Organizational Aspects of Caring

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DURING THE TWENTIETH CENTURY BIOMEDICAL knowledge has exploded beyond all expectations, medical technologies have exceeded every prediction, diagnostic accuracy and therapeutic results have improved markedly, and the list of illnesses that respond to modern therapy has grown significantly. Despite these achievements, voices from many quarters suggest that something is fundamentally wrong with the enterprise. In the memorable words of John Knowles, we are "doing better and feeling worse" (Knowles 1977).

Escalating costs, lack of universal health insurance coverage, and similar issues receive the greatest exposure in the popular press, but these are not the only concerns warranting attention. Equally troubling is the manner in which medical care is delivered. Increasingly, physicians and other providers are perceived as lacking in compassion. Doctors are seen as coldly analytical and uncommunicative. Patients sense that physicians are losing the human touch and are more interested in their diseases than in them as people. Whether accurate or not, the Norman Rockwell image of the friendly, gentle, sympathetic, unhurried, communicative

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family physician of nostalgic memory remains powerful. Increasingly, today's medical care providers are perceived as having forgotten, or perhaps never having learned, the advice of older clinicians, expressed well by Francis Peabody of Harvard University long ago, that "the secret of the care of the patient is in caring for the patient" (Peabody 1927, 882).

In this article we attempt to reassert the fundamental importance of caring in the doctor–patient relationship and to suggest ways in which the administrative organization of medical services, including their financing, can promote or inhibit expressions of caring by physicians and other medical personnel. We begin with a brief statement about caring and why we believe it is fundamental to effective medical practice. This is followed by a discussion of certain features of the social organization and financing of modern medical care and their implications for the ability of care providers to deal with patients humanely. Throughout, we comment on the policy implications of our analysis.

Why Caring Matters

Physician competence has three components: knowledge, skills, and caring. The first two are assumed and require no further elaboration. We believe that caring is as integral to medical competence as are knowledge and skills because caring fosters the bonds of trust that enable doctors and their patients to communicate. Effective communications are important for compelling reasons: *85 percent of the information that physicians require in order to make a diagnosis is supplied to them by patients (Hampton et al. 1975), and patients' participation and understanding are fundamental for successful management of illness*. Hart explains:

> Accurate diagnosis requires that patients give intimate confidences to health workers, creating personal relationships on which continuing mutual responsibility can and should be built. We have good evidence that the quality of these continuing relationships profoundly affects compliance, dropout rates, investigation rates and willingness to "wait and see," hospital emergency admission rates, and average length of stay. (Hart 1992, 773–4)

Caring relationships in medicine are characterized by expressions of humaneness by physicians and other health care providers toward patients as evidenced by such qualities as interest, concern, compassion,

sympathy, empathy, attentiveness, sensitivity, and consideration. Caring physicians relate to patients as people, are both aware of and sensitive to their feelings, and develop an empathetic capacity to experience vicariously patients' thoughts and experiences without requiring them to be spelled out. By projecting themselves into the patient's position or state of mind, doctors are able to become more sensitive to signs of stress, emotional disturbances, and expressions of pain and to appreciate feelings, tendencies, and intentions as well. These are the qualities to which we refer when we use the phrase "caring physician."

The importance of caring in the doctor–patient relationship can be illustrated by research on just one facet of practice: compliance with medical regimens. This research suggests that attention to the quality of the instructional process significantly enhances the likelihood that patients will follow prescribed courses of treatment (Svarstad 1976; 1986). An examination of the particular features of the instructional technology reveals that many of these elements are premised on an underlying attitude of caring. Svarstad's research suggests that, in order to be instructionally effective, the doctor or nurse must address the patient as a unique human being, with particular needs, levels of comprehension, and personal concerns. The instructional process must be addressed to the whole person and be consistent with lifestyle and personal preferences. The professional who is sensitive to those concerns can adjust the regimen to lessen its interference with the person's needs and goals, thus making the regimen more acceptable. Communicating clearly, listening and responding carefully to feedback, and demonstrating concern about the regimen's fit with patient needs are components of a basic humanizing process.

Leiderman, Crowley, and Scott (1994, 4–8) have argued that the quality of caring in the doctor–patient relationship can be specified. By this, they mean that it can be defined, articulated, and analyzed in cognitive, affective, and behavioral terms; people can learn how to express it; and it can be incorporated integrally into the routine practice of medicine. It can be taught as part of basic medical education (Roter and Hall 1992; Leiderman, Crowley, and Scott 1994, 12–17), and medical practices can be organized, administered, and financed in ways that will cultivate and sustain it.

