Report Number 6

INSTITUTE
ON HUMAN VALUES
IN MEDICINE

Conference on Human Values in Medicine for the Six Medical Schools of Philadelphia

Society for Health and Human Values
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Thomas K. McElhinney

Society for Health and Human Values
CONFERENCE ON HUMAN VALUES IN MEDICINE
for the
SIX MEDICAL SCHOOLS OF PHILADELPHIA

Co-Sponsors
The College of Physicians of Philadelphia
and
Institute on Human Values in Medicine
24-25 October 1975

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Edmund D. Pellegrino, M.D.
Chairman of the Board, Institute on Human Values in Medicine
Chairman of the Board and Director, Yale-New Haven Medical Center

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President, The College of Physicians of Philadelphia

Report Prepared by
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Associate to the Director
Institute on Human Values in Medicine

The Institute on Human Values in Medicine is an activity of the Society for Health and Human Values (Ronald W. McNeur, Ph.D., Executive Director). Financial support for this Conference was provided by the National Endowment for the Humanities (Grant #EH-10973-74-365) and The Barra Foundation of Philadelphia.
Resource Services are designed for activities associated with human values program development in the education of health professionals (including interdisciplinary courses - the humanities and medicine). The Institute's Board is also open to innovative projects of various types.

Resource Service visits to particular schools are made by teams experienced in human values programs. A team assists a health profession school in its evaluation of the levels of commitment to different approaches to human value questions within the school. Human values programs in other institutions are described, and future options for the host school are considered. Through Resource Service conferences the Institute provides an opportunity for representatives of several schools to study the nature of existing programs, and to explore means for introducing human values aspects into the curricula of their own schools.

The event described in this report was one of the Resource Service activities of the Institute on Human Values in Medicine. Further information on the programs of the Institute may be obtained by writing:

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CONTENTS

PREFACE

PART I INTRODUCTION
1. Background of the Conference
2. Narrative of the Conference

PART II THE INTER-SCHOOL WORKSHOPS
1. Summaries of Inter-school Workshops
2. Commentary

PART III REPORTS BY SCHOOLS
1. The Reports
2. Commentary

PART IV CONCLUSION
1. Summary of the Conference
2. Acknowledgement of Financial Support

APPENDIX

A. Agenda and Conference Leaders
B. Participants
C. Paper Presented by H. Tristram Engelhardt, Jr., M.D., Ph.D.
D. Paper Presented by Daniel M. Fox, Ph.D.
PART I - INTRODUCTION

1. BACKGROUND OF THE CONFERENCE

Over a period of four years the Institute on Human Values in Medicine has conducted many conferences and visits on medical campuses designed to encourage the development of teaching programs in human values in medical education. The Philadelphia area has six medical schools within the city limits. This circumstance provided an unusual opportunity for the Institute to have a specially focused conference in which the efforts of the six individual schools might be examined and areas for cooperative effort explored. The Institute worked in collaboration with The College of Physicians of Philadelphia, which has a distinguished reputation and is in a position to bring together all of the medical schools.

Dr. John Hubbard, President of The College of Physicians, was eager and enthusiastic to join the Institute on Human Values in Medicine in sponsoring a Program Development Conference. He offered the facilities of the College as the locale for the Conference, the first to be held on a multi-university basis.

A planning meeting was arranged between representatives of the Institute and the College and the Deans of the six medical schools: Hahnemann Medical College and Hospital of Philadelphia, Jefferson Medical College of Thomas Jefferson University, The Medical College of Pennsylvania, The University of Pennsylvania Medical Center, The Philadelphia College of Osteopathic Medicine and Temple University School of Medicine. All agreed with the desirability of the Conference and plans for the program were outlined. The Conference agenda and leadership, and selection of representatives from each school, were then decided upon.

The Institute and College staffs collaborated closely in the preparation of the Conference. Approximately a month prior to the Conference, all participants received a packet of materials which included information on the Conference and selected publications outlining the nature of the engagement of the humanities and medicine. This material contained examples of several medical schools in which successful human values programs were in operation. Upon arriving at the Conference, each delegate received further publications and other informative literature.

2. NARRATIVE OF THE CONFERENCE

Each of the six medical schools was to have approximately six delegates: including the Dean and representation from senior faculty, junior faculty and students. The actual number of participants was thirty-four. The opening welcome was given by Dr. Hubbard, who also introduced the two major speakers and moderated the question period which followed the presentations. H. Tristram Engelhardt, Jr., M.D., Ph.D., University of Texas Medical Branch at Galveston and Daniel M. Fox, Ph.D., State University of New York at Stony Brook, presented the opening addresses. Dr. Engelhardt emphasized the need
for understanding the necessary relationship between medicine and human values, while Dr. Fox detailed the difficulties for the humanist working within a medical setting. (Copies of their addresses are appended to this report.). Dr. Pellegrino stressed the importance of opportunities for medical educators to discuss questions of human values in medicine, and the unique situation in Philadelphia wherein several schools might find occasion to co-operately develop human values programs. He noted the success of many human values programs throughout the country. He also indicated that each school must develop the style most appropriate to its own particular needs, for no one model has been found to be adequate for the variety of approaches to medical education which may be observed in American medical schools.

The remainder of the first day was divided into two workshops with four section leaders. The assignment of participants to particular sections ensured that every school was represented in each section and that a maximum amount of exchange of information among the schools might occur. Some time was therefore allotted to the description of human values work in progress in each school. Certain questions were developed for consideration in the workshops, however, each leader was free to develop his workshop according to the needs of the group. The basic questions under consideration in the workshops and summaries for each discussion group, are discussed below. The reports from each workshop were given to Dr. Pellegrino for incorporation into a later summary session.

The second day of the Conference began with a panel moderated by Dr. Pellegrino. Panelists were the four workshop leaders and the two speakers of the previous day. Dr. Pellegrino addressed questions to each panelist which would re-enforce points made in the workshop sessions, while at the same time establishing the areas of concern for human value programs in medical education.

Dr. Harrell described the situation he faced when he pioneered the development of a department of humanities in a medical situation. He referred to the increase of hard science in curriculum time and a loss of quality in patient care as two factors which led him to include a strong emphasis on the humanities in the program developed at Hershey.

Dr. Fox addressed the question of the role of the Social Sciences in medical education. He felt that these disciplines could provide a setting for the individual and for values as well as addressing the real problems of medicine, especially those relating to the role of medicine in society.

The relation of human values programs to bioethics was considered by Professor Vastyan. He indicated that bioethics was one dimension of the human values question. A division which might be made was the use of human values programs to promote perception, to develop compassion in the student, and to clarify values and choices.
Dr. Hudson continued by drawing the options of approaching history in depth or as a survey. He believes the latter is to be preferred in a medical school because it is the best means of conveying the insights which are the results of historical research. Relevancy does not need to be contrived for history and medicine because it is an integral part of any good teaching of history.

The integration of history and bioethics at Galveston was explained by Dr. Engelhardt. He spoke of the role of the humanities in outlining the geography of ideas and in showing how ideas bear upon the human condition.

The panel's formal remarks concluded with Dr. Hunter's statement on the need for relating the medical school to its parent university. He uses an interdisciplinary approach with an emphasis on specific problems. In order to develop particular sessions, he suggested the use of a protocol developed by the reflections of university and medical school personnel.

