these terms is univocal: Science can mean a systematically developed
and logically coherent body of knowledge, or a body of pre-propositions,
or a discipline of reasoned facts, or a predication of subject matter
through causes. Art, like philosophy, admits of no commonly accepted
definition.

It is therefore necessary to develop the philosophical method we
will choose to focus on the distinguishing feature of medicine.

SECTION II: WHAT IS PHILOSOPHY?

I. CHAPTER ONE: THE NONUNANIMOUS NATURE OF PHILOSOPHY

St. Augustine indicated that the philosophical task is to try to
understand the world. Search for this kind of "wisdom" offers an im-
portant clue about the nonunanimous nature of philosophizing. The
reason that so few philosophers agree--often so annoying to thoughtful
people from other disciplines--is that their attempts to understand the
world are all relative perspectives on that world, conditioned, at the
very least, by the questions they ask and the matters of importance in
the culture in which they live.

The locus of meaning lies in the interhuman event that in turn is
the source of interpretations of the world. Thus philosophy is ulti-
mately an interpretation of interpretations about the world. Its roots
lie in the verbal dialectic of history. Since this verbal dialectic
itself is an interpretation, it too is subject to philosophical cri-
tique. A philosopher can never rest secure in his or her own thinking.
Hence, philosophy is basically a search for the origins of meaning in
interpretive signs about the world, our language, institutions, sciences,
and art. Merleau-Ponty calls this unearthing of the origins of meaning
an "architectural" task.

Simultaneously with unearthing, the philosopher constructs a set
of his own interpretative signs. Merleau-Ponty calls these a kind of
"algebra" of history, symbolic abstractions from everyday language that
express interrelationships discovered. This function of philosophy
is ultimately based upon choice.

The choice that relativeizes all philosophical thought is, as
Whitehead put it, a choice to consider what is important about matters
of fact. Matters of fact are the immediate, rich, and vast experiences
that inundate each moment of existence. The choice used to select what
is important, or what is remarkable or noticeable about this experi-
ence, is largely dictated by cultural concerns, present and past, and
personal concerns of the philosopher.
This choice necessarily leaves behind matters taken for granted and casts an identifiable tissue of significations on the philosophy so constructed. Later, others will question both this tissue and the matters taken for granted, giving birth to a history of thought. In this initial choice, Aristotle noted, philosophy and tragedy, indeed, all disciplines, coalesce.

II. CHAPTER TWO: THE WORLD OF THE STREET

A. A Defense of Our Choice for a Philosophical Perspective

The philosophical perspective used in this work is guided by the motives and guidelines mentioned in Section 1, Chapter II. It is an eclectic perspective guided by empirical realism and the validity of science. These characteristics are necessary to examine the real effects of the clinical interaction.

But this perspective is also motivated by a reading of philosophical concerns since Descartes. All philosophy, since Descartes, is an attempt to reinsert man into the world of experience.

As remotely related as philosophers are, Kant, Hume, James, Dewey, Husserl, Heidegger, Sartre, Marcel, Scheler, Schutz, and Merleau-Ponty are related in their common attempt to describe the origins of meaning of the "bathos of experience," as Kant called it. James, Dewey, Husserl and his followers, were united in their insights about the origins of science in the "world of the street," the sense-world, the Lebenswelt. To a certain extent, this concern rediscovered Aristotelian realism about the unity of the body and soul, and the role of sense experience in the construction of concepts and sciences.

The radical empiricism that can result from this trend can be discovered from various starting points. One may start with language, as did the later Wittgenstein, and discover that language does not refer to objects but to other everyday languages. One may begin with geometry, as did Husserl, who discovered that the concept of a circle depended upon prior life-world experience in perfecting a circular object. Or one may start with perception, as did Merleau-Ponty, and discover that the world is already interpreted by the body prior to conceptions. One may start, as did MacIntyre and Gorovitz, with scientific canons of correctness and be led to a discovery of individuals in the nonscientific world of the everyday. Or one may start with the physiological organization of the body, as did Dewey, and be led to the nature of experience. The approach is endless; the discovery the same. Science, institutions, concepts, organizations, theories, laws, philosophy itself, all depend upon a logically prior world of experience.

B. Description of Radical Empiricism

The understanding of what is important about medicine and about recent philosophical thought leads to adoption of a radical empiricism.
This empiricism is characterized by:

1. Ambiguity rather than the clarity of science. However, like Kant, this empiricism will respect the insights of the sciences and the autonomy of morals.

2. Realism rather than idealism. This philosophy limits speculative philosophy.

3. Pragmatism in Dewey's sense. Man is homo faber and homo symbolicum (Cassirer) logically prior to being homo rationalis.

4. Radical reflection on the reasons for action. It maintains a critical distance from actions. As such, it is rational in that its maxims and axioms are descriptive, not prescriptive. It delineates realms of discourse, but does not command actions.

5. Deciphering life, not explaining it. Meaning arises in the interhuman event through bodily expression and language. Hence worlds of experience only exist as perceived and communicated.

6. Appreciation of the reality of relationship and historical change. This reality is decorated with value.

7. Hence, it is a lived logic, a thinking, a search.

III. CHAPTER THREE: THE REFLEXIVITY OF THE BODY

Of greater importance for a philosophy of medicine is what the body interprets the world to be prior to any conceptualization. Merleau-Ponty sets up this analogy: the body animates the world of experience as the heart does the organism. The body is a means of presence in the world as well as an absence, a distance from experience which allows it to be questioned.

Avenarius' attempt to describe pure experience (Kritik der Reinen . . . commentaries by Lenin), which influenced Ernst Mach, fails because he did not take into account the impossibility of pure experience. The source of this argument is that the body perceives in two ways, prior to thought and conception. It perceives a phenomenon and it perceives that it is perceiving that phenomenon. This double perception can be called the reflexivity of the body. In Section 3, we will use this concept in exploring the nature of disease. At this time, three important points need elucidating, and terminology needs clarifying.

A. Three Important Points

1. While the immediate presence of the phenomenon can be localized in one or more sensoria, the reflexive presence is possessed by the body as a whole. Homogenity of the body.

2. Because of the immediate presence of the phenomenon, the body pre-consciously selects that which it regards as important, what is to its advantage, from what is "matter of fact." Selectivity of the body.
3. The body organizes its perceptions of what is important and creates a bionomic order or a unified structure of experience prior to conscious reflection on the contents of perception. Bionomic organization of perception.

B. Clarification of Terminology

It should first be noted that all distinctions made herein are logical, not serial. When we speak of three worlds of experience, we are therefore describing three simultaneous activities of the body.

1. The immediate presence of the phenomenon to the body we shall call "brute" experience, world #1: the lived body, ground, the preexpressed or prearticulated. The reflexive presence of the body to its immediate presence we shall call "expressed experience," world #2: the lived self, figure, expressed or articulated sign. World #3 will be the symbolizing activity of the body, a world of experience created by conceptualization, abstracting, speech, institutionalizing, and the like. It is the world of scientific symbolizing, articulation in systems of "thought," and institutions. This realm is properly the realm of "consciousness," which in turn can be immediate and reflexive. To use older terminology, world #1 is the "bathos of experience"; world #2, the life-world; and world #3, the more abstract "scientific world."

2. By "lived body," we shall mean the body (my body) insofar as it cannot be objectified. As such, the immediate awareness of perception constitutes a material a priori of undeniable experience. I perceive that I am perceiving, therefore I am.

3. The "lived self" is the other side of immediate presence of phenomenon. It is the reflexivity of the body, the proto-selection of importance from brute experience, the preconceptual articulation of the world. Its interpretations of the world, indeed, its creation of an individual's world of experience, are expressed in signs that are not yet concepts. The lived world is the individual bodily history. When this concept and the concept of the "lived body" are used to describe health and disease, we shall see that the world of experience created by the lived body (that is, the lived self) is a partially public world. The scientific world, on the other hand, is more totally public in that it expresses scientific laws that can be grasped in different cultures by different lived selves.

IV. CHAPTER FOUR: PHILOSOPHY AS RADICAL REFLECTION

The distinctions made in the prior chapter enable us to see that philosophy can be either the activity of the lived self or a discipline shared by others. One might recall Merleau-Ponty's distinction between an archaeological activity and an algebraic activity (worlds #2 and #3 respectively). Philosophy can be a personal discourse, as Socrates' was, about the life-world, and the origin of meaning in everyday languages. In fact, Socrates' life was an attempt to discredit much of what was contained in world #3.
However, as a world #3 activity, philosophy can be either radical reflection on the life-world or critical reflection on world #3.

V. CHAPTER FIVE: THREE PHILOSOPHICAL MODES TO BE EMPLOYED

Based on the development in this section, we will employ three successful modes of philosophizing on medicine. First, we will describe what is important about the clinical relationship. At this point, again, others may find different matters of fact to be important. It is worth noting, however, that matters of fact not considered important are usually taken for granted. Descartes, for example, seemed to take the unity of body and soul for granted. What interested him was how any distinction might be made between them. What is regarded as important, however, should never be separated from matters of fact. We have already argued that the world of brute experience is inseparable from worlds #2 and #3. Only logical distinctions can be made for purposes of clarification. As Thomas Aquinas said, "distinguuo ut unitur."

Secondly, Section III will contain radical reflection on what is more important and what is most important, in an effort to cull the distinguishing feature of medicine from all other features.

Finally, in Section IV, critical reflection will take place on the distinguishing feature of medicine, which we will describe as a corporeal ontology.

Terminology again needs some clarification. What is important as a result of description we shall call "modes" of the clinical relationship. Those features considered more important shall be called "forms," and the feature regarded as distinguishing medicine from all other disciplines shall be called its "form." Forms and form are the result of the radical reflection, a kind of heightened form of dialectical reasoning. The necessary material a priori of the form of medicine we shall call "structures." Structures are the result of critical thinking and can constitute a world #3 philosophical discipline. We do not intend to signify by any of these words some immutable essences that idealists are fond of. Instead, at the most, these modes, forms, and structures are present to an increasingly universal degree (from modes to structures) in medical practice throughout history. In other words, modes appear less universally than structures in historical development.

SECTION III: WHAT IS MEDICINE?