We emphasize this point for a reason: although a great deal has been written about the importance of caring in medicine, too often authors list *all* of the humane qualities and expressions of affect that are desir-

able for physicians and other care providers to display. We find this use of the term infelicitous. The tendency to define caring in a broadly inclusive fashion to encompass all imaginable desired humane qualities is responsible, we think, for imparting the impression that caring is an impossibly general, vague, mysterious, all-encompassing, intractable quality that defies systematic description and analysis. This impression leads some to conclude that one is asking too much of physicians to possess and display all these implied qualities, and, therefore, that caring ultimately is a matter about which little or nothing can be done. We do not accept this conclusion.

At the same time, even though caring can be specified and analyzed, ultimately it implies naturalness and spontaneity. These statements are not contradictory. It is perfectly feasible to specify the component parts of caring; to isolate, analyze, and explain them; and, in the end, to relate them to one another and thereby restore to the concept its essential wholeness. In this respect, the concept is analogous to a graceful golf swing or a fine stroke in tennis, which appear natural and spontaneous to the observer, yet nevertheless can be analyzed in minute detail. No athlete could perform successfully if she or he had to focus on every aspect of a move while performing. Conversely, few would be able to master a swing or ground stroke without engaging in intensive, detailed articulation of the component parts and then internalizing them to produce a single, unified, and spontaneous action.

Although caring is manifested in physicians' attitudes, feelings, and actions (Hall, Roter, and Katz 1988; Roter and Hall 1989), the organizational and administrative (not to mention cultural) contexts in which doctors and patients interact crucially affect the ability of each to act toward the other in a caring fashion. We stress this point because the focus of much that has been written about caring physicians is the individual. In this literature, caring is conceived as a personal attribute reflecting the personality, predispositions, and motivations of the individual care provider. In one sense this is true, if only because patients make judgments about whether or not they are being dealt with in a caring manner primarily on the basis of interactions with their individual care providers. Without denying the important role that personality and attendant predispositions and motivations play in promoting expressions of caring, nevertheless we must recognize that the organizational context in which medicine is practiced is at least equally relevant to the likelihood that medical care will be delivered in a caring manner.

If they are to be consistently humane, health care encounters must be organized and administered in ways that ensure that ordinary caregivers, especially those who may not be exceptionally caring and compassionate by temperament, will nevertheless be provided with opportunities, skills, and contexts that allow them to deal with their patients in caring and compassionate ways. Moreover, from a policy point of view, we believe that changing the organizational structures in which physicians are socialized and practice medicine is likely to prove more fruitful in the long run than efforts to try to change either the individual personalities of physicians or the processes by which they are selected into the practice of medicine. Our aim in this essay is to illustrate and analyze some of the ways in which organizational and administrative practices impinge on caring and to propose mechanisms that will enhance humaneness in delivery of health care.

Analysis of caring in the broader organizational context within which medicine is practiced requires a way of conceptualizing it that will enable us to take into account how that context affects the interpersonal relationships between doctors (and other care providers) and their patients. We believe that concept may be expressed as the relational distance that develops between doctors and patients. Any social, organizational, administrative, and financial arrangements within practice settings that contribute to distancing physicians from their patients will result in tendencies to dehumanize them and will ultimately diminish the physicians' competence to heal. Alternatively, social arrangements and organizational, administrative, and financial processes that diminish personal distance between physicians and their patients will allow relationships of controlled intimacy to develop (Leiderman, Crowley, and Scott 1994, 8), contribute to effective communication, and, ultimately, enhance the physicians' competence.

Caring and the Organizational Context of Medicine

One can easily become pessimistic and discouraged when considering the impact of organizational arrangements on the doctor–patient relationship. Most discussions of this topic are replete with examples of (and complaints about) the myriad ways in which organizational arrangements intrude on and disrupt doctor–patient relationships. Comparatively little has been said about how such arrangements might create and

sustain a level of relational distance between doctors and patients that would nurture a caring attitude. To appreciate this point we need only consider two of the most commonly mentioned organizational problems in medical practice today: time and continuity of care.