Dr. Pellegrino summarized this segment of the program by stressing the common objective outlined by the panelists; namely, responsiveness to the patient and satellite persons (family, other health professionals, society). Pellegrino also suggested that a variety of solutions are possible; however the objective must be delineated before a means is selected.

Following the panelist's presentations, the Conference participants discussed several aspects of a medical-humanities engagement. The use of pre-medical education as a locus for the humanities was vigorously debated. Although changes in pre-medical education might have utilitarian value, the influence of admission expectations, and the significant factor of the training within the medical school, must be priority items.

The final portion of the Saturday general session included remarks by the co-chairmen, Drs. Pellegrino and Hubbard.

Dr. Hubbard outlined the possible roles which The College of Physicians might offer; to wit, an informal unifying force through occasional events, a meeting place for events initiated through the several schools, and as a home for an operating agency or institute. While the College would cooperate, the emphasis would be on programs initiated by the medical schools. Dr. Pellegrino stressed the importance of co-operative events. One advantage would be the gathering of adequate resources and the need for a "critical mass" of humanists which precludes professional isolation for the humanist in a medical setting. Co-operative efforts would also tend to eliminate duplication of efforts.

As a final summary of issues, Dr. Pellegrino outlined the spectrum of concerns which may be denoted "medical humanism." He distinguished humanism, the humanities, and humanitarianism according to the attendant emphasis upon affective and cognitive modes. He further specified the difference between the liberal arts and a liberal education.
concluded by stating that the major fault of medical education is that it does not allow development of a critical attitude to its own ideology. The humanities, at their best, present disciplines which free the mind to do the distinctively human and are therefore essential parts of a sound system of medical education.

The Conference concluded with a workshop in which each school formed a separate section in order to evaluate what had been learned and to explore plans for the future. Summarized reports for each school are included below.

PART II - THE INTER-SCHOOL WORKSHOPS

1. SUMMARIES OF INTER-SCHOOL WORKSHOPS

Each summary is derived from notes taken by one of the workshop members.

Section A, chaired by Al Vastyan

The members first related their experiences with human value problems and programs. Then a list of "values for insertion in medical education" was prepared. Twenty-four items were placed on the list and several were discussed. A good portion of the second session was devoted to the problems of the evaluation of those programs which attempt to support human value interests. The difficulty of evaluation was admitted. It was noted that some testing of evaluative techniques is now being conducted. The issues listed are:

- introduction of self to patient, education of patient, continued interest in patient, tolerance/respect of other opinions, compassion, diversity of opinion, respect of patient rights (privacy), appreciation of multiple manifestations of problems (also sources), education of patients (risk factors), communication skills, treat patient with dignity, uniqueness of patient/each person, psychological vulnerability of sick patient, community education, lack of role model, lack of concern, lack of action, competent care, participation of patient as person, patient satisfaction, openness/critical ability, commitment/advocacy role, irony/perspective, ambiguity/live with uncertainty.
Section G, chaired by George Harrell

Workshop I

Problems identified:
   a) When to involve students during their 4 years in medical school
   b) Should involvement be considered for the pre-med? Human attitudes and values are formulated early.
   c) Should 1 year elective be offered to some medical students who are more interested in humanities - to work, perhaps abroad, in an underprivileged area
   d) Recruitment of Faculty - How to get faculty involved in the program
      1) Advertise generally
      2) Identify interested parties and involve them
   e) What do we teach?
      1) Body of knowledge (The Oath, etc.) or
      2) Identify specific problems as "medical ethical problems" - case reports with problem solving approach
   f) How to evaluate?
   g) How to provide the tools for the medical student to modify, at least think about and be exposed to, his personal ethics.
   h) One danger of medical ethical course is the didactic presentation of a "new morality" without offering enough ethical choices.
   i) What do students see as priorities?
      1) Prestige
      2) Money
      Therefore where do "human values" stand on the priority list?
   j) Where do students attitudes come from - and why does "human value" seem to drop on the priority list as students proceed through medical school? Is it due to the faculty they contact during the 3rd and 4th years?

Workshop II

Problems
   a) Evaluation
      1) Long term
      2) Short term
      3) Testing cognitive functions
      4) Evaluating affect with patients, perhaps patient interviews
   b) Implementation
      1) Should course be required? Should it be elective?
      2) How to motivate students
      3) Need one strong individual to run course
      4) Eventually, need a medical school department
      5) Is there a need for a faculty course and a student course to instruct and build a cadre of "medical ethics" teachers?
      6) Suggestion: Build up a central group of " ethicists " in Philadelphia under the aegis of The College of Physicians and each school could use them as a central pool
      7) Perhaps we need also a "core" of students to whom other students can bring issues
Section R, chaired by Robert Hudson

Workshop I

Is there a problem?

- more humanistic approaches in the past
- too much technological development
  a) squeezes out humanities
  b) establishes new ethical questions
- city hospital: house staff one culture; patients another
- question of care for minorities and women
- human values: relate to society
- health care is not emphasized - only medical care
- basic question: What is role of physician?
- care of patients can't be equated with care for patients
- Are a caring physician and a technically excellent physician mutually exclusive?
- Who should be promoting health? (physicians are trained to cure disease)
- medicine shares responsibility for preventive medicine with the individuals
- medicine has room for physician technicians as well as physician humanists
- Physicians have important role as responsible citizens
  a) BUT shouldn't physician have a social role; not merely a citizen obligation
- perhaps medical school faculty should not be the group to choose the students for admissions
- medical students have their identity
- medical student very enthusiastic about medicine; not interested in sociology, culture, etc.; may be better to try to during graduate medical education; when sociological problems limit application of medical technology
- pre-med education is very dehumanizing - competition, grades, cheating
  a) pre-med - non-clinical educators may be latently hostile to the grade grubbing pre-med students

Who creates the atmosphere?

- can it be altered
- faculty sets the atmosphere
- faculty use student as allies in their own professional battles
- admission process selects on basis of achievement (no person oriented students); greater emphasis on things rather than persons
- rush to medicine due to other factors than motivation towards humanism
- interview has tremendous limitations
- 5-6 yr. college-medical school programs are dehumanizing
- specialties can be down-graded by including women
- admitting women into medicine will not necessarily humanize it ("women can't be stereotyped")
- circular arrangement exists - medicine relates to social structure which relates to medicine
- humanity doesn't equal humanities
- language effects
- must get dehumanizing aspects out of medical education

Can values be altered?
- yes
- even physicians can change
- takes knowledge, skills - judgement to make good physician
  a) judgement is least developed on graduation from med school
- steps in changing values
  a) awareness of what values are
- students aren't taught to ask questions, etc., styles should be opened up
- medical schools excel in transmitting knowledge BUT must start to teach judgement
- humanism should be taught by clinicians
- there needs to be more history and future in medical education. "Should the RX of medicine be rated X"
- humanist should teach the faculty

Workshop II

What is happening?