I. CHAPTER ONE: THE UNANIMOUS NATURE OF MEDICINE

Unlike philosophy, medicine is capable of greater agreement about its definition. However, recent thinking is vague about its nature, perhaps due to positivistic descriptions such as "medicine is what doctors do." Hippocrates, Galen, Aristotle, Socrates, and Plato devoted considerable effort to discovering the nature of medicine. Hippocrates called it healing. Socrates, Plato, and Aristotle developed a more rigorous philosophical conception of medical practice and theory. During the Middle Ages it was sufficient to describe a physician as
vir bonus mendendi peritus.

Due to the rapid rise in complexity of modern medicine, however, and secondary to the task of developing a philosophy of medicine, recent descriptions of medicine as a science or as an art are insufficient. Medicine is not entirely an "applied science." It cannot be reduced to biology or chemistry, as some would like, because medicine is a relationship between human beings, not a study of objects.

Medicine is at once the most humane of the sciences and the most scientific of the humanities (Pellegrino). As a profession, it is a certain power of handling symbols as well as signs--world #3 realities as well as world #2.

II. CHAPTER TWO: IS MEDICINE A UNITARY DISCIPLINE?

A. There can be no philosophy of medicine unless medicine, as such, is an integral discipline. The medical event is a clue to its unity, just as its complexity indicates why medicine is neither science and art nor both. The medical event is a restoration of well-being or cure. When a cure does not take place, medicine is said to have "failed." Secondary factors in the medical event then take place, factors such as "management" of the patient's illness, control of symptoms, or reduction of suffering. The medical event is a special form of individualizing knowledge, and as such establishes medicine as an integral discipline. It remains to develop this point conceptually.

B. Conceptual Arguments for Clinical Interaction as the Source of the Integrity of Medicine as a Discipline

1. The clinical interaction both reflects and influences social morality. Legal, moral, political, and economic considerations surround the action.

2. The clinical interaction represents a social division of labor from which medical practitioners derive education and prestige.

3. The interaction is a source for patient education and rights.

4. Distinctions of primary, secondary, and tertiary care are at least partially based upon the degree of patient participation present in disease and cure.

5. The internal distinction in medicine between research and patient care, theory and practice, depends on the clinical interaction as point of reference.

6. Elements involved in medicine (biology, chemistry, physics, mathematics, technology, interperson relationships, explanation, values, ethics, politics) cannot be unified except through the interhuman event. An understanding of the clinical interaction necessarily involves all these elements. E.g., pathology can be understood
without reference to a clinical patient, but not vice versa; diagnosis as an art can be understood without reference to an individual problem, but not vice versa.

7. Historical: the motivations for knowledge and skill in medicine have always stemmed from the clinical interaction (cf. Lain-Entralago, La Historia Clinica).

8. Distinctions between health care teams can be fruitfully drawn, based upon the directness of clinical contact with patients (Pellegrino).

9. The analogical explanations and symbols used to trace the genesis and causes of disease depend upon clinical interaction for their conceptual validity. History-taking or biography is essential to medicine, and history-taking involves interhuman interpretation. Clinical interaction is the material a priori of medicine as a discipline.

III. CHAPTER THREE: WHAT IS IMPORTANT ABOUT CLINICAL INTERACTION?

Medicine is a form of relationship. It is now necessary to describe important features of this relationship, bearing in mind the discussions of importance and of matters of fact developed earlier: the selection of what is important should not be misconstrued as a complete catalog of features of medicine.

A. Descriptive Catalog of Important Features of Medicine: MODES

1. As a Relationship:

   a. It is a locus of mutual responsibility.

   1) It is a relationship of sociological and epistemological division of labor.
   2) It is a relationship of imbalance implying greater responsibility for greater degree of knowledge.
   3) It is a didactic relationship.
   4) It is a relationship of intermediacy and intervention.

   b. It is a relationship of trust.

   1) Medicine as assistance: extending a helping hand.
   2) Prediagnostic judgment: gives rise to primary, secondary, and tertiary care.
   3) Diagnosis depends upon objective givens and subjective interpretations.
   4) Individuation: as science, it is the prediction and control of disease. As art, medicine deals with an individual lived body and lived self.
c. It is a relationship dominated by the necessity to decide.

1) The tension between medicine as assistance (clinical) and medicine as explanation (pathological) can be bridged by an experimental judgment.

2) This experimental judgment is a kind of empirical-inductive reasoning to be outlined later. It is dominated by the individuation of b. 4), above.

d. As a relationship it is capable of multietiological description.

1) The curative intention of patient and physician is a telos of restoration.

2) Motives of the relationship are also many: attitudes toward disease, seeking confirmation, love of the discipline, a check-up, an irritation or disruption of life, fear, and so on.

3) The distinguishing feature depends upon the primacy of some modes over others. Initially it can be noted that what is primary is not forgiveness (religious relationship) or coping with guilt (psychiatric relationship) but well-being.

2. As a Relationship with Structure

These initial observations indicate that the medical relationship has a structure capable of being examined by a critical reflection. Three immediately obvious structures or axioms are:

a. Man cannot be understood in the medical relationship in purely mechanical terms.

b. The medical relationship assumes that human beings are responsible and reasonable.

c. The medical relationship assumes that well-being or relief from suffering is an obtainable goal.

B. A Genetic Description of Medicine

Medicine is the art of applying science and persuasion through a complex human interaction in which a mutually satisfactory state of well-being is sought, and in which the uniqueness of values and disease determines the nature of the judgments made.

The unique form of this relationship will emerge in the next chapter.
IV. CHAPTER FOUR: REFLECTION: WHAT IS MORE IMPORTANT?

A. Inadequacy of Definitions

Definitions leave behind the historical and the concrete in favor of what is more important for understanding. To know well, one must know something in detail. Because brute reality is almost infinitely rich, the knowledge gained by definitions is necessarily superficial knowledge.

Given this caution, the medical relationship is established by a form of medical judgment.

1. All judgments "relate." In this case, medical judgment relates a body of scientific knowledge to a lived body and a lived self.

2. This judgment is a judgment of discovery of an unforeseen relationship. The concept of tragic judgment developed by Aristotle is helpful for understanding the parameters of the medical judgment as discovery. Diagnosis.

3. It is an anticipatory judgment based upon the organization of the body and its world. Prognosis.

4. It is a judgment governed by therapeutic necessity. This form of therapeutic necessity leads to the following characteristics:

a. It is a judgment of individuation made about a concrete lived body and lived self.

b. It is a judgment formed both "personally" (in Polanyi's sense) and "rationally" (in a scientific sense). In other words, it is a judgment of a medical three-world experience and the patient's three-world experience.

c. It is therefore a "notional inductive judgment." Comparison with "imaginative preconception of natural laws," "experimental idea," "empirical-inductive reasoning," and "idee directrice" (Bernard) will take place at this point.

B. The Distinguishing Feature of Medicine: Its FORM

1. A definition of medicine involves finding its distinguishing feature or form. Philosophizing upon the form will lead to structures and to the possibility of a rigorous science of medicine, understood in the Aristotelian sense.

2. Medicine is an interhuman event, as distinct from a person-thing relationship.
3. It is an interhuman event of consent (assent plus assent), which distinguishes it from other personal relationships that do not involve consent. As such, it is a meeting of two personal intentions, the offering of technical help and the hope of getting well. The medical event, therefore, is two personal intentions effecting a techne iatrike, a craftsmanship of healing. As the intensity of care increases, the intensity of personal involvement of patient-consent decreases.

4. It is an imbalanced techne whose ultimate balanced source is the realization of death in both patient and physician.

5. It is a didactic relationship distinct from law and education by the act of individuation with a social purpose. In medicine, there is no "action at a distance" from the body.

6. It is a consenting relationship governed by a telos, for its form:

   a. Motive: The subject feels ill. Minimally:

      1) There is a sign or symptom in the lived body, with which one does not feel able to cope.
      2) It is interruptive of an ability to function as a lived self (historical identity and values).
      3) It is a deviation from the subject's conceptual idea of well-being, a highly value-laden conception involving social function, identity, and interpersonal relationships.
      4) There is fear; the subject seeks information on pathogenesis, and seeks confirmation as individual worth.

   b. Telos: To be "cured." Minimally:

      1) Restoration, at least asymptotically, to the former state of perceived health or well-being. This is a "personal" restoration, not just an organic one.
      2) Corporeal information is sought about disease, not only valued in itself, but also valued anticipatorially, for avoidance in the future.

7. The form of medicine: perceptions of "illness," as well as the judgment of diagnosis, prognosis (anticipatory), and therapeusis all depend upon working WITH AND THROUGH THE BODY. Through this touch of the body, the physician touches the lived self, the personal life of the patient. This form of medicine offers the following structural considerations for an ontology of medicine:

   a. The body must be capable of forming scientific and conceptual formulations of the causes of disease.
b. The lived self of patient and physician must be capable of forming notional judgments.

c. The lived body of patient and physician must have a direct, undeniable but prearticulated awareness of pain.

C. The Lived Body and the Lived Self: Health and Disease

Discussion of the concepts of health and disease is characterized by confusion. This section is designed to help clarify the sources of that confusion.

1. Both patient and physician are capable of a scientific or conceptual understanding of health and disease. This world #3 level of experience is an abstraction from the everyday. In this level, a "symptom" is a symbol of disease. Well-being is either ideally defined on the basis of a balance or homeostasis of the body, or alternatively, defined (mostly by the patients) in terms of a life philosophy (e.g., the ability to experience life to its fullest).

2. Simultaneous with world #3 experience, the lived self of physician and patient experiences "dis-ease," which is distinct from scientifically explained "disease." This dis-ease is not yet a scientific symptom, but a sign of the lived self. In this world of experience, pain and suffering are interruptions of the lived self, forms of the powerlessness of purposive action. Dis-ease is not a symptom, but a sign of interruption.

3. Simultaneous with world #2 is the world of brute experience. Pain and suffering are experienced immediately, by the lived body. But this pain and suffering may not be interpreted by the body as a dis-ease.

The above considerations lead to the following brief digression on the relationship between medicine and religion and medicine and psychiatry. The digression is intended to point up the form of medicine more clearly.