Few would disagree that becoming properly acquainted with patients is possible only when a reasonable amount of time is allocated for consultations and when continuity of care is sustained. However, most strategies for cost containment currently under consideration or in practice emphasize efficiency and productivity. They encourage the processing of patients at a pace that interferes with the development of close doctor–patient relationships. Moreover, medical care has become increasingly specialized and fragmented, and, especially in serious illnesses, numerous professionals become involved in the patient's care, leading to confusion about who is in charge and responsible for what. More and more, patterns of practice within the community and in hospitals make it unlikely that physicians will be in attendance often enough and for the length of time required to assess the appropriateness of pending decisions in relation to patients' and family wishes, or, in many instances, even as they affect the patients' clinical condition.

The pessimism surrounding discussions about time and continuity of care among physicians extends to other medical care providers as well. Doctors are not alone in being subjected to organizational arrangements that promote distance between themselves and patients. In theory, nurses should be well situated to deal with patients in a caring fashion, but nursing practice is seldom organized to promote either continuity of care or empathic relationships with patients. Because of assignment to wards for specific periods of time rather than to panels of patients, nurses are barred from realizing the full benefits of their strategic location in the care process. Moreover, humane care requires that doctors and nurses function effectively as partners. Poor communication between physicians and nurses, strained by the lack of mutual respect and feelings of antagonism that generally arise in segregated training experiences, sometimes throws up additional barriers to humane medical care.

Although grounds for pessimism are real, the picture is not altogether bleak. There are compelling reasons for concluding that organizational structures can be reconfigured in ways that will help to close relational distances between doctors and patients to more acceptable levels of controlled intimacy. To appreciate how this might be possible, we must first understand how organizational processes affect the quality of patient care.

These effects are illustrated by drawing on two related areas of organizational research: (1) stress and coping, and (2) determinants of morale and job satisfaction among caregivers. Research on both topics suggests strongly that administrative structures and arrangements powerfully affect the relational distance between caregivers and their patients and further supports the conclusion that organizational arrangements for dealing with the problems of stress, morale, and job satisfaction can significantly improve the quality of the care that is provided to patients.

Stress and Coping

Coping with the stresses of clinical practice can have a potent impact on the quality of patient care. Numerous research studies show that, in the absence of effective mechanisms for coping, staff are highly vulnerable to burnout (Kasl 1978; Maslach and Jackson 1979; House 1981; Dolan 1987; Parasuraman and Hansen 1987). Burnout—physical and emotional exhaustion and a diminution of positive feelings, empathy, and respect for patients and clients—leads care providers to distance themselves from patients, to develop attitudes of protective cynicism, to dehumanize patients, and to treat them in demeaning ways.

The ability of care providers to cope with the stresses of their jobs is a product of two factors: the tasks implicit in a situation and the ability of persons or groups to manage them (Lazarus 1966; Mechanic 1978; Pearlin and Schooner 1978; Dohrenwend and Dohrenwend 1981; Lazarus and Folkman 1984). In particular, group structures and social supports can be crucial for determining the way individual members of staff manage stressful demands. For instance, group patterns of mutual assistance, teamwork, information sharing, and solutions derived by group processes provide important and tangible instrumental assistance in enabling individual staff members to manage and cope successfully with difficult and upsetting tasks (Mechanic 1974). Supportive group processes bolster staff members' self-esteem, their sense of personal efficacy, and their personal empowerment. These systems of support promote group members' ability to help one another during times of stress and encourage other members of the team to feel comfortable with their own efforts and themselves. The studies also suggest that having a sense of control over one's work, experiencing group support, having opportunities to use one's skills, and gaining feedback on the value of one's role all alleviate stress, powerfully

mitigating the tendency of care providers to respond to the stresses of working in clinical settings through personal detachment.

Morale and Job Satisfaction

Another body of research bearing on staff burnout concerns the maintenance of professional morale and job satisfaction. This research links burnout to a variety of outcomes measuring interpersonal relations, performance, and job turnover. Job satisfaction of staff can be a powerful determinant of patient satisfaction, and patient satisfaction in turn is related to compliance with medical regimens (Maslach and Jackson 1982; Gray-Toft and Anderson 1981; 1985; Weisman and Nathanson 1985).