Penn
- Course in behavioral science in 1st year under revision
- Courses available in college

Jefferson
- Course: Medicine and Society - behavioral science, ethics, politics, legal
- required course poorly attended - 35-40/205 students attend
- interdepartmental courses hard to manage

Osteopathic
- Course: Behavioral medicine
- History of medicine; human sexuality required
- Course in legal medicine; required

MCP
- Behavioral science
- Bioethic group - extracurricular
- legal medicine seminar

Hahnemann
- includes behavioral science; death and dying; culture aspects of pain; roles of profession; Grey Panthers
- last yr. all seminars; now lecture plus seminars; 18 groups; 16 students/group
  a) 2 yrs/wk
  b) project; write paper on some aspect of health care delivery
- 3rd yr. human sexuality course compulsory
- 1st yr. basic science; 2nd yr. clinical; 3rd yr. lecture/clin.:
- 4th yr. track
  a) mental health and society

Temple
- electives: Death and dying; drug industry; drug addiction and
  alcoholism; legal medicine
- behavior science introduced; developmental (human growth)
- 2nd yr. behavioral science
- course in medical ethics; 1st year required; no paper or exam
- elective history of medicine

What is the content of course?
- integrate it into the clinical courses
- getting community medicine to be visible
- hard to make humanist emphasis in clinical years
- could multiple school program work?
  a) could have rotating course
  b) maybe workshops
- only three medical schools in the USA have departments of humanities
  (or ethics)
- a lot depends on how it is presented
- television hook-up between schools might facilitate cooperation
- humanists seem to be more interested in participating in medical
  school courses
- need money to implement programs

Section T, chaired by Thomas Hunter

What is the problem?

Why do we have the problem?

Not unique to medicine - all areas of technology share
A product of the times
Day of patient trust is over
How to gain trust
University system destroys trust, i.e., too many agents
Public expects too much from medicine

How to select students

Performance in college
Human Qualities

How should faculty be rewarded?

Performance
Human qualities
What is content of Human Values Program?

Lectures no good
Must permeate structure of medical education
Senior faculty has to give priority
Professor of Medicine has to support
Case oriented
   Lectures don't do job
   Mid day course
   Foster controversy
   Protocol in advance
   Video Tape
   Show there are no final answers

Bad Aspects
   Superficial
   Case presentation
   Talk about Death and Dying
   Medicine is the most humane of the sciences and most scientific
   of the humanities

2. COMMENTARY

In the first two workshops the participants were able to share information about programs in the several Philadelphia schools and to state reservations about contemporary teaching of health professional students. By finding that others, both within one's own school as well as in the other area schools, are concerned with human value questions in medical education, an individual can be supported in his own efforts. Thus, the workshops could provide a positive re-enforcement for the participants.

On the other hand, the diffuse interests represented (in one workshop two dozen items were listed), and the complexity of identifying educational objectives for the comparatively "soft" data of the human value programs, may tend to discourage some potentially valuable work. In addition, the different levels of engagement represented in the experiences of the participants made the discussion too simple for some and, perhaps, too complex for others. Since the tone of the workshops was to introduce the problems it is likely that the former reaction was more common. However, general response to the workshops was very favorable.

Several points developed in the workshops may be mentioned because they indicate where future thinking about human values programs will need to achieve clarity.

1. Any program will need to be justified in its particular selection of topics among the possible directions which might be chosen. Even with a major commitment to human values work, it seems that a school would have difficulty in covering all the interests represented within its constituency; therefore, identification of issues and the rationale for the priorities which are chosen will be prerequisites in establishing new courses and approaches.
2. No agreement exists about the ideal time for the introduction to human values work. Substantial arguments may be presented for courses from pre-med to continuing education as well as for a continuum of training. In similar fashion, the choice of required versus elective courses is undecided. The relation of implementation to the problem of selection cited above (#1) is self-evident; goals may well suggest means.

3. The selection process for students is a significant factor in human values programs. Consideration of admissions procedures should be related to the programs offered by a school. It appears that interest in human values programs might be included among criteria used in selecting students.

4. The role of faculty in a medical school has been under general scrutiny. Significant disagreement about modeling, about authority figures, etc., exists. The workshop participants generally agreed that enlightened faculty were necessary for the development of human value programs. The place of faculty interested in human values questions needs further exploration.

5. The question of the evaluation of a human values program was important to many discussants and is an issue which needs consideration. One source of confusion about evaluation is the problem of multiple goals mentioned above (#1). Where distinct but related ends are interblended, the possibility of analyzing particular achievements is minimal.

Another problematic in evaluation arises from a misunderstanding of the kind of data which are available. Human values programs, in the full diversity with which the material may be approached, are not all amenable to the same kind of investigation. As an example, ethics may be taught as history, theory or method. A student's understanding of the historical or the theoretical can be measured by rather standardized tests, while the development of the skill to approach new situations with adequate ethical insight must be studied in a different fashion. It is yet another matter to explore whether exposure to a course in ethics has helped individuals to become better moral agents or more humane practitioners.

The question of evaluation is complex, related not only to the ends which are desirable but also to the data which are attainable. For some desirable ends (as humaneness), the data may be difficult to quantify.

6. The question of co-operative effort by the various schools was raised in the workshops. While each school is developing its own style, it may also be possible to combine efforts through shared faculty, interchange of course credits, and common programs and conferences. Since some schools have parent universities from which humanists may be drawn while others do
not, joint faculty appointments may present an attractive option. The ability to transfer credits from one school to another already exists, similar courtesies for courses in human values may be developed. Faculty from the humanities hired to serve in a medical school should maintain contacts with their specific disciplines. They also profit through inter-change with other humanists working in similar positions. The need for a "critical mass" of humanist faculty is an important understanding about human values work. Co-operation among the schools could provide this association more quickly than the efforts of any one institution.

The major barrier to these efforts is probably the lack of a simple mechanism for accomplishing inter-school assistance. It was suggested that The College of Physicians of Philadelphia might offer the means for bringing together the efforts of the individual schools.

PART III - REPORTS BY SCHOOLS

1. THE REPORTS

Some reports are in the first person, others combine only the recommendations which arose from the Conference, and each is summarized. All of the schools expressed appreciation for the format of the meeting and for the work of the sponsors.

A. The Hahnemann Medical College and Hospital of Philadelphia

The Conference was informative in that we learned about concerns which others have which we also share and those areas in which our progress is good and the great deal which we might do in addition. We found the notion of co-operative work with other schools and The College of Physicians an attractive prospect.

A faculty committee to carry out a survey of present activities and to develop plans and goals for further action will be appointed by Dean DiPalma.

B. Jefferson Medical College of Thomas Jefferson University

1. A review of existing programs should be made for the Curriculum Committee and reported to the General Faculty.

2. The clinical clerkships and the contributions of the residents and attending physicians should be evaluated with results reported to the General Faculty.

3. Immediate "feedback" for students should be emphasized as an important educational strategy.

In addition, selected faculty members should meet to discuss "Human Values in Medicine." These faculty will form the core for teaching in this area.
C. The Medical College of Pennsylvania

Our school had just completed a study by an Ad Hoc Committee on Bioethics. Many of the problems were known to us and much of our work confirmed. We learned (1) that all six schools are exploring human values, with students as important factors in seeking change; and (2) that inter-medical school co-operation would be important.

Our major recommendation was that the program suggested in the Bioethic Committee report, which was supported by the Conference findings, be initiated.

D. University of Pennsylvania Medical Center

The aim of medical education should include the training of a humanistic doctor. With this in mind the group attending from the University of Pennsylvania felt that the following recommendations should be passed on to the Medical School: 1) that a task force be developed of those interested in increasing emphasis on humanities in medical education; 2) that there should be greater recognition of faculty interests in humanism on behalf of tenure committees; 3) that the medical school and teaching faculty be encouraged to place greater emphasis on the quality of human life in their clinical teaching; 4) that superb clinical teachers should be encouraged to deal with humanistic areas; 5) that a survey of medical school course catalog be performed to highlight those courses that presently relate to some aspect of medical humanism; 6) that there should be representation on the curriculum committee of those specifically interested in medical humanism; and 7) the selection process for a medical school should somehow or other take into consideration factors which might suggest a "humane" interest in the student applicant.