**Medicine and Religion**

While medicine deals with dis-ease through symptoms and the immediate experience of pain, religion does not primarily deal with expressions of bodily dis-order. Instead, religion views the body and the lived self as expressions of the invisible (sacral nature of the body). For religion, dis-ease is not detected through the body per se, nor is the telos of religious interactions effected through action with and through the body. Sin and illness for religion are a dia-thesis of personal unity. Instead of direct intervention on the body, religion works on the lived self through the body by an "action-at-a-distance," a therapy of the word (Lain-Entralgo).

Religion attempts to remove guilt and anxiety through a mediator-
ship with that which is beyond man's control. Religion, psychiatry, and medicine conjoin in relationships of mediatiorship. But psychiatry and medicine are distinct from religion in that the mediatorship in the former is between man and what is within his control. The source of the conjunction of the three is the body's interpretation of the world. But the distinction between medicine and religion is clear enough to postulate that medical judgment is distinct from ethical or moral judgment.

**Medicine and Psychiatry**

Although psychiatry is a branch of medicine, it shares with religion a concern primarily for the lived self. It therefore shares with religion a methodology of therapy of the word. Unlike religion, and like medicine, it is a mediatorship with that which is within man's control. It does not seek to remove guilt and anxiety; rather it helps patients cope with them. It is a form of secular religion. The therapy or words is primarily used, as in religion, to effect a cure (as in medicine) which consists of constructing a biography with the patient. The psychiatrist helps form a personal identity for the patient from which the patient can construct a possible future. A "normal" person has a sense of a possible future through experience as a lived self in the past.

The concept of "biography" is essential to the distinction between medicine and psychiatry. For psychiatry, the nature of the dis-ease is primarily an interruption of the lived self. The subject finds an inability to cope precisely because he or she lacks a sense of being a lived self, lacks a sense of personal identity or history, whereas in medicine, the subject seeks help precisely because the pain or suffering interrupts a well-established lived self. An immediate awareness of pain or a dis-ease in the lived self becomes a medical symptom because the patient has an experience of the lived body not being this way. A dis-ease in the lived self becomes a psychiatric symptom, often without pain in the lived body, because the patient no longer has a lived self.

**D. Medicine as Craftsmanship**

The concept of "cure" and the binality of telos, restoration and information, lead to a further consideration of the nature of medicine as skill. The physician must have skill in experiencing the immediate awareness of pain shared with the patient (compassion presupposes a shared bodily structure), the notional empirical exploration of the lived self (skill in relating dis-ease with values of the lived self), and perceiving the necessary relationship in world #3 between symptoms and remedies. Skill or craftsmanship (techne) involves knowing the what and why of a action, unlike art, which can be instinctively correct without such knowledge. Hence modern medicine has an additional telos of individuation, the application of science to specific individuals.
E. Definition of Medicine: Three Theses

Medicine is formally a mutual consenting interaction to effect individualized well-being in and through the body. This formality is possible (its ontological structure) because the body is an artist. The body is both the act of interpreting the world (artist) and the product of that interpretation (art). It is both lived body and lived self. Dis-ease is an interruption of the product. Physiological pain is an interruption of the artist.

1. The medical or clinical interaction is a medical event in which rationalized individuation takes place, where "rationalized individuation" entails discovery of a necessary analogous relationship between scientific pathogenesis and the individual patient.

2. Where "medical event" is the individualized praxis produced by two or more personal intentions effecting a craftsmanship of healing (techne iatrike) in and through the body.

3. Where "craftsmanship of healing" is a judgment of interpretation relating science to specific individuals, mutually motivated by human concern, in which an ontology of man is presupposed.

   a. Any judgment linking knowledge and individuals is moral. The moral realm is composed of art and ethics. What is ethical in each case has as its bottom line the lived self of the patient and the presupposed anthropology.

   b. The presupposed anthropology has as its starting point the condition of possibility for the medical event, namely the perfectibility of a human being in and through the body.

   c. Medicine as a disciplined body of knowledge in physicians is a science respecting the perfection of lived bodies concretized by skill in experiencing connections between corporeal symptom and remedies.

SECTION IV: CRITIQUE OF MEDICINE: A CORPOREAL ONTOLOGY

I. CHAPTER ONE: ONTOLOGICAL CRITIQUE

A. Kantian Critique

Following the radical reflection that issued in a definition of medicine, the critical reflection on the form of medicine will issue in an ontological critique. A critique uses the critical powers of reason in constructing a rational approach; it examines forms or structures of experience, not the concrete and various matter of that experience; it examines the unitary features of a discipline, not the individualities; it examines relationships of implication, not linear causes; and it results in an ontology of conditions of possibility.
The Kantian critique of pure reason was an attempt to search for the conditions of possibility of synthetic a priori judgments present in the physical sciences.

B. Characteristics of a Critique of Medicine

The critique we will construct does not start with synthetic a priori judgments, but the capacities to act in the medical relationship. It focuses on the forms of interaction, the distinguishing features of medicine. It takes as its material a prior starting point, the clinical interaction itself. The question guiding the critique will be: How is it possible to effectively apply universal science about causes of disease to an individual lived self?

One should note from the outset that the conditions of possibility established herein are conditions of possibility of a reality experienced by those partaking in an effective relationship of healing. Cures take place. How is that possible?

II. CHAPTER TWO: NECESSARY CONDITIONS OF POSSIBILITY FOR THE CLINICAL INTERACTION

A. Optimum Interaction

The clinical experience of medicine demands a critique precisely because it is a form of experimentation on a human being. We will be describing a form of medicine that is ideal, namely, that takes into account all of the forms mentioned so far.

B. The Structures of Medicine

We have argued that medicine is constituted by the clinical relationship. But modern medicine is far more complex than that. Modern medicine involves preventive, community, crisis, and experimental care. All of these, however, derive their meaning from the medical judgment that must relate scientific knowledge to individuals.

The focus on clinical relationships is therefore appropriate but not comprehensive. These relationships involve another set of complexities, a juggling act of interactions. In order to clarify these interactions, the conditions of possibility or structures of medicine will be treated in three ontological levels: the world of scientific thought, the everyday world, and the world of the living body. By "ontological" is herein meant that all three occur simultaneously but are distinguished for the sake of logical clarity.

1. The Structures of the Scientific World (level three)

Medical judgment is an act relating scientific knowledge to individual human beings. Conditions of possibility:
a. Scientific explanations are real in the sense that they are capable of being extracted from and applied to living human beings, often with beneficial effect.

b. Scientific explanations involve true causality in the Aristotelian sense.

c. Medical scientific judgments differ from pure science in that they are governed by individualization.

1) Individualization is a science of individuals.
2) The extent of individualization is the source of the distinction between primary, secondary, and tertiary care.
3) Rehabilitation depends upon the extent of individualization, which in turn depends upon the discovery of the "wisdom" of the body.
4) Medical judgments are anticipatory.

d. Medical scientific judgments are like those of pure science in that they rest upon culturally conditioned and value-laden notions of disease from the everyday world (level two) and universal structures of the body (level one).

1) Coherence is an insufficient condition of medical theory.
2) Grounding in the everyday world would lead to medicine as culturally relative. This too is an insufficient condition for the reality of cures.
3) Medical judgment must be grounded in the universal structures of lived bodies.

e. Medical judgment is empirical-inductive, but this process depends upon analogous "judgment" made on level two and level one.

1) Medical judgment involves facts and values.
2) Medical judgment is uni-ascendant, in which one party retains an imbalance of responsibility.
3) Medical judgment is a moral act. There is no morally neutral medical judgment.

f. Medical judgment is threefold: diagnostic, prognostic and therapeutic. All three depend upon reference to a body.

1) Diagnosis links symptoms with scientific causes. This judgment rests upon the body, the universal structures of bodies, the truths and myths of the everyday world, and the accuracy of the scientific model and tools.
2) Prognosis links this disease with similar patterns. It is governed by scientific and everyday pattern recognition, probability, and the experience of the body. It is more art than science. The limit of prognosis is death. Prognosis is anticipatory judgment, resting on the anticipated nature of the body.

3) Therapeusis links diagnosis and prognosis with the interpretations of the lived self and lived body. Due to this link, medical judgment is governed by a necessity to decide. This necessity gives rise to contractual relationships and the involvement of human and civil rights.

2. The Structures of the Everyday World (level two)

The structures of medical judgment imply, as their condition of possibility, the existence of structures in the everyday world. These are:

a. Notional judgment, an everyday, gradual growth of a notion through empirical-value experience.

b. Mutuality of everyday lived selves: a commonality.
   1) A commonality in language.
   2) A commonality in shared objects.
   3) A commonality in the source of individual identity.
   4) A commonality of experience.

c. The possibility of perception of the other as lived, and not just as object.

d. The integrity of the lived self:
   1) Which, absent, constitutes dis-ease for psychiatry.
   2) Which, when present, constitutes dis-ease for medical science and the motivation of seeking help.

e. The origin of values shared with others.

f. The praxis on which theoria is based.

3. The Structures of the Lived Body (level one)

The condition of possibility of levels two and three is the body as:
a. Simultaneous with itself: self-reflexive before intellectual articulation (level three) or praxis (level two).

b. Art and Artist: creator of the world of perception and the object of its own creation.

c. Compassionate: identity of direct, immediate experience.

d. Protoselective: the body as primarily and originally selective of importance from matters of fact. The source and origin of values, including the values upon which both ethics and concepts of disease are based.

e. Constituting a facticity of an individual world not shared with others in the same way.

f. Constituted by a universal structure. This is the "wisdom of the body," personal unity of the body, source of the lived self, body experienced as centered unity, homogeneous with itself.

g. Hence, the condition of possibility of the application to and derivation from a lived body of any knowledge or praxis whatever are the "permanent" organic structures and functions of the body, not just as parts, but as a homogeneous whole.

4. Summation

Bodies interact with other bodies. Each body arranges its world through interaction with lived and nonliving objects. These arrangements are not capricious, because they rest upon common universal structures of lived bodies; neither is there one reality common to all, as each body arranges and articulates (levels two and three) its experience in different ways. The "world" formed by the lived body is in part a common world.

The source and origin of common world #2 and #3 reality is the primal distinct experience simultaneously interpreted by the body as a whole. Thus, facts are already values. Thus medicine as science is also forced by the body to be medicine as art.