Of special interest in the present context is the fact that much of the research on burnout among human services workers points to features of the organizations in which they work as decisive in determining whether or not burnout, and therefore distancing, will develop. For example, emotional exhaustion, an antecedent of detachment and the depersonalization of clients, tends to be higher among staff who perceive themselves as having little influence on policies and decisions of the employing organization, for those who have to deal with more bureaucratic inconvenience or demands, and for those who have fewer opportunities to be creative in carrying out their work. A common theme emerging from hospital studies of burnout among nurses is that organizationally induced stress generated by an unresponsive bureaucracy is significantly more predictive of burnout and resignations than emotional stressors inherent in the work itself, such as dealing with patients suffering from AIDS or cancer.

A host of organizational factors is associated with higher job satisfaction and lower turnover among hospital workers. These include decentralized decision making, self-scheduling flexibility, adequate staffing, specialization, the practice of primary nursing, opportunities for professional development and continuing education, and organizational arrangements that promote interactions and communication between nurses and physicians (McClure et al. 1983; Hinshaw and Atwood 1984; Prescott 1986; Kramer and Schmalenberg 1988; Clifford and Horvath 1990). These studies indicate that organizational and administrative arrangements governing the contexts in which medical care is delivered affect the quality of patient care through the medium of staff burnout, and that burnout is a primary cause of dehumanization of patients by care providers.

Manipulating Organizational Structures to Enhance Caring

Given that organizational structures and administrative arrangements directly affect patterns of communication between caregivers and patients, we are led to ask if these structures and arrangements can be manipulated to induce positive communication patterns between doctors and patients. At the interpersonal level, research supports the conclusion that the physician's personal accessibility, style of relating to the patient, and clarity of communication are associated with client satisfaction (Lochman 1983; Cleary and McNeil 1988; Roter and Hall 1989). The likelihood that these behaviors will occur in turn heavily depends on the amount of time that physicians have to engage the patient, whether contact with patients over time is sufficient for them to appreciate patients' needs, and the degree of flexibility in their roles. Organizational environments that allow autonomy give clinicians more flexibility in arranging how they complete tasks and deal with clients (Greenley and Schoenherr 1981), and such flexibility often enhances the clinician's behavior and results in higher levels of patient satisfaction (Mechanic, Weiss, and Cleary 1983).

In general, loss of flexibility is not self-imposed; it is organizationally induced. For example, HMOs often schedule physicians' time so that patients with a problem who want immediate access to their personal physician cannot readily schedule an appointment. Many of these patients are diverted to an urgent care clinic or emergency room where they see an unfamiliar doctor. Such scheduling procedures result in discontinuity of care, which undermines patient satisfaction.

Primary Care. The growing interest in primary care has spawned a vast literature, much of which assumes that responsibility for the comprehensive health care needs of patients must be vested in an individual practitioner, most typically a general internist, pediatrician, or family practitioner. Neglected in many of these discussions is the fact that primary care entails a set of functions that can be organized in ways that can make it more (or less) effective, efficient, and responsive to patients and more (or less) attractive to physicians. Although the physician remains the core of primary care practice in the United States, organizations can be modified to make the role more enjoyable and less onerous. Working in teams makes it possible to share continuing responsibility and to provide opportunities for leisure and renewal. The availability of nurse practitioners, social workers, and other personnel provides a

broader range of talent and expertise to deal with the varied preventive, curative, and rehabilitative responsibilities of primary care. In addition, programs of patient education have been shown to have dramatic effects on health status outcomes (Mumford, Schlesinger, and Glass 1982). Group practices of diverse professionals provide opportunities to use new educational materials and media, to improve follow-up of patients, and to provide more comprehensive and responsive care.

The Critically Ill. Patients value a caring physician in most instances, but the critical need for caring is magnified during serious illness when the patient is frightened, insecure, and uncertain about the future. In such instances medical care and caring are truly tested, and these processes are at greatest risk of breakdown. The difficulty is compounded by the fact that patients have developed high expectations and are confused and alarmed by the uncertainty of the medical response. Physicians, too, have difficulty in dealing with uncertainty, and commonly disengage from patients as uncertainty increases, becoming evasive and communicating in an ambiguous way.