E. Philadelphia College of Osteopathic Medicine

1. That the Department of History of Medicine be the base for developing programs in other human value areas.

2. That a Clinical Chaplain be appointed.

3. That emphasis be placed on attitudes to the human body.

4. That a review of the College be undertaken to determine the actions necessary to maximize humanistic emphases.

5. The attempt to evaluate the "humanistic status" of students and faculty should be undertaken.
F. Temple University School of Medicine

The Temple delegation found it useful to have time to talk about the development of their own program. The opportunities for co-operative efforts by the same schools ought to be encouraged. We were pleased at the progress of our own program, but are seeking to increase the time devoted to human values. Our final workshop provided an excellent setting for a sustained exploration of opportunities (it lasted until 4:00 p.m.).

2. COMMENTARY

The single common factor reported by the schools was the need for a committee to investigate the question of a human values program. For Temple the conference provided an opportunity for reflection by members of an existing committee; for the Medical College of Pennsylvania review committee, the conference re-enforced its own findings; while for the other four schools the conference was a stimulus for recommending the establishment of new committees.

Three of the schools (Hahnemann, Medical College of Pennsylvania, Temple) commented on the desirability of inter-school co-operation. Since each has now created a committee, it is possible that a conference next fall might be again called for the purpose of bringing together the members of the several committees. Each school might report on the development of its program and on proposals which have been submitted to curriculum committees, etc. The possibility of establishing co-operative efforts could also be explored further.

PART IV - CONCLUSION

1. SUMMARY OF THE CONFERENCE

The general goals set for this conference were to increase interest in human value programs and to initiate new activities among the health profession schools in Philadelphia. Although the Institute on Human Values in Medicine has conducted its Resource Services programs through visits to individual schools and through regional conferences (for almost one half of the Nation's medical schools in the last three years), the Philadelphia program provided two extra elements in that the Institute enjoyed the co-sponsorship of The College of Physicians of Philadelphia, and that this was the first program to attempt to bring together all of the schools in a city where a sizable number of schools is found.
The following observations may be made about the conference:

a. An increase in interest in human value programs was demonstrated by the remarks of the participants and shown in the reports of the schools.

b. The co-operation and guidance of the deans of the several schools were significant contributions to the general success of the undertaking.

c. New activities were reported in at least four schools, and a stimulus for action in each of the schools was noted.

d. Although Philadelphia, like other metropolitan areas with a number of health profession schools, hosts activities of interest to all, this conference provided a forum for inter-school co-operation in human value work. While this first event generated a desire for more co-operation in this field, the means for continued inter-school efforts have not yet been established.

e. The College of Physicians of Philadelphia and the Institute on Human Values in Medicine remain interested in the further development of programs within the several schools as well as in future inter-school events.

f. Although the impact of new interpersonal relationships cannot be measured, an important contribution of the conference was the opportunity for persons from various schools to learn what others engaged in the education of health professionals understood about human values work.

2. ACKNOWLEDGEMENT OF FINANCIAL SUPPORT

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AGENDA AND CONFERENCE LEADERS

FRIDAY

1:30 p.m. Welcome and Introduction of Leaders
John P. Hubbard, M.D.
President
The College of Physicians of Philadelphia

1:45 p.m. Presentation A (The Nature of the Problem: A Physician's View)
H. Tristram Engelhardt, Jr., M.D., Ph.D.
Associate Professor of Philosophy of Medicine
University of Texas Medical Branch, Galveston

2:15 p.m. Presentation B (The Nature of the Problem: A Humanist's View)
Daniel M. Fox, Ph.D.
Assistant Vice President for Academic Affairs
State University of New York, Stony Brook

2:45 p.m. Question period

3:15 p.m. Break

3:30 p.m. Workshop I (What is the problem? Why is it a problem?
What is meant by "human values"?)

Leaders:
George T. Harrell, M.D.
Vice President for Medical Sciences Emeritus
The Pennsylvania State University

Robert P. Hudson, M.D.
Chairman
Department of History and Philosophy of Medicine
University of Kansas Medical Center

Thomas H. Hunter, M.D.
Director
Program in Human Biology and Society
University of Virginia School of Medicine

Professor E. A. Vastyan, B.D.
Chairman
Department of Humanities - College of Medicine
The Pennsylvania State University

5:30 p.m. Cocktails

6:00 p.m. Dinner

7:15 p.m. Workshop II (What is the content of a human values program?
How can a program be implemented?)

9:30 p.m. Friday session ends
SATURDAY*

9:00 a.m. Panel Presentation (What is being done? How is it being done? What are the results?)

10:45 a.m. Break

11:00 a.m. Workshop III (Styles of engagement)

12:30 p.m. Lunch

1:30 p.m. Presentation C (Summary)
    Edmund C. Pellegrino, M.D.
    Chairman of the Board and Director
    Yale-New Haven Medical Center
    Yale University

2:30 p.m. Workshop IV (Future possibilities, by school)

4:00 p.m. Conference ends

* The Saturday session was amended following the panel presentation so that all participants remained together for discussion and a summary by Dr. Pellegrino. Workshop IV was then incorporated into the luncheon session and the conference ended at 1:30 p.m.
APPENDIX B

PARTICIPANTS

Conference on Human Values in Medicine
The College of Physicians of Philadelphia
October 24-25, 1975

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APPENDIX C.

HUMAN VALUES IN MEDICINE

H. TRISTRAM ENGELHARDT, JR.
HUMAN VALUES IN MEDICINE

How could there be even a suspicion that medicine is structured by something other than human values? What values are there other than human values? Could one believe that medicine is free of human value? Here, I will briefly consider why, indeed, understanding human values is central to understanding medicine. The reason for the defense of this point, which should be obvious, lies in the fact that claims are made that truths exist in science in some sense outside of, or independent of, or in contrast with, the values of humans. I will now briefly argue that such is not the case—there is no such ultimate contrast. In doing so, I will say a few things about science in general, and medicine as an instance of scientific investigation. I will contend that science in general and medicine in particular are of the fabric of human values. In nature we find ourselves—not something alien, but our very image; and this gives the humanities their central place. There is a puzzle, though, because nature does at first reflection appear alien. Diseases, illnesses are brute surd facts that are forced upon us. And it would seem that science gives a picture of that brute reality. There is, moreover, a conception of science as an attempt to be objective, to provide descriptions of the world in value-free terms, uninfected by the charm of human expectations. This view of science construes knowing as a sort of picture taking, a representation of a cold and solid reality that confronts us. This view is expressed in attempts to quantify disease, health, human adaptation, even human experience, and to consider such quantification a portrayal of reality as it exists in itself. This is often expressed in terms of rendering the art of medicine a science—of finding measures for otherwise clinically appreciated distinctions, for stating them in quantitative, not qualitative, terms. This picture is used at times to develop a contrast between the objective language of the sciences of medicine, and the subjective language of the art of medicine.