The primal experience of the body must be present in interacting lived bodies, as in the medical relationship, in order that scientific explanations have a common base. Thus, "it hurts" is understood by the physician in a direct way (compassion) and simultaneously in an indirect way, through the commonalities posed in the everyday world (the interruptive effects of pain on the lived self), and through the scientific conceptions of pain. But without the direct experience of "hurting," no science of individuals can be created with understanding, nor could the clinical relationship "work."

Put another way, medical science refers to its own collective body of theories, to the everyday world of values and dis-
ease, but primarily to the individual body, both in its universal organ- 
ganic structures and functions, and its individuality, its proto-
selective mode of interpretation of its direct experiences.

C. Medicine is Multietiologic

Medicine as the clinical relationship involves discovery of real relationships between causes of health and illness and the effect of these causes on individuals. The material a priori of medicine is the body as art and artist, as a simultaneous movement of direct experience, integral experience, and proto-interpretation. The motivating causes of medicine on the part of the patient are, immediately, a sym-
tom in the body with which we cannot cope, more remotely, a symptom recognized by us or others against the history of the lived self (the origin of the scientific conception of health and disease), and most immediately, the fear of the unknown, producing a wish for cure and for information.

The telos of medicine is restoration and information, i.e., personal cure. Remotely, medicine is guided by the desire to perfect the structures of the human body.

Constitutively speaking, medicine is ultimately an intuitive act effected in and by the body. This act is acquired through skill in perceiving analogous relationships between scientific knowledge and specific human problem (pattern recognition). The most satisfactory and ideal form of medicine would produce a skill in medical judgment resulting in a mutually satisfying solution in the lived selves of both physician and patient.

D. The Possibility of Anthropology

The conditions of possibility of medicine themselves have condi-
tions of possibility. These in turn reveal the bare bones of an outline for philosophical anthropology.

III. CHAPTER THREE: CORPOREAL ONTOLOGY

The structures of medicine depend upon a "brute reality" in bodies. This brute reality is an unarticulated absolute, that is, a universal structure of being alive. In view of the rejection of the model of "human nature" derived from the Greeks because of static and idealistic interpretations, and the rejection of "natural law theory" attendant upon the former rejection, it would seem best to call this universal reality an ontological structure of the human body.

The question of universal application to individual human beings is not new. Plato treated the question and resolved it by arguing that the physician has a proton philon for human nature as realized in an individual and concretized as iatrification for the medical event. From this view, the concepts of art, procuring a good, hubris in prac-
tice, and of human nature come to light.
Aristotle solved the same problem by resting the proton philon in a oikeion, a union in nature. Thus customarily, he brings the love of being back into the individual from the ethereal realm of idealism. The physician was to be a servant of art and logos, and thus, a servant of concrete human nature. Briefly, ethical theory can differ as a result of the difference in solutions to the perennial medical problem regarding interactions.

In the Middle Ages, the concept of cure was broadened to include remote and proximate causes of well-being. The Christian view of the ultimate cause of being led to a concept of art as overcoming nature, and of man as the center of the universe.

Further historical tracing leads to the insight that the solution to the question of how universal medical knowledge can be applied to individuals can lead to totally different conceptions of man. The brute reality discovered by the structures of medicine today can lead to an anthropology resting on a logos andriothetos (Merleau-Ponty), a prearticulated wisdom of the body. This structure allows for relativized everyday practices and medical theories, while simultaneously insisting upon the universal organizations of the body grounding medical cures and medical causes of disease.

From this conception can be derived an anthropology of personal integrity, social structures, political life, ethical theory, and scientific truth. Some typical expostulations are:

A. Health and well-being are desirable goals. In fact, they are among the fundamental needs and aspirations of man.

B. The body is the source of personal identity.

C. If there be any dualism in man, it is not a dualism of mind and body, but a dualism of perception and behavior. (Behavioral psychology neglects the protoselection of the body.)

D. This dualism has ethical ramifications. Thus, virtue is also a desirable goal.

E. There is an absolute value in humanizing the world.

F. Individuality and sociality are ultimately integral in the body.

G. Moral agency is distinct from utilitarian purpose.

THREE CONCLUDING POSTSCRIPTS

I. The Relationship Between Art, Medicine, and Ethics

The question of the relationship is important. It will indicate how medicine is an art and also involves ethics. All application of knowledge to individuals is described as the moral realm. The moral
realm is subdivided into art and ethics. By "moral" realm is simply meant that class of judgments which by necessity involve values. By so doing, art, medicine, and ethics all touch upon the fundamental needs and aspirations of mankind.

A. The Relationship Between Art and Medicine

When individualized, the logos of medicine will be beautiful. There is an aesthetic delight that occurs when the "right" decision is reached, when economy of means and perceptions of ends bring about a rightness in treatment. However, the following distinctions accrue between art and medicine:

1. Art recreates a public sign, deriving from it an instrumentality of meaning. Medicine attempts to remove public signs (symptoms) through eradication of the causes. In this sense, medicine has a private aim through individualization, while art has a public aim through symbolism.

2. Should an artist wish to heal a community, he perceives the dis-ease of the community through the lived self and jiggles the Lebenswelt. Medicine perceives dis-ease to the end envisioned by the patient, not the community per se, and works upon the lived body. Medicine heals, not by jiggling the lived self, but by jiggling the body.

3. Art and ethics both deal with what ought to be, whereas medicine deals with what is.

4. In art, there is no necessity to decide. Enjoyment is its goal. In medicine and ethics, there is a necessity to decide.

B. The Relationship Between Medicine and Ethics

Medicine is intrinsically moral. Is it intrinsically ethical? Both medicine and ethics are governed by the necessity to decide, the concrete, individual problem, and similar judgmental structures. The only difference between ethics and medicine lies in the reference to the body intrinsic to medicine. Ethics may or may not involve direct action upon a body. Medicine must make such action in order to be medicine. An additional possibility for a distinction lies in the way ethical decisions are made. Generally, one rationalizes the rightness of action before performing it. Only post factum does ethical decision-making return to reasoning. But medicine must involve the structure and function of the body before it makes more concrete the possibility of reasoning prior to action. In other words, a proposed or possible action for ethics is less concretely visible than a sick body. Consequently, we are more apt to fool ourselves making ethical decisions than in making medical ones. The test of decisions for medicine lies in the effects on a body; the test of ethical decisions frequently lies in the more nebulous realm of consequences of actions.
B. Ontological Axioms for Medical Ethics

We avowed at the start of this work that medical ethics consists largely of assertions, some of which are not "lightly matched for their implausibility," to use a phrase of John Barth's. We now have presented an ontological basis for ethical decisions. Because the "brute reality" of bodily structure and function is prearticulated, all ethical axioms are relative in their formulation but simultaneously absolute in their ground.

Typical axioms that can be deduced from the corporeal ontology presented earlier are:

1. Medicine is based upon the presupposition of the absolute value of the individual.

2. Health and virtue are fundamental needs of man.

3. The individual derives "value" from protoselection of the body and universal structures of organization.

4. Personal identity does not lie in self-consciousness primarily, but rather in the reflexivity of the body in which a world of common objects is created. Thus, to argue that a fetus is not a person is insufficient.

5. As the level of care increases, the level of involvement of the lived self of the patient decreases and the responsibility of the health care professional increases. Medical ethics is an ethics of susceptibility.

6. Optimum medical care is directly related to the optimum involvement of the lived self of patients, as their values determine the consequences and identification of well-being and dis-ease.

7. Medicine presupposes that human beings are reasonable people.

8. The value of an individual does not depend upon economic status, but upon bodily integrity.

9. The wish and intention of the lived body coupled with the values of a community of lived selves govern the "rightness" of ethical decisions about individuals.

10. Value interactions take place as follows:

    science of medicine \rightarrow knowledge and myth of patients
    everyday praxis of medicine \rightarrow lived selves of patients
    lived body of practitioner \rightarrow lived body of patient
An example of value misfire would be as follows: An examination of the lived body of patient without attention to the lived self. A scientific answer to questions about a disease when an everyday answer is intended, and so on. Concrete ethical examples will be offered for each value interaction.

C. Qualities of a Good Physician and Medical Education

"Medicine absorbs the physician's whole being because it is concerned with the entire human organism." -- Goethe

It can be seen from the preceding philosophical discussions that medical education suffers from an overdose of science and cookbook how-to's, rather than offering a profound awareness of the value of the individual and the values of that individual in the diagnosing and treating of disease. Without disparaging the scientific aspects of medical education and of a good practitioner we offer the following characteristics as necessary for good medical practice:

1. Skill at individualizing knowledge. This is an art, not an applied science. It takes time, experience, and pattern recognition.

2. Corporeal attentiveness. The assumption that lab work-ups are sufficient to practice medicine stems from training in tertiary care settings where the involvement of the patients' lived self is minimal and the disease is complex. Lab work-ups and Harvey Teams all neglect the concreteness of the individual and his or her values. Students need to give attention to the lived body itself.

3. Explorative Skill: Training in each step of empirical-inductive decision-making is necessary. The relationship of two lived bodies making protoinductions about one another, the guiding hand of the notional induction on level two as it influences the scientifically reasoned induction on level three, and the canons of correct medical reasoning are all necessary components of a medical education.

4. Medical practitioners must be able to put the human body back together again after dealing with it piecemeal in organ-system study. No one body resembles another perfectly. No one lived self resembles another perfectly. Medical education should create a balance between study of parts and wholistic study.

5. Good medicine is guided by the pressure to decide, the source of contractual relationships between physicians and patients, and the origin of the bond between medicine and ethics. A good medical education explores the relationship between ethics, medicine, and the law.

6. Medicine is a techne iatrike, a craftsmanship of healing. Practitioners need help in maintaining their love for human beings in the concrete, for healing takes place through both science and art, through knowledge and care. The culture and character of the physician
can be enhanced through dialogue with the patient. Since dialogue no longer means "reasoned discussion," but rather "rapping," perhaps we could offer a new word: "diazone" (from dia-zoon), a process of proto-attention to the body of the patient and its messages, the symbolic and value-encased commonalities and differences of the lived selves, and the scientific analysis, discussion, and application--all guided by the concerns of the patient for well-being, a concern only the patient can articulate with satisfaction. With this craftsmanship in hand, the famous words of the Hippocratic corpus will echo in our own time: "Where there is philanthropia, there is also love for the art of medicine (philotechnia)."

2 , "The Most Humane Science: Some Notes on Liberal Education in Medicine and the University," Sixth Sanger Lecture, Medical College of Virginia.


9 , Embers of the World, Conversations with Scott Buchanan, ed. by Harris Wofford, Jr. (Santa Barbara: Center for the Study of Democratic Institutions, Vol. III, #2 of the Center Occasional Papers).


27 G. Maranon, Critica de la medicina dogmática (Madrid, 1950).
28  Von Weizsäcker, Grundfragen medizinischer Anthropologie (Tübingen, 1948).

29  Max Scheler, Die Stellung des Menschen im Kosmos (Darmstadt: Reichl, 1927).


35  H. Tristram Engelhardt, Jr., "The Ontology of Abortion," Ethics, 84 (no. 3; April, 1975), 217-34.


40  Harold M. Graning, "Concept of Patient Care," in Ibid., pp. 16-17.


50 Edward O. Dodson, "Further Thoughts on Molecular Biology and Metaphysics," Perspectives in Biology and Medicine, 18 (no. 3; Spring, 1975), pp. 306-312.


59 Marx W. Wartofsky, "The Mind's Eye and the Hand's Brain," draft of a paper to be delivered.

60 Alasdair MacIntyre, "Towards a Theory of Medical Error," a draft of a paper now being redesigned, delivered at the Society for Health and Human Values meeting, Nov., 1975, with Samuel Gorovitz.


OBJECTIVE

This study is an attempt to document the frequency with which practicing physicians are presented with certain problems in the human dimension of medicine and the relative difficulty they experience in dealing with these problems. General areas include: abortion, drug abuse, contraception, sexual problems, death, counseling, geriatrics, social/political aspects of health care, physician-patient relations, and personal problems associated with being a physician. (See copy of questionnaire for the specific areas.)

BACKGROUND

A useful development in medical education is the documentation of what active primary care practitioners actually deal with on a day-to-day basis. This allows medical educators in academic and tertiary care centers to evaluate the relevance of their educational programs for future primary care practitioners.

Medical education in the recent past has focused almost entirely on the biological aspects of disease. A large proportion of patients, however, present symptoms for which the physician does not find an advanced stage of organic disease. "Greater attention must be given in the education of the medical student and the house officer to people and to the psychosomatic and functional problems which overlie early or incipient organic illness." In addition, a small but growing number of medical educators have begun to explore the human values associated with the practice of medicine. Each of these efforts needs an empirical research base.

Medical educators have limited awareness of the types of problems faced in the daily office practice of medicine. This means that faculty, curriculum planners, and course designers need information from the world of medical practice.

Recent studies have shown that it is advisable to involve practicing, primary care physicians and medical students, in planning improvements in curriculum. It is apparent that the problem areas in the human dimensions of medicine need to be identified and described by practicing physicians so that effective education experiences can be developed and implemented.

METHODOLOGY

In order to provide data on the human dimensions of medicine encountered by physicians, a research tool was developed (see question-
This questionnaire was refined through several cycles of interviews with medical educators and by pretests with practicing physicians. The protocol for this study was approved by the Committee on Clinical Investigation of the Pennsylvania State University College of Medicine in August, 1975. Eight hundred of the 1,328 active members of the Pennsylvania Academy of Family Physicians were sent a questionnaire and explanatory letter (see copies). In order to sample only the experience of mature physicians, questionnaires were sent only to physicians between the ages of 35 and 60, who have been in practice for at least five years. Doctors were selected from every county in the state to ensure a mixture of practice settings and patient populations. The data were compiled and analyzed by the author with the assistance of the staff in the Office of Research of the Department of Family and Community Medicine.

Preliminary analysis of the data is presented in this report. Further analysis of response patterns correlated with the parameters of physician age, sex, number of years in practice, and practice setting awaits future funding.

ANALYSIS

Demographic Data

Three hundred seventy questionnaires (45 percent of those mailed out and 28 percent of all active members) were used in this preliminary analysis. This response compares very favorably with the 30 percent average return rate for questionnaires issued by the Academy for other purposes.

Most of the respondents are between 37 and 56 years old and have been in practice between 10 and 29 years.

Table 1.

<table>
<thead>
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<th>Year of Birth</th>
<th>Age</th>
<th>Number of Responses</th>
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<tr>
<td>1910 - 1919</td>
<td>57 - 66</td>
<td>38</td>
<td>10</td>
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<tr>
<td>1920 - 1929</td>
<td>47 - 56</td>
<td>202</td>
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<td>1930 - 1939</td>
<td>37 - 46</td>
<td>109</td>
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<td>1940 - 1949</td>
<td>27 - 36</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
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<td>3</td>
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<td>Totals</td>
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<td>100</td>
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Table 2.

<table>
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<th>Number of Years in Practice</th>
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<td>Number of Years</td>
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<tr>
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</tr>
<tr>
<td>Totals</td>
</tr>
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</table>

Three hundred fifty-four (96%) of the respondents are males; fifteen (4%) are females.

Ninety percent of the respondents spend more than 75 percent of their time providing direct patient care. Seventy-five percent spend from 1 to 25 percent of their time in teaching and 60 percent spend 1 to 25 percent of their time doing administrative activities.

Sixty percent of the respondents are solo practitioners, while 15 percent are in partnership and 10 percent are in single or multispecialty groups. Four percent are in government service and 3 percent are on the faculty of a medical school or are associated with a residency program. The remaining 8 percent work in some other practice setting.

Fifty percent of practice settings are suburban, while 27 percent and 23 percent are rural and urban, respectively.

Most respondents receive some income from welfare clients.

Response Patterns

For this report, only "strong" responses, containing a number 3, were selected. These areas very commonly present problems in a physician's practice (frequency of 3) or are extremely difficult to deal with when they do occur (difficulty of 3). Some items were considered to be both very common and extremely difficult to deal with (3-3). The following three tables rank the items according to these three parameters.

Frequency

Of the 25 percent of respondents who wrote comments, approximately 3 percent expressed some confusion regarding the instruction for this section. They were unsure whether to rank the frequency of occurrence in their practice or the frequency with which these areas actually presented problems. The assumption was made that the majority of respondents answered according to the instructions, ranking the relative
frequency that these areas actually present problems in their practice.

To roughly gauge the relative frequency, a tally was made of all the times that a three (3) appeared in the frequency column (3-0, 3-1, 3-2, 3-3).

Table 3.

<table>
<thead>
<tr>
<th>ITEM #</th>
<th>KEY WORDS</th>
<th># of 3's</th>
<th>%</th>
<th>MOST FREQ. COMBINATION</th>
<th>%</th>
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<tbody>
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<td>7</td>
<td>Geriatrics</td>
<td>198</td>
<td>53</td>
<td>3-1</td>
<td>60</td>
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<td>1</td>
<td>Contraception</td>
<td>97</td>
<td>26</td>
<td>3-0</td>
<td>64</td>
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<td>9</td>
<td>M.D.-Patient Relationship</td>
<td>89</td>
<td>24</td>
<td>3-1</td>
<td>53</td>
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<tr>
<td>28</td>
<td>3rd Party Payment</td>
<td>79</td>
<td>21</td>
<td>3-3</td>
<td>73</td>
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<td>6</td>
<td>Counseling</td>
<td>70</td>
<td>19</td>
<td>3-1</td>
<td>64</td>
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<tr>
<td>33</td>
<td>Patient Education</td>
<td>57</td>
<td>15</td>
<td>3-1</td>
<td>70</td>
</tr>
<tr>
<td>46</td>
<td>Professional-Private Conflict</td>
<td>50</td>
<td>13</td>
<td>3-3</td>
<td>40</td>
</tr>
<tr>
<td>19</td>
<td>Dying Patient</td>
<td>49</td>
<td>13</td>
<td>3-1</td>
<td>61</td>
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</tbody>
</table>

Geriatrics presented problems in daily practice most frequently. This frequency is far ahead of the other items. With the exception of item 28, the six areas that presented problems most frequently were not felt to be particularly difficult areas (mostly 0 or 1 in difficulty).

Difficulty

In like manner, a rank order of difficulty was judged from a tally of all the 3's that appeared in the difficulty column (0-3, 1-3, 2-3, 3-3).
Table 4.

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<th>% of 3's ( /370)</th>
<th>MOST FREQ. COMBINATION</th>
<th>%</th>
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<td>1-3</td>
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<td>13</td>
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<td>1-3</td>
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<td>3</td>
<td>Drug Abuse</td>
<td>75</td>
<td>20</td>
<td>1-3</td>
<td>87</td>
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<tr>
<td>43</td>
<td>Battered Child Syndrome</td>
<td>49</td>
<td>19</td>
<td>1-3</td>
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<td>23</td>
<td>Heroic Measures</td>
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<td>13</td>
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<td>Suicide</td>
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<td>1-3</td>
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</tbody>
</table>

Relatively few areas were felt to be extremely difficult to deal with. Judging from the scores and comments written on the questionnaires, it seems that mature physicians have learned through experience to cope with the difficult and frequent problems. Since 86 percent of the 3's in this column were in the 1-3 category, it is reasonable to conclude that the most difficult areas to deal with are those which occur only occasionally. Most of these items (13, 3, 43, and 23) have only recently been recognized as proper areas of concern for physicians.

Frequency and Difficulty

The unusual combination of very common problems that are extremely difficult to deal with (3-3) occurred only 230 times out of 18,130 responses, or 1.2 percent. Of these, the most common items were:

Table 5.

<table>
<thead>
<tr>
<th>ITEM #</th>
<th>KEY WORDS</th>
<th>#</th>
<th>% of All 3-3 Responses #/230</th>
<th>% of All Respondents #/370</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>3rd Party Payment</td>
<td>58</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>29</td>
<td>Malpractice</td>
<td>38</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>47</td>
<td>Physician Life-Style</td>
<td>31</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>46</td>
<td>Prof.-Private Life Conflicts</td>
<td>20</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>Alcoholism</td>
<td>16</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Social/Political Aspects</td>
<td>14</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
It is notable that except for item 13 (alcoholism), none of these areas of greatest frequency and difficulty are given much attention—i.e., curriculum time—in traditional medical education. They represent fairly recent changes in the social/political environment. We can expect an acceleration of such changes in the foreseeable future. There is an increasing need for effective educational experiences to properly prepare physicians to cope with the shifting social and political climates.