But what could it ever mean to have a scientific view, say of disease, except in terms of human values? Could there ever in theory or practice be a value-free science of medicine? The answer is surely no. Science in general, and medicine in particular, are human endeavors pursued for human purposes. It is never as if we knew the world as it is apart from us. The world we know is always our world. We describe the world in the categories of human experience, we give it coherence in terms of the generalizations we make. The laws we discover are ineluctably generalizations made in terms of the goals and conditions of human expectations. We do science in order to predict, explain, and control the world about us as it exists for us. Similarly, we do medicine in order to be able to make prognoses, give diagnoses, engage in treatment.

I have been making a somewhat abstract point, so I will repeat the issue at hand a bit more amply. Medicine is necessarily an expression of human values; it is a human enterprise. The mistake that may be made is to think that medicine could be a-human, a-temporal, express truths-in-themselves that will exist unaltered, timelessly. In contrast, the history of medicine shows medicine as the expression of particular historical appreciations of
reality. What I am offering is a reminder about science in general, and medicine in particular: they are expressions of human values. One would think that this would be patently the case with medicine, because for anything to count as a disease, as pathology, not simply as an illustration of pathology, requires a notion of pathos, suffering. But the meaning of pathos will always be in human terms. We call processes diseases because those processes fail to lead to or preclude goals that we hold should be open to humans (compare our judgment of a process that would cause deafness with a process that would cause taste blindness to phenylthiocarbamide), or which are associated with pain not a part of a process that leads to such goals (compare the pain of angina with the pain of teething), or affront our notion of human aesthetics (that is, constitute a deformity--compare vitiligo with having a white forelock). Talk about disease and health is in the end transmuted talk about the goals that humans have. Disputes concerning what will be called diseases concern, as often as not, disputes concerning the nature of man and the goals of human life.

A case in point gives useful illustration of the ways in which expectations and goals structure our appreciation of reality. The case is one from the Vietnam War.

Fear of Flying: A 26-year-old SSgt AC 47 gunner with seven months active duty in RVN, presented with frank admission of fear of flying. He had flown over 100 missions, and loss of several aircraft and loss of several crews who were well known to the patient (note: the use of the word 'patient' already places the issue in a medical context, inviting medical intervention) precipitated his visit. He stated he would give up flight pay, promotion, medals etc., just to stop flying. Psychiatric consultation to USAF Hospital, Cam Ranh Bay, resulted in 36 days hospitalization with use of psychotherapy and tranquilizers. Diagnosis was Gross Stress Reaction, manifest by anxiety, tenseness, a fear of death expressed in the form of rationalizations, and inability to function. His problem was "worked through" and insight to his problem was gained to the extent that he was returned to full flying duty in less than 6 weeks. This is a fine tribute to the psychiatrists at Cam Ranh Bay. (633 Combat Spt Gy Dispensary, Pleiku AB).2

The moral of this case is that the language of medicine is theory-laden and that medical theory includes evaluative judgments; values structure our view of the world. This case does not simply show that medicine can be put illicitly into the service of political power. The issue is more profound: reality assumes the contours which our values and expectations dictate. What will be seen as normal or abnormal depends on human goals, human values, not merely on statistical distributions. To identify something as a disease requires evaluation, not just description. Thus, a rare musical ability counts as a talent, not a disease, though arteriosclerosis, common in persons over fifty, is still a disease.
Not medicine only, but science generally, turn on human values; the reflections of physicists show similarly the ingredient of human values. The way physics portrays reality is not the way a photographer makes a portrait. The picture is drawn in the language of our concepts, structured by the impress of our values and expectations. We fashion the contours of reality. Reality exists in and through concepts. One might here remember Richard P. Feynman's somewhat tongue-in-cheek remarks concerning the structure of protons, namely, that they are made of red, blue, and yellow quarks held together by gluons.

If experiments continue to confirm the need for quarks in protons, this is the way the theory will apparently develop: quarks of three colors, so nine in all, and eight kinds of gluons. This part sounds elaborate but is mathematically simple. And a long range force--which sounds simple but appears mathematically a bit unnatural. Suggestions to explain this long range force, such as Kauffmann's, all seem a little awkward and without an inner beauty we usually expect from truth. But sometimes the truth is discovered first and the beauty or "necessity" of that truth seen only later.3

Ideas of truth, beauty, and necessity structure the presentation of even such pure sciences as physics. Science and the reality it portrays are structured by ideas, including special value-judgments about how science should be pursued and how reality should be appreciated.

Let me repeat my point one more time: medicine is, as is science generally, structured by human values--objectivity, reproducibility of data, measurability. There is no way away from human values--we live inescapably in a world of human experience. In fact, it is somewhat otiose even to say human values. All the values we could ever know are human values. Any and all gods and goddesses, should they wish to speak to humans, must speak in human terms, use the language of men.4 The humanities exist to make plain to us these values, our values, which structure our lives, and fabric our experience. They remind us of our limits. They give us counsel concerning our finitude. The humanities help us to see clearly what we would otherwise do darkly without reflection.

Once more, these points should be clear in the case of medicine. Medicine exists because we do not want pain, do not want limitations on our actions, do not want premature deaths. Medicine does not exist as an end-in-itself, it exists as a means to these values. The humanities offer us a way of becoming clearer about these values and the ideas about reality which guide the practice of medicine. Moreover, the humanities, as modes of disciplined reflection upon the human condition, place medicine with respect to other elements of human life. After all, medicine does not have an absolute claim against all other enterprises: at some point we will build zoos, art museums, and public gardens instead of more hospitals. Health is not an absolute value; disease is not an absolute disvalue. In fact, life itself does not have an absolute value. Or, to put it another way, life has no intrinsic value. It has only instrumental value. Life has the values it allows us to achieve, and medicine is a cardinal enterprise because it bears centrally on
the scope of values we can achieve, because it sustains life and its quality. T. S. Eliot remarked:

Birth, and copulation, and death.
That's all the facts when you come to brass tacks:
Birth, and copulation, and death.5

And medicine bears on them all. It defines our limitations through prognosis and diagnosis. It attempts to blunt those limitations through therapy. But all these maneuvers of medicine are directed to the achievement of values.

And, again, the humanities—philosophy, history, literature—are those enterprises which explicitly reflect upon or explicitly attempt to realize human values. These bear upon medicine in helping understand the values which guide its conduct and structure its experience. The problem of human values from the physician's point of view is to become clear about the values which direct the practice of medicine. The issues with which medicine is centrally concerned, the ones which give medicine its nexus, are issues concerning values. Clinicians choose on the basis of values they hold about the human condition.

Consider what the issue might be with respect to death and dying, if not the question of the point of life and the significance of death. What if someone decides that people when dying either deny that they are dying, get angry about it, try to bargain their death away, become depressed concerning it, or accept it? That may be psychologically interesting (though I am hard pressed to think of much more one could do about any problem other than to deny it, get angry about it, become depressed concerning it, attempt to get rid of it, or simply accept it) or administratively useful (it may help us in dealing with dying people). But such insights seem somewhat trivial until one can say something about the value of truth. Otherwise, why not simply deny that one is about to die? What is the good, the point of accepting death other than as a means toward becoming a more compliant patient? One cannot, in short, deal with death and dying, illness and disease, merely psychologically. One must in the end explore the values which structure our lives, give sense to our deaths. One must make value-judgments and judgments in the theory of value.

On another issue, should one treat individuals at great cost when there is little or no hope that such treatment will be of any use to the person treated? One might think here of the Quinlan case. Surely medicine does not exist simply to support human life as such—if so, the preservation of human cell lines in culture would be of real consolation to those who die. Rather, medicine exists in the end to enrich the lives of persons. Making sense of such issues requires reflection on the nature of humans and on the anatomy and geography of the values we hold. To decide what should be treated, how much to treat, when further treatment has no point, requires appeals to the values that give life its purpose, endow life with quality, give spring to human action.