OBSERVATIONS

In general, those areas which most commonly presented problems (7, 1, 9, 28, 6, and 33 in descending rank order) were not the same areas that presented the greatest difficulty when they occurred (21, 13, 3, 43, 23, and 22) or that were both common and difficult (28, 29, 47, 46, 13, and 8). Two exceptions are notable. The influence of third-party payment on the delivery and quality of medical care (item 28) was so common and difficult that it was ranked in the top four on both Table 1 and Table 3. With some form of national health insurance being inevitable, we can expect physicians to experience even greater discomfort in the near future.

Alcoholism was considered extremely difficult to deal with, a distinction shared only with the death of a child. Twenty-seven percent of all respondents felt that it presented a problem occasionally (50%), commonly (30%), or very rarely (16%).

Geriatrics presented problems in daily practice very frequently for 53 percent of all respondents. This is twice the response level of any other item. Several factors could contribute to this finding. There are more elderly people alive now, both absolutely and as a percentage of the population. Complaints of elderly patients are often chronic in nature. Geriatrics has only recently been recognized as a subspecialty and few physicians have had training in its principles. Students and residents planning to practice primary care need adequate experience dealing with the unique challenges presented by geriatric patients.

CONCLUSIONS

These statistics document the frequency and difficulty of problems in the human dimension of primary care. One may hope that the questionnaire encouraged the participants to examine their daily practice from a new perspective. They also learned that at least one academic institution desired their contributions to the design of medical education.

The relatively high return rate and the enthusiastic nature of many of the comments indicate that practicing physicians are willing to contribute toward improving medical education. In general, they felt that they were not well prepared by their education to deal with the common and difficult areas in the human dimension of primary care.
There is presently renewed enthusiasm for improvements in education in primary care and human values in medicine. It is hoped that empirical studies such as this will be useful in efforts at the interface of these two movement.
REFERENCES

1. Based on interviews with twenty primary care physicians and pre-testing of an earlier version of this questionnaire in the State of Tennessee in the spring of 1975.


4. Hunt, Lorraine (ed.), Institute on Human Values in Medicine, Human Values Teaching Programs for Health Professionals, Society for Health and Human Values, April, 1974.


6. Thomasma, David C. (personal communication), Coordinator of Human Values and Ethics, University of Tennessee Medical Unit.


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Hollander, Rachelle (Editor), Medical Ethics Film Review Project. The Council for Philosophical Studies, 1974 Institute on Moral Problems in Medicine, The University of Maryland, College Park, MD. 20742.


Dear Family Physician:

I am a resident in Family Medicine who is concerned about the lack of teaching effort in the human dimension of medical education. As a member of the American Medical Student Association's task force on primary care, coordinator of their afternoon sessions at the 1975 Congress on Medical Education, and currently a senior advisor to AMSA's Committee on Medical Education, I have had the opportunity to discuss this problem with concerned students, medical educators and practicing physicians in various parts of the country over the past several years. In growing numbers, they are expressing frustration at the way in which significant aspects of medical practice are either ignored or poorly dealt with in current training programs.

The educators responsible for teaching medical students and resident physicians are greatly challenged to provide meaningful and relevant educational experiences in the human dimension of primary care. The purpose of this study is to identify the most common and difficult problems in ethics and human values actually dealt with by you, a practicing physician. You could help greatly by taking a few minutes to answer the attached questions about the subject you know best—your medical practice. I welcome comments upon any of the areas mentioned or upon your answers in the spaces provided or on a separate piece of paper. (Please note the number of the item you are commenting upon.)

The potential benefits of your participation are to make a contribution to the relevance of the courses and educational experiences being designed in medical schools and health care centers across the country. Please fill out the enclosed sheets and return them anonymously in the pre-addressed, stamped envelope provided for your convenience. The data from this study will be processed this Fall, so please do not delay in returning your form. Confidentiality of responses will of course be observed; please do not include your name on the form.

Return of this form will be interpreted as informed consent allowing your responses to be used for the purposes of this study. Thank you for your contribution to the future of medicine.

Sincerely yours,

J. Patrick Tokarz, M.D.

Enclosures

JPT:gs
1. Date of Birth: ____________________________________________

2. Sex: [ ] Female [ ] Male

3. Undergraduate College Major: ______________________________

4. Year of Graduation from Medical School: ____________________

5. Number of Years in Practice: ________________________________

6. Please indicate the approximate percentage of your time spent in:

   ______ Direct Patient Care
   ______ Teaching
   ______ Research
   ______ Administration
   ______ Other (specify) ______________________________________

7. Please indicate your type of practice organization (indicate % if more than one

   ______ Individual ________ Hospital Based
   ______ Partnership ________ Federal Government Service
   ______ Single Specialty Group ________ Community Health Center
   ______ Multispecialty Group ________ Other __________

8. Would you characterize your present practice location as:

   [ ] Rural
   [ ] Urban
   [ ] Suburban

9. What percentage of your monthly income is derived from welfare clients?

   _______________________________________________________

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The following is a list of problem areas. Please read through the list, adding additional areas from your own personal experience. Then, rank the areas from zero (0) to three (3) according to the following guidelines. Please base these responses on your personal experience as a physician.

<table>
<thead>
<tr>
<th>Frequency: these areas present problems in my practice</th>
<th>Difficulty: When these areas do occur, how difficult are they to deal with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Never</td>
<td>0 - Not Difficult</td>
</tr>
<tr>
<td>1 - Occasionally</td>
<td>1 - Occasionally Difficult</td>
</tr>
<tr>
<td>2 - Commonly</td>
<td>2 - Quite Difficult</td>
</tr>
<tr>
<td>3 - Very commonly</td>
<td>3 - Extremely Difficult</td>
</tr>
</tbody>
</table>

### GENERAL AREAS

<table>
<thead>
<tr>
<th>Freq.</th>
<th>Diff.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Contraception</td>
</tr>
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<td></td>
<td></td>
<td>2. Abortion</td>
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<tr>
<td></td>
<td></td>
<td>3. Drug Abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Sexual Problems</td>
</tr>
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<td></td>
<td></td>
<td>5. Death</td>
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<tr>
<td></td>
<td></td>
<td>6. Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Geriatrics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Social/Political aspects of health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Physician-Patient Relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Personal Problems of being a physician</td>
</tr>
</tbody>
</table>

Please use this space to record any additional general areas you feel should be included.

A.

B.

C.

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**SPECIFIC AREAS**

<table>
<thead>
<tr>
<th>Freq.</th>
<th>Diff.</th>
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<tbody>
<tr>
<td>11.</td>
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<td>12.</td>
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<td>13.</td>
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<td>27.</td>
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<tr>
<td>28.</td>
<td></td>
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<tr>
<td>29.</td>
<td></td>
</tr>
</tbody>
</table>

11. Contraception for teenagers without their parents permission
12. Genetic Counseling
13. Alcoholism
14. Conflicts between your own and your patients' feelings about abortion
15. Value decisions regarding the appropriate use of psychoactive drugs
16. Sexual dysfunction (repression, impotence, premature ejaculation, non-orgasmic patients, neurotic beliefs)
17. Different sexual lifestyles (homosexuality, transexualism, celibacy, promiscuity)
18. Venereal Disease
19. Dying Patients
20. The Family of Dying Patients
21. The Death of a Child
22. Suicide
23. Extraordinary measures to prolong life (when to cease therapy)
24. Allocation of scarce resources: Manpower
25. Allocation of scarce resources: Organ Transplants
26. Allocation of scarce resources: Equipment (e.g. artificial kidney)
27. Allocation of scarce resources: Facilities
28. Influence of third-party payment on the delivery and quality of medical care
29. Concern with malpractice suits influencing type of care given (i.e. unnecessary tests and procedures to cover yourself legally thus adding to the rapid inflation of medical costs)
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Never</td>
<td>0 - Not Difficult</td>
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<td>1 - Occasionally</td>
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<td>2 - Quite Difficult</td>
</tr>
<tr>
<td>3 - Very Commonly</td>
<td>3 - Extremely Difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>30.</td>
<td>Communication with Patients</td>
</tr>
<tr>
<td>31.</td>
<td>Non-compliant Patients</td>
</tr>
<tr>
<td>32.</td>
<td>Conflicts between your own beliefs and value systems and those of your patients</td>
</tr>
<tr>
<td>33.</td>
<td>Patient Education</td>
</tr>
<tr>
<td>34.</td>
<td>Dealing with manipulative or &quot;crock&quot; patients</td>
</tr>
<tr>
<td>35.</td>
<td>Sexual overtones of the doctor-patient relationship</td>
</tr>
<tr>
<td>36.</td>
<td>Pressure to compromise quality of care to meet patient demands (i.e. demanding a shot for a cold)</td>
</tr>
<tr>
<td>37.</td>
<td>Relating to patients much older than you</td>
</tr>
<tr>
<td>38.</td>
<td>Relating to patients much younger than you</td>
</tr>
<tr>
<td>39.</td>
<td>Counseling: Individual</td>
</tr>
<tr>
<td>40.</td>
<td>Counseling: Marital</td>
</tr>
<tr>
<td>41.</td>
<td>Counseling: Family</td>
</tr>
<tr>
<td>42.</td>
<td>Medical consequences of divorce</td>
</tr>
<tr>
<td>43.</td>
<td>Battered Child Syndrome</td>
</tr>
<tr>
<td>44.</td>
<td>Mental Retardation</td>
</tr>
<tr>
<td>45.</td>
<td>Dealing with anxious and fearful patients</td>
</tr>
<tr>
<td>46.</td>
<td>Conflicts between professional duties and private life</td>
</tr>
<tr>
<td>47.</td>
<td>Concern with your unhealthy lifestyle (eg. stress, overwork, poor diet, smoking, insufficient exercise) setting a poor example for patients</td>
</tr>
<tr>
<td>48.</td>
<td>Becoming aloof as a person as a defense against constant dealings with sickness and suffering</td>
</tr>
<tr>
<td>49.</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>
INTRODUCTION

An ideal physician would be a self-actualizing, aware human being, skilled and competent in the art and science of medicine. An important part of the art involves skills and knowledge of interpersonal dynamics, emotions, ethics, and human values. For the sake of convenience, these areas are rather loosely referred to as the human dimension of medicine. Modern medicine shares with other components of society a painful dehumanization resulting from rapid increase in scientific knowledge and technology. Medical educators and medical students, those who should know the situation the best, often state that the process of medical education itself has a negative or dysfunctional effect on the development of a humanistic physician.