To decide what medicine should do for the dying, how it should bear on sexuality and reproduction, how we should speak about health and disease, require an appeal to human values. The humanities reflect on the ways in which we do this. Medicine without such reflection is blind and literally
pointless. In these terms one can gain some cash value for the clichés about the inhuman nature of technology, including medical technology. Technology without a clear understanding of the purposes it is to serve is a bastard enterprise conceived outside of the legitimate relations between human power and human goals. Medicine, for example, when blindly applied to preserving life at any cost is a parody of the proper dedication of humans through medicine toward the achievement of human values, the values of persons.

To recapitulate: values structure medicine. Values give form to our language about the world, they shape our conceptions of health and disease. Values direct our actions in attending to patients. Moreover, this condition is inescapable. There is no such thing as an objective science of medicine in the sense of a medicine devoid of the directions given by values and the character of human experience. Even to wish for such a thing would be to wish for the incomprehensible and useless—the most squared of all circles. Human endeavors are by nature shaped in terms of human expectations and values. It should be clear from this that the humanities are not to be considered afterthoughts in medicine. In particular, questions of medical ethics are in this light not extraneous issues. They are questions about the very core of medicine, insofar as they bear on the values that guide the conduct of medicine.

If values play such a large and prominent role in the enterprises of medicine, it would follow that medicine, if it is to treat the whole patient, must attend to the values that give coherence both to medicine and the action of patients. Plato's remarks in the Charmides concerning treating the whole patient are appropriate here:

I dare say that you have heard eminent physicians say to a patient who comes to them with bad eyes, that they cannot undertake to cure his eyes by themselves, but that if his eyes are to be cured, his head must be treated too. And then again they say that to think of curing the head alone, and not the rest of the body also, is the height of folly. And arguing in this way they apply their regime to the whole body, and try to treat and heal the whole and the part together.
Did you ever observe that this is what they say?
Yes, he said.
And they are right, and you would agree with them?
Yes, he said, certainly I should.
...as you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul.6

Plato's argument is as usual complex in its intent. One thrust of it is, though, that one cannot truly attend to the values of the body without placing them in context of the values of the soul. Medicine is incomplete and one-sided in the absence of attending to the guiding values of human life. In particular, if one is to engage in medicine with the patient's values in mind, one must reflect on the role of values in human life. If one is, for that matter, to understand what medicine is about, one must lay out its presuppositions, the ideas and values which are the necessary conditions for the coherence of its practice.
We are forced then to sustained, careful reflection upon the meaning of medicine. We are constrained to attend to the role of the values which structure it, if we are to do justice to the goals and purposes of medicine and their bearing on the human condition. And it is out of this that interest in teaching the humanities in medicine should be derived: the conviction that medicine practiced in the light of its history, with a sense of the values open to humans, will be a better medicine because it will be conceived out of an interest in supporting the goals of human life. We should not do all we can do through the technology of modern medicine. To decide what we should do with our increasing technological power, to decide what we will do, given our scarce resources, will require developing a better understanding of our values and the scope and nature of human life. Medicine must work with the humanities towards this end.

FOOTNOTES

1. The argument here is in a Hegelian mode, that the knower and the known are not ultimately disparate. As Hegel put it, we find in nature "only the mirror of ourselves." Hegel's Philosophy of Nature, Vol. 3, ed. and trans. M.J. Petry (London: George Allen and Unwin, 1970), p. 213, S 376, Zusatz.

2. PACAF Surgeon's Newsletter, 7 (December 1966): 5.


4. Theological claims are then in the same position as scientific claims—they must be put within the bounds of human experience and human language.


I am uneasy before such opaque abstractions as Humanities and Medicine. This uneasiness is a result of the biases of my two occupations, historian and administrator. I behave coherently only when I see or imagine people in class, cultural, clinical or institutional settings. My work requires obsessive attention to the practical problems of people thinking, feeling and acting on behalf of their perceptions of misery and happiness. I differ from most of you, who work with similar problems, only because many of those to whom I pay professional attention died before I was born.

When I am required to engage the words Humanities and Medicine, as I am today, I envision 19th century civic statuary; draped and well-padded figures symbolizing ideas we ought to value. I imagine the secular goddesses who adorn our older governmental and educational temples: Knowledge, Truth, Beauty, Virtue, Art, Science, Industry, Liberty, Justice...and, I suspect, Humanities, and Medicine. For past generations, these frigid functionaries represented abstractions which were outside, above and, most of all, good for us. When the findings of natural and social science required us to doubt the validity and reliability of neatly hierarchical answers to vexing questions about nature and society, the several notions of culture were invented. The goddesses remind us of what we should pay tuition to learn to label and respect. The standards and verities of culture comfort citizens whose fathers' achievements help them to rise but do not prevent them from falling into the anonymous mass. Other images also adorn public buildings as advertisements for our collective selves; abstract designs, strange figures and shapes. These designs are not mere decorations, but rather an alternative definition of culture: the statement that the relativity and variation of human life, even our fears and fantasies, must be included when we put our environment in intellectual order.

Although these remarks will resonate later in this talk, for the moment they must be anticlimax to my apology for the iconoclasm that follows.

Whatever "is the relation of humanities to medicine"--the "problem" I was asked to address--the relations of humanists to physicians can be described with dull precision. I use the words humanist and physician to mean simply the disciplines you find in these categories in most United States universities. Physicians encounter humanists as patients, entertainers, neighbors, friends, students, subjects and occasionally as sympathetic or uncomprehending audiences. I labor these lists to remind you that in the most intense of these relationships either the humanist or the physician is inarticulate, even passive: teacher to students; critic to criticised, artist to audience; physician to patient. Each behaves according to rules of decorum which are clearly understood and rarely broken.

In recent years, considerable uncertainty and confusion occurred when a few physicians and humanists proposed new relationships in which exchanges of perceptions and values might occur. The terrible secret of each group has surfaced in a number of instances. Physicians' privately low opinion of the insight, usefulness and entertainment value of humanists is paralleled by humanists' cynicism about the economic motives, moral acuity, and personal sensitivity of physicians. As often happens among people who spend most of their work and play time with colleagues who share their values and habits, both physicians and humanists find it difficult to communicate with and appreciate each other in any but the most professional or, to avoid euphemism, superficial social relationships.
The goddesses, who symbolized a common cultural vocabulary to our grandparents and even our parents, have lost their spiritual power.

The new relationships between physicians and humanists exist mainly in universities. An increase in political self-assertion and influence among members of various minority ethnic and racial groups and by women became unignorable in academic politics about a decade ago. In this political climate, it seemed sensible to many academic physicians that their students needed to know more than biological and clinical science in order to treat patients and contribute knowingly to the public's health. Earlier, during the scientific campaigns of the cold war in the 1950's, there was lamentation that education emphasizing the humanities and even the social sciences left students ignorant of many of the central issues and institutions of our time. The flush academic market of the 1960's, when resources seemed available for almost every need, facilitated alliances between humanists and physicians on various campuses. For a few years, plans were made, experiments were launched. Many people who did not notice that the projections of futurists and their base in predictive demography have been consistently proven wrong during the past two centuries, believed that academic politics, or at least the relations between physicians and humanists, had lost some of its brutality, though never, I must add, its pettiness.