The inability of most medical schools to accomplish the very difficult balance in the scientific and human dimensions of modern medical education and practice contributes to the growing crisis in modern medicine. There is a need to reinforce certain elements in the training of physicians so that they can perform in a compassionate, reasonable, and humanistic way in caring for patients. Many thoughtful educators see developments in three areas to be of maximum importance. These are the growing effect of the specialty of family medicine, the inclusion of a more organized and rigorous approach toward the teaching of human behavior in medical schools, and the growing number of medical institutions with programs in human values. This report is a summary of a case study of the experiences and impressions of the teaching faculty of the Departments of Behavioral Science, Family and Community Medicine, and Humanities of the Milton S. Hershey Medical Center of the Pennsylvania State University as they focused on their experiences in teaching and learning about the human dimension of medicine.

METHOD

The content and process of several core courses and electives offered to medical students during their basic science years by these three departments were studied. The goal was to identify both traditional and innovative elements in the preparation of future doctors. Background reading, observation, and both informal and structured interviews were used. The faculty interviews addressed three basic questions. They first attempted to develop an expression of the goal of medical education as perceived by the teaching faculty. A functional definition of the ideal, humanistic physician was sought by successive approximations. The faculty was asked to list particularly good or desirable qualities in practicing physicians that they looked for when seeking a physician, followed by a list of negative behaviors, attitudes, or behavior traits. Second, they were asked how they attempt in their specific teaching activities during the first- and second-year core curriculum to optimize the shaping of such an ideal physician. The third area involved an exploration of their perceptions
of impediments in the current educational process toward growth in the human dimension of medicine as well as potential developments to overcome these.

The similarities and differences of the approaches among the three departments and among individual faculty members were examined. A summary of the data generated is presented, followed by the author's own impressions and reactions as an outside observer.

DATA

The four-year curriculum of the medical college at Hershey is organized along a traditional pattern of two basic science years and two clinical science years. The content and emphasis of undergraduate instruction at this college is somewhat unusual due to the inclusion of three innovative departments all of which are actively engaged in teaching first- and second-year medical students. The Department of Family and Community Medicine is responsible for 12 percent of curriculum time in the first year and 9 percent in the second year. The Department of Behavioral Science is responsible for 6 percent in both years, and the Humanities Department 6 percent and 3 percent respectively. Collectively, these departments are responsible for approximately 20 percent of the total curriculum hours of the first two years. This unique curriculum context has a major influence on what is taught and how it is taught.

The Department of Family and Community Medicine teaches in seminars, correlation conferences, and practice tutorials. The subject matter varies from primary, comprehensive, and continuous care to health maintenance, common diseases, intrafamily psychodynamics, and the doctor-patient relationship. The Department of Behavioral Science presents courses in the integration of bio-psycho-social substrates of behavior, variability in human development, and behavioral correlates with disease and health. They further offer courses in medical statistics, research design, primate behavior, biofeedback, memory, and behavior modification. The Humanities Department offers electives in politics, history, government, literature, philosophical ethics, law, human values in medical care, drama, death, dying and grief, and selected topics by request. There are close working relationships among the faculty in these three departments, and resources such as videotaping equipment and expertise in areas of special interest are often shared. As at most new medical institutions or those undergoing major curriculum reform, the actual educational situation is dynamic and continuously evolving.

RESPONSES OF THE FACULTY

Department of Family and Community Medicine

Question 1 (A): What do you consider to be particularly good qualities for practicing physicians?

The responses of the faculty to this question lend themselves to
grouping in four categories. The members of this department repeatedly listed the physician's attitude to be of primary importance. They valued his ability to convey to the patient and the family a genuine sense of concern for them as people. They stressed the ability to impress patients as being persons truly compassionate and understanding of their problems and the significance of illness in their lives.

The category of responses that appeared next in frequency involved medical excellence. This was described as technical competence (a sound, up-to-date scientific basis for his practice), as well as clinical judgment or wisdom (the happy combination of knowledge, experience, and judgment that conveys to the patient a feeling of mature confidence and competence). Included in this category is a recognition of a physician's own limitations and a willingness to consult other physicians or health care professionals to complement his own talents and abilities. A further aspect involves intellectual honesty; i.e., an open representation of the facts surrounding an illness balanced with the proper amount of reassurance and maintenance of hope within the patient and the family.

The third most common group of responses dealt with the physician's awareness of his own personal needs. This was expressed as a physician who is self-aware and confident in his roles of physician, citizen, and human being. The faculty stated they would seek a physician who had attained a happy balance between dedication to his profession and the ability to organize his time effectively so as to ensure his own personal life-style. They desired a physician who had attained the ability to enjoy being a good physician.

The fourth category of responses dealt with the physician's concept of his role in health care. The faculty sought a physician who saw himself as a teacher, or one who recognized the necessity of educating patients about their own health or disease. They desired a physician who was oriented toward health and prevention of disease rather than intervention in the late stages. It was felt that an ideal physician should be aware of the costs of health care and should let the patient know how much different alternative approaches or procedures would cost in terms of money, time, and pain. They felt the physician's goals should include an active understanding of the principles of human behavior as well as the importance of family and social networks to people and to their health and disease.

Question 1 (B): What do you consider to be negative or bad qualities in a practicing physician?

The greatest number of responses to this question related to negative attitudes. These were listed as arrogance or a demeaning attitude toward the patient, superficiality or the projection of a cold, impersonal, distant, and aloof personality, dishonesty or a lack of respect for patients as mature people, and irresponsibility for and abuse of the powers and status bestowed upon them. Frank ineptitude or poor medical ability was listed only rarely, possibly because the faculty in this department would have had little occasion to come in
contact with truly inept physicians while seeking care for themselves and their families. In contrast, many of the interviewees listed negative personal qualities of a physician such as imposition of personal values that interfere with optimal patient care. They also did not want a physician who would allow his situation to overwhelm him beyond the point of optimal patient care or to the point of neglecting the personal needs of the physician's own family. They also rejected the crisis- or disease-oriented physician, or one who accepted a too-narrow definition of his role and responsibility in society.

Department of Behavioral Science

Question 1 (A): Good qualities. The interviewees in this department overwhelmingly stressed technical competence in a physician's field of specialty above all other concerns. The next greatest concern related to the physician's concept of his role. They desired a physician who would recognize that the patient is a party to the decision-making process and therefore needs an honest and fair representation of the facts and of the physician's own thoughts. To this end, they desired an unhurried manner and skills in interpersonal relations. This was further expressed as the ability to establish rapport with many types of people and a sensitivity toward the needs of various people in the doctor-patient encounter. This was expressed as the ability to effectively communicate and a recognition of the importance of eye contact. Only a few respondents verbalized a desire for a caring physician or one who would be able to understand the patient as a person in the context of society. No mention was made of a desire for a physician who had a well-balanced life-style.

Question 1 (B): Bad qualities. Almost all the responses to this question by the department involved negative attitudes expressed by the physicians. These were described as hurried, overextended, cold, rude, or busy. A lack of regard or respect of the patient, such as keeping a patient waiting without an explanation, was mentioned quite often, as well as discriminatory treatment toward women. Several people criticized a physician's use of an emotional or psychological explanation for symptoms, which they felt was a way of overcoming that physician's lack of knowledge or understanding.

Department of Humanities

Question 1 (A): Good qualities. The faculty of this department listed first an attitude of caring and specific skills to convey this attitude to the patient. They desired an alert human being who knows how to listen. They assumed technical competence and desired beyond this an apparent competence, which in combination with the physician's personal skills would enable him to calm the anxieties of troubled patients. They sought respect for the patient as a man or woman of the utmost dignity, and wanted gentle honesty as well. A few respondents valued the skill of the proper use of time and in the technique of laying on of hands. One respondent mentioned desirability of a high rank in his profession as evidence of his clinical and personal skills.
The characteristics of a humanistic physician were likened to those described by Carl Rogers as characteristics of a helping relationship. Accurate empathy, congruence, and nonpossessive warmth (love) are both necessary and sufficient.

Question 1 (B): Bad qualities. Once again, the most common responses concerned negative attitudes. Specifically, condescending, dogmatic, or paternaistic attitudes were condemned. The respondents further disapproved of inappropriate intimacy or a poor understanding of the belief systems and assumptions of other people. They did not like physicians who would leave a patient waiting longer than necessary for results of tests or those who were abrupt or curt with patients. One faculty member of this department did mention that he would not want a physician who had not taken the time or effort to fully develop himself as a healthy human being and who would thus serve as a poor role model for his patients.

After encouraging the faculty to think in terms of the ideal humanistic physician whom they might seek to care for themselves or for their families, I then explored with them the question of how their specific teaching activities in the core curriculum might contribute toward or impair the growth of medical students toward such an ideal physician. We further looked at their concepts of the current educational process as a whole and its effect on growth in the human dimension of medicine.

The following summary is a condensation of responses obtained during more than forty separate faculty interviews. In order to convey a sense of the attitudes of the three departments, the phrases used are in the exact words of an individual whenever possible. Each direct quotation represents a separate individual's answer, which should explain any conflicting statements.

Family and Community Medicine

The teaching faculty of the Department of Family and Community Medicine recognizes the very high priority of the human dimension of medicine in what they are trying to impart to medical students. They use the small-group format, which allows students to interact over a long period of time with mature practicing physicians, recent graduates of residency programs, current residents, and their fellow students. Practice tutorials, family assignments, student involvement in curriculum planning and teaching, the development of close relationships between faculty and student, the pairing of seasoned and neophyte teachers, weekly review and preview conferences of students and faculty, and oral examinations are felt to be key factors contributing toward the growth of humanistic physicians.