Although you are familiar with the many reasons to educate physicians broadly as well as deeply, you may not be fully acquainted with what happened in those universities where influential physicians had money and motive to introduce humanists into the medical curriculum. After some years of teaching, talking and reading about humanities in medical education, I am persuaded that hardly anything has happened to medical students as a result of the activities of people like myself.

What has happened, however, is that, in response to disdain, resistance and occasional attention from scientific and clinical colleagues, medical humanists, whether trained as physicians or in the humanities, are behaving in a manner that has, over the past century, signalled attempts to create new medical specialties. Clinical and scientific turf has been staked out. The poor, the excluded, in this year's codeword the disadvantaged, have been invoked as providing special reason for concern, and of course uncompetet for subjects of the new specialists' skills. Federal and foundation subsidies for research and training have been sought and won. A national society has been formed, with the familiar pattern of invitational memberships, limited in number, in its initial years. Manifestos are written. Curricula are circulated. A journal has been announced, and editors of older journals in adjacent fields worry uneasily about competition from these unfamiliar new enthusiasts. Institutes and conferences are convened. The time is coming when a few members of the proto-specialty, ethicists for instance, will be proposed for membership in the most exclusive society, the fortunate people whose professional time is reimbursable by third parties.

Whether the medical humanists follow family physicians to prosperity or abdominal surgeons to oblivion, their perverse urge to repeat the past reflects badly on humanists' comprehension of our own modest contribution to informed intelligence; the assertion of a non-cumulative as against a cumulative past.
Biological, physical, and clinical scientists have little professional need to pay close attention to the past. They are generally correct to conclude that almost all the past science they need to know is contained in, indeed made possible, the most recent significant paper in their fields. Their useful past is cumulative and optimistically progressive. Their education and their work contradict the humanists' proposition that much that is interesting and instructive in the past cannot be retrieved, ordered and comprehended without deliberate effort.

The assumption that the increasing specialization of labor in the 20th century has been both inevitable and desirable is an example of the near triumph of the cumulative past. This assumption is generally unexamined, and becoming increasingly unexaminable by victims of higher education in the United States. The belief in a cumulative past, the notion that hardly anything that happened or was thought before is worth attention, leads directly to the conclusion that education need consist of little else than logically connected abstractions and methods for transforming empirical evidence into testable hypotheses. We can usefully spend our careers applying the methods absorbed in our training to data in order to produce new theory, which will in turn be tested by our methods. When exceptions to received theory become intellectually unbearable, a new theory or paradigm will be invented to comprehend old truths and transform recent exceptions into normal cases.

Conventional images of knowledge exploding, of disciplines and professions fragmenting into new specialties are seductive but suspect. It remains to be demonstrated that increments to knowledge themselves produce changes in the division of labor. An example of this point is obtained by looking at the names of departments, schools and colleges in university catalogues from various nations. Exploding knowledge, allegedly transcending nationality, race, culture and class, has instead produced notably different divisions of human labor.

It is, moreover, far from self-evident that specialization has been a response to the biological or psychological limits of human comprehension. Medical educators, in the United States the most skilled clutterers of minds, have not yet exceeded students' capacity to absorb information under stress. Every critic of narrow specialization claims that depth need not be sacrificed to breadth of understanding. Almost every creative scholar—clinician, natural or social scientist, humanist—has been led by his or her questions to acquire proficiency in one or several adjacent disciplines.

Particular divisions of labor have never been satisfactorily explained without reference to behavior rooted in the classic motives of blood, money, and sex, as well as, and occasionally instead of, the practical application of new knowledge. Some years ago, for example, misreading of an essay by Lord Snow on Cold War politics titled "The Two Cultures and the Scientific Revolution" stimulated a number of people to set up in the cultural marketplace as mediators between the natural sciences and literary culture. There were no incentives for these mediators to ask whether the alleged two cultures were the result of transitory social and political forces. Neither did the mediators seek any insight from the accidents that had enabled them, unlike their benighted audiences, to be bi-cultural. Some years earlier, during the Second World War, committees of American educators found significant roots of the decline of free institutions and of the moral perversion that contributed to genocide in the curricula of colleges and universities. Whatever the immediate merits of this retrospectively implausible position, its adoption contributed generously to the creation of captive audiences for the three great academic faiths, natural science, social science, and the humanities, in the
1950's and 1960's During the anti-war movement of the 1960's, these captive audiences were destroyed when many people came to the conclusion, itself a result of discrete events, that curricula may be largely irrelevant in determining foreign policy and national character.

I ramble in point, which is that medical humanists, whose existence responds to both the contemporary division of labor and the critique of that division, are caught in a painful conflict. They will be ridiculed and ignored by most physicians and scientists because they challenge the contemporary social, economic and intellectual order in medical education and practice. They may be destroyed if they are successful because a significant decline in specialization and intellectual fragmentation can eliminate the modest demand for their services that now exists. They will surely compromise their intellectual and moral integrity if they fail to question the assumptions which lead them to struggle to become another medical specialty.

This conflict is not nearly as abstract as my words. Few individuals have ever traded security for truth. Those whom we venerate for doing so can usually be found to have actually exchanged security for salvation, which is a better bargain.

Medical humanists, when they are visible at all, are a rebuke to their colleagues. At best they are suffered because it is temporarily fashionable to notice deficits in the prior education or current perceptions of students, physicians and basic scientists. Unlike most other newcomers to medical curricula in the twentieth century, however, medical humanists do not display new knowledge in the usual definition of that phrase. To those who have been trained to accept a cumulative past, revealed in the rewarded perceptions of the present, humanists' knowledge is by definition old, disconnected, quaint, perhaps picturesque, but never significant or elegant. Like family physicians, medical humanists look backwards for their justification. Unlike family physicians, however, they have no economic base in patients' demands and the medical polity.

More important, unlike family physicians who nod perfunctorily to a mythical past and then embrace current conventions of science and practice, humanists are trained to ask questions about the purpose and function of myths and conventions. The application of critical methods to the myths and conventions of medicine reveals that superbly education physicians have been exceptional in the history of medicine. Few have had time and talent for the arts, letters, philosophy and brilliant social discourse while conducting busy practices, teaching and performing research. The special excellence of William Osler and others who have become statues and portraits is uniqueness. They are Representative Men in the transcendental, not the democratic, sense of the phrase. Moreover, most of the physicians who made major contributions to humane letters were not outstanding medical men. John Locke, John Keats, Anton Chekov, and William Carlos Williams were not particularly notable physicians. Anyone with a taste for logic and arithmetic can readily demonstrate that contemporary physicians are the most broadly educated, by any reasonable definition, of any in history.
The minority of superbly educated physician-humanists of the past need to be seen whole. There are many accounts of clinicians and investigators who were brilliant in all forms of discourse, well-acquainted with great texts in ancient and modern languages, and gifted in arts and letters. These outstanding individuals, like the general practitioners in the sustaining myth of family physicians, reflect the class system of the medical profession -- a class system that is always changing in fascinating ways as the society of which it is a part changes. Physicians have usually shared values, tastes and standard of living with the people who populate their practices. The humanist physicians of the past generally received liberal (that is, classical) educations as a result of their fathers' social class and aspirations. They attended medical schools that preferred the affluent and offered upward mobility mainly to those already moving. Except for a few famous years of revolution and upheaval in a handful of places anybody in recent centuries who confused the humanities with humanity, or medicine with the aggregate health of the public, was regarded as dangerous or silly by most of the humanists and physicians who have left records of their views.