One characteristic of the department's activities is that the students do not have to overwork themselves to do well. The lesson in this is that valuable learning can be enjoyable and done in a relaxed atmosphere. We stress common problems and practical solutions to dealing with the intricacies and
difficulties of relating to people. We deal very directly with many of the commonly described problem areas in the human dimension of medicine. The small scale of the seminar group and the continuity of association with the same pair of faculty members throughout the year adds a significant personal dimension to the learning activity. Perhaps the most valuable aspect of this experience is the opportunity for students to get to know practicing physicians as human being. My obligation is to be a humanistic physician and to be aware of what I am doing and point it out to the student.

This department's major problems include delineation of the core content of Family Medicine, the training of effective teachers in the small group format, and the inability to effectively evaluate their educational presentation in regard to subsequent physician behavior and attitude.

There tends to be a conflict of sorts between the hard-core sciences versus soft-core attitudinal courses. I thing the necessary balance has been greatly overloaded on the side of hard-core sciences. Because our students are overworked and pressured by these other departments, our efforts are robbed of the full impact which they might otherwise have.

The major strength in this department is that all the faculty members have experience in actually dealing with patients, which thus ensures their understanding of the relevancy of what they teach.

One advantage we have over other teaching faculty in the other areas of the basic sciences is that we have daily experience in the actual practice of medicine; thus, we are able to better judge our own internal consistencies. We are given the privilege not of teaching theory, but what we have honestly learned through actual experience.

When I look back at my own medical education, I feel my training was grossly insufficient in the practical aspects of human behavior. The skills which I most desperately needed and had very little formal help in developing involved interpersonal relations, behavior modification, and an understanding of the motivation behind patient behavior. Basically, counseling is catalyzing communication between related people in conflict, and I think that certain skills relative to small-group communications can and should be taught in a medical education setting.

The majority of the teaching faculty felt that the most effective learning in the human dimension of medicine took place in the preceptorship setting; that is, one-on-one contact between the student and a very good practicing physician with constant interaction concerning patient care over a reasonably long period of time. It is very hard to verbalize or intellectualize the formation of attitudes and behaviors that are crucial in this growth process.
One explanation for this department's approach toward teaching is their perception of their role as that of bridging the gap between the basic sciences and the clinical disciplines. They see their job as supporting the medical students so that they develop appropriate adaptive behavior toward the necessary external stresses involved in medical education and practice. Their goal is to enable the students to face the issues directly and continue to be themselves as they deal honestly with the problems inherent in the practice of medicine.

One faculty member described the roles of the various departments in this way:

I feel that all three of these departments have very complementary functions and yet unique approaches toward this area of education. Our department focuses on people as patients, and our information is directed toward application in the clinical situation. I see the focus of the Humanities Department as studying people as people. I get the unfortunate feeling that the Department of Behavioral Science teaches people as objects of scientific investigation. I would like to see them be more concerned with utilizing the knowledge of the basic sciences to increase the self-awareness of the medical students. I feel that they are too concerned with the scientific level of biological phenomena rather than a more pragmatic or useful approach toward understanding and dealing with people. I feel that both of the other departments have a more didactic approach toward the problem of personal relations. I feel it is our particular responsibility to incorporate the didactic data which they present into the clinical setting.

The teaching faculty recognized the importance on a subliminal level of displaying a model relationship toward students. They attempt to be open, flexible, and reasonable with students and display a positive outlook toward their role and their profession. The faculty recognizes that the formation of attitudes and behavior patterns is much more important than the learning of facts in their educational experiences.

I see a very strong parallel between the relationship of a teacher to his students and a doctor to his patient. If we cannot conduct ourselves as teachers in relation to students as one human being to another—if we cannot be open and respond when a student drops by, then we are not being accessible. We are teaching that it is okay not to be accessible when one proceeds as a professional person. The professor who is always away or in his research laboratory or otherwise not available to the student as an individual is reinforcing what I would consider a very negative behavior pattern.

The faculty hope that they encourage critical thinking and problem-solving skills as well as proper use of resources. They feel they increase the students' communication skills by having them present seminars on topics of their own choice, as well as involving
them actively in discussion sessions.

Behavioral Science

The Department of Behavioral Science utilizes a combination of core courses and electives. Their course content has been carefully developed with close attention to how similar materials are being presented at other medical institutions. The methodology includes the large lecture format for many of the core courses with small seminars in most of the electives.

Behavioral science has a heavy data base which must be delivered by a rather rigorous approach. Our main purpose is to impart the latest and most relevant knowledge in the many fields of behavioral science that are related to clinical situations.

Some of the major problems are to define the essential body of knowledge relevant to medical education and to identify the most effective methods of presenting this to medical students.

Unfortunately, we do not devote much time or energy toward practical training in interpersonal relationships, one of the real problem areas with which our department might be of some help. This is a very vital dimension of the medical profession in which there are some principles and skill which possibly could be effectively taught in the basic science years. Most medical students are very sheltered through their long years of schooling. They are then thrown into the excessive demands of the clinical years without adequate preparation and often fall into inappropriate behavior patterns as a defense against undue stress.

Further observations of the faculty of this department are:

Education in the human dimension of medicine takes place at three levels: Knowledge, attitudes, and skills. This department gives the greatest emphasis at the knowledge level, which probably has the least effect on clinical behavior (which is the only true measure of teaching effectiveness). Affecting the way the students think about things (that is, their attitude toward people or subjects) would be a much more effective approach toward modifying their behavior than the knowledge route. Even more effective would be direct involvement with teaching clinical skills.

Ideally, practicing physicians should determine what are the most relevant aspects of a discipline and academicians should then concentrate on how best to teach it effectively. We should have more dynamic interaction between academicians and practicing physicians for the benefit of both. The most important benefit of such interaction, however, would be the
improved relevance of medical education for students, and thus the improvement in patient care.

The ideal practicing physician would certainly be a self-actualizing humanist. Unfortunately, the real practicing physician is more often an ignorant, overworked, compulsive neurotic. I feel that this is the result of a very poor medical educational system which, in turn, is the result of a materialistic, capitalistic society which has allowed technology to drive it out of control in regard to basic human values and a sense of rational priorities.

The university medical centers contribute grossly to the problem by making a ruinous life-style mandatory for medical students and floor physicians. Medical institutions have a responsibility for dealing with the question of what is a reasonable workload for students and practicing physicians. They must recognize that time for leisure and recreation is crucial to help the profession.

The last few years have seen a very dangerous explosion in the amount of knowledge which is being overloaded on to present-day medical students. This leads to chronic frustration, cynicism, and a feeling that there is no time to think or to reflect about the larger things in life. Most basic science teachers are actually researchers who are not comfortable in a personal relationship with students. The lecture hall or didactic format which is so common in the basic science years implies a very authoritarian "teaching at" attitude, which I feel is part of the dehumanizing process.

Several faculty members’ feeling toward the departments are expressed in the following quotations:

I think the Family and Community Medicine Department is a group of clinical people whose role it would be to integrate the whole show. They are the only ones who actually attempt to cover the whole spectrum. They should be actively engaged in synthesizing all the other activities here and in the creation of a truly Renaissance physician.

The Humanities Department is still struggling with the problem of whether to adapt their disciplines to what is relevant or to continue demanding a rigorous approach to a truly academic discipline.

There is definitely the lack of an ideal balance between the efforts of the hard-core departments and the other courses which stress the human dimension of medicine. Unfortunately, these three departments have been added to an already overloaded system, which greatly detracts from our effectiveness. I feel that the end result is somewhat dysfunctional and leads to a dehumanization during medical education.
The Department of Humanities, by contrast, is composed of specialists in five separate fields, and the curriculum format is a selective requirement; i.e., all courses are elective as to type, number, and timing with the basic stipulation that all medical students should experience a minimum of two electives during their four years of medical education. The content and style of these electives vary greatly. The small-seminar format is observed whenever possible. The primary goal is to generate the student’s thinking and develop problem-solving ability relative to the recognition of the role of human values in all aspects of living, including medical practice. A further goal is the recognition of the essential value of the humanities as disciplines in their own right and their role in fostering the full human growth and potential of human beings who are, coincidentally, medical students and health practitioners. The following quotations concisely present the views of the members of this department:

The real task of our department is to increase, enlarge, and develop the whole perceptual apparatus of future physicians. We must continually ask how the knowledge we present complements or adds to the perception developed by scientific knowledge. Our goal is to add a psychedelic or mind-expanding dimension to medical education. Our chief priority is to help prepare the ideal physician by contributing in whatever way we can to the medical education process. Our challenge is to translate the romanticism of humanistic studies into the reality of medical education while preventing the "ghettoizing" of humanism.

We operate on essentially three separate levels: (a) The development of conceptual clarity concerning our discipline, (b) education in our discipline that is complementary to medical education, and (c) active political and social reform.

Our basic approach toward students is to allow them to select the discipline and topics they are most interested in and then provide them with a vigorous experience in a seminar fashion which is designed to stimulate their thinking and their ability to deal with the material presented. Our content is as varied as the many disciplines represented by our department. One common thread is that all knowledge shows the error of dogmatism. Our process involves an emphasis on talking things out in small seminars. This dialogue is a very important growth process in which students experience growing confidence in their ability to defend their position and to think clearly.

Our inspiration comes from the conviction that medicine must continue to be more than a science. The human dimension is vital to its survival as a truly noble profession.

There is probably no correlation between the performance of students in our classes and their later behavior as practicing physicians.
Our department has an impact on the medical education Gestalt at many levels. We have a need to feel relevant and useful in affecting people; i.e., helping them to become "better physicians." Our goal is to sharpen the perception of future physicians as to what the ethical issues are in the practice of medicine and how to deal with them.

Our goal is not to become "relevant," but rather comprehensible and complementary to the main thrust of medical education. One impediment to our work is the frequent prejudice and preconception of medical students as to what is relevant and genuine for medical education.

The real task is to humanize all of medical education by making it more efficient and effective so that students won't continue to be overloaded and crushed.

Author's Impressions

The similarities of approach in the goals of these three departments in this area outweigh the technical and structural differences. All three departments are comprised of individuals who recognize the human dimension of medicine as a very important aspect of medical education. Most members of the faculty recognize the difficulty of addressing both the affective and cognitive aspects of education for humanistic health care and are quite eager to continue developing effective approaches toward a supportive environment for the growth of an educated, compassionate, and competent health care practitioner. A widespread desire to increase intra- and interdepartmental synergistic cooperation, particularly at the clinical level, is beginning to find expression through joint activities.
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