Perhaps the appropriate comparison is between the new medical humanists and public health physicians. Both groups began with criticism of the dominant social values of practicing physicians; the medical humanists in the middle decades of our century, the public health physicians a century ago. Both have roots in academic medicine. Both claim responsibility for groups of people rather than individuals with particular complaints.

There are, however, two significant differences between the public health and humanist medical specialties. The early public health physicians in Europe and the United States derived much of their practice from dramatic changes in biomedical science, especially the emergence of such disciplines as cellular pathology, bacteriology and epidemiology. At the same time, they acquired skills in the politics of public and voluntary association activity and developed effective demand for their services. Public health has nevertheless remained the most marginally accepted of medical specialties.

Compare the relatively disadvantageous position of medical humanists. They work in areas of knowledge which are held in low regard by most of the people they seek to influence. In addition, they function politically mainly as clients in search of patrons. They are often unwilling, even when technically able, to engage in the constituency politics of the American academic and research marketplace.

I have not expressed myself clearly enough. A recapitulation in plainer English is needed.

Medicine and the Humanities are difficult abstractions, evoking suspicion because they are supposed to be Good for Us, though in different ways.

Physicians and humanists have very little regard for each other, except as potential consumers who will praise passively each other's work.

A curious recent event in higher education is the attempt of the people I call medical humanists to infiltrate the medical curriculum, to specify areas of practice, to establish associational machinery, and in general to behave as a proto-specialty.
This proto-specialty rests, however, on basic sciences (history, philosophy, theology, the arts) which, in contrast to the bio-medical sciences, regard the usable past as a series of discrete events, many of which are worth recalling and preserving. In contrast, most scientists are trained to view the useful past as cumulated in dominant contemporary theory and practice.

The humanists' view of the past requires them to assume that any division of labor and all specialization is transient. Moreover, all specialties are sustained by myths which, however useful in the present, must be examined critically by conscientious humanists.

The humanists' professional skepticism about conventional views of past and present creates undiplomatic and anxiety-provoking challenges to colleagues. In the slightly longer run this skepticism leads to self-destruction.

There is, moreover, no comfort in any analogy between medical humanists and public health physicians who, a century ago, challenged conventional views of medical education and practice and have retained a significant role, however marginal, in medical affairs.

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Having argued that medical humanism, despite its past achievements and short-term prospects, may not have a happy future, I could be seated and scribble notes for a counter-rebuttal to the rebuttal my friends will no doubt make. Or I could provide evidence in pedantic point for those of my assertions which are derived from historical research, rather than my prejudices.

I choose neither alternative because I am committed to the study and teaching of the humanities as a source of personal satisfaction and as a civilizing influence. I am, in addition, eager to prevent medical humanists from talking mainly to each other.

It is essential that medical humanists seek to be useful in contemporary health affairs. By useful I simply mean perceived as having knowledge and skill which can be applied to the care of patients. After some years of helping to manage an academic health center, and several as Associate Director of the Federal agency which provides most of the funds for research on health services, I am persuaded of the pertinence of my skills as an historian, of the need for more systematic application of humanists' knowledge and training to the problems I encounter, and of the general disinclination of either my colleagues in the humanities or those in academic and research administration to take seriously my opinions about humanists and the humanities. I persist, however, in my conviction that it is useful to understand such matters as the philosophical and historical background of law and regulation, the interplay of culture and personality, artists' and poets insights into perilous encounters, the complicated logic that should govern decisions about individual and group rights, the historical and comparative dimensions of proposals for standards of adequacy in health care, and the curious ways ideas, men and institutions influence each other over time. I believe it is demonstrably in the public's interest to subsidize people to engage these and related issues in research, teaching, patient care and administration.
These issues are not now perceived as sufficiently compelling of the public's interest to require the investment of adequate resources. There are many reasons for this state of affairs. Not least of these reasons are the ignorance and arrogance of many otherwise superb medical humanists. Many are content to lament their uncomprehending audiences rather than to learn about which problems, stated in what terms, are on the agendas of those who influence the distribution of resources. Most humanists know but do not apply the finding that there has never been more than a limited, and now declining, market for knowledge for its own sake in any field of inquiry.

Arrogance, a combination of pride and insecurity, is more difficult to challenge because it serves important needs. There is a limit to the amount of non-comprehension and disdain people can experience before they decide that the clinicians, basic scientists and medical students who scorn and belittle them are just a bit insufferable, maybe even contemptible. Since admitting to such feelings is destructive of economic security, it is prudent to decide to do your own work, for your own small audiences, and to ignore the hostile environment. Arrogance, reciprocal arrogance I remind you, is probably easier on the nerves than is whoring after acceptance.

The patrons of the handful of medical humanists are skilled in practical affairs. Like most patrons of the humanities since the French Revolution, they are successful merchant princes or captains of erudition who, having compartmentalized their lives, do not always preach what they practice. Medical humanists like other workers in patronized disciplines before them, need to exchange ambivalent comforts of clientage for the more uncertain dignity of the transactions of constituency politics.

I need not expand here on the theory and practice of constituency politics, just as I do not argue the value of the humanities to an audience which has invested time in this meeting. I will conclude by speculating on possible results of the unlikely event that my analysis convinces anyone to attempt action. A cadre of humanists will address the public purpose of medicine—the care of patients, the statement and defense of standards of human function, the control and prevention of disease, the promotion of well-being...I do not argue about how best to phrase each issue. These humanists will use their special skills and trained insight to assist medical, basic science and social science colleagues to describe, assess, criticize, preserve and change as they address particular matters of public purpose. The vehicles for the humanists' influence will be research, creation, performance, counseling and teaching. The practical importance of the humanities--not their transcendent or even relative importance, just their usefulness--will be demonstrated to legislators, trustees, funding fathers and skeptical colleagues through carefully managed strategies and tactics of persuasion. The small professional associations now competing for funds and attention will pool their efforts in order to achieve greater impact. They will abandon, for example, all remaining public traces of polemical positions on disputed issues of health care. Trade-offs and exchanges will be made as it is customary in the closed politics of the academic, professional and governmental worlds. Administrators and agencies will not be asked to support the research and teaching activities of humanists because they ought to. Such moral imperatives, especially if heeded, create unseemly personal dependence in contemporary health institutions.
Our common culture is no longer expressed in precise images, representational or abstract. Statues are no longer erected to celebrate neutered nouns; academic buildings are not decorated with the carved names that appear on reading lists. Other cultures are acknowledged more effectively in international politics and their domestic results than in the decorative arts.

Like most historians, I am not trained to describe contemporary society and culture in ways that differ from the ordinary observations of members of my race, ethnic group, class and sex. I suspect, however, that my discomfort with the abstractions of medicine and the humanities is more than personal. Medicine and the humanities are abstractions of low and declining utility for the middle class mostly white male professionals who dominate health affairs in the contemporary United States. I do not know what new abstractions will emerge and be valued as the demography, economics and politics of health affairs inevitably change. For the present, there are more than enough insoluble problems requiring approximate answers to engage the skills and perceptions of all of us, working collaborately and separately. Over a century ago, Thomas Carlyle was reported to have heard that a noted American transcendentalist had agreed to accept the universe. "By God she'd better", he is supposed to have said.