All these problems are compounded in the hospital, where many people become involved in treatment and where communication among caregivers commonly breaks down. Patients and their families may avidly seek information and cues about what is happening, but may receive conflicting information and mixed messages from varying personnel. The complexity of hospital care and the ambiguity that frequently surrounds responsibility for coordinating efforts are sources of distress for patients and their families. This is an area where the potential for using computer technology to improve communication should be evident. As simple a device as a single computer file and a clinic- or hospitalwide interactive network to which all caretakers have access can help tremendously to resolve many of the problems to which we have alluded.

Compliance. We have already mentioned the relation between caring and compliance. Research on compliance shows that adherence to a medical regimen depends crucially on the quality of the instructional process, and that patient comprehension and recall can be enhanced by explicit directions, a clear explanation of the purpose and importance of the medications prescribed, written compliance aids like instruction cards, and strategies like categorizing and repeating the advice, simplifying complex concepts, and being consistent (Svarstad 1976; 1986). These approaches can be enhanced through organizational arrangements.

Job Descriptions. Many essential aspects of caring that are now

treated informally can be formally built into the treatment process by defining clearly the functions to be performed and specifying how they are to be performed and who is responsible for their completion. The introduction of new personnel on a service requires that they be instructed explicitly about norms and procedures. A well-managed setting can improve performance not only in a technical sense, but also in creating a treatment climate that patients find supportive and caring.

Large clinics and hospitals, like any other organization, must properly train and supervise other participants in the delivery of care. Aides, orderlies, receptionists, administrative personnel, and others often convey the character of the institution to its public. Patients may be pleased with the caring of their physicians but soured by the discourtesy, ineptitude, and unpleasantness of personnel who answer the phone, schedule appointments, perform procedures, arrange admission, and perform a variety of other maintenance activities. Health settings have a great deal to learn from well-run service industries, which have developed superior systems of personnel training and supervision. Insensitive behaviors, often disorienting to sick patients and their distressed families, are clearly modifiable with careful planning and good management.

The quality of the patient's experience during illness is a product of all the interactions that take place, and poor control over the emotional climate of the hospital can undermine even very effective caring relationships between patients and medical and nursing staff. Patients come into contact with a wide spectrum of personnel of varying education and preparation who, depending on their demeanor, can intrude on the patient's privacy and sense of dignity. By and large, hospitals have given little attention to in-service training of these other personnel. In many hospitals, there is a significant social and cultural gulf between staff at various levels of the status hierarchy, and staff are often stratified by race and economic class as well. The quality of training and supervision of these staff members, and the extent to which management recognizes their special needs, can be decisive in developing a pleasant work context for them that is consistent with humane health care for patients.

Caring and Time

Caring takes time. There is no way around this fact. Fiscal schemes that require physicians to deal with patients in assembly-line fashion work against caring. In addition, under most schemes, medical and surgical

procedures are reimbursed more generously than cognitive services (i.e., informational, educational, and management services), which are reimbursed not at all or only at very low rates. In this sense, insurance companies or providers have largely adopted payment schemes that make it difficult for doctors and patients to achieve optimal relational distance in the course of clinical encounters. Alternative proposals such as the resource based relative value scale (RBRVS) are intended to correct this problem (Hsiao et al. 1988).

In their paper on the doctor–patient relationship, Thomas Inui and Richard Frankel comment on the clash between fiscal imperatives and the precious commodity of time (Inui and Frankel 1991, 4). Pressures for productivity and cost constraints have conspired to speed the processes of care, thus limiting direct doctor–patient interaction. Inui and Frankel report research showing that the average face-to-face time now available for internists to get acquainted with new patients in office practice is 11 minutes per patient, and that the number of minutes hospital patients can expect to see their physician per day is four. The time pressure now operating on doctors to process patients in assembly-line fashion is dramatically revealed in detailed studies of the dynamics of the doctor–patient relationship. On average, "physicians do not even permit their patients to explicate the reason they have sought consultation with a physician for more than 18 seconds without interrupting, controlling, or diverting the stream of narrative" (Inui and Frankel 1991, 8). Whatever else might be achieved within so short a span, it occurs at the expense of a caring relationship. The lack of sufficient time spent in communication becomes even more critical when we realize that 88 percent of diagnoses are established by a brief history and physical examination, and that in 56 percent of cases the proper diagnosis has been assigned by the end of its history-taking phase (Hampton et al. 1975). The absurdity of noncommunication between patient and physician becomes more evident as high-cost laboratory and instrumental procedures are substituted for relatively low-cost face-to-face communications.

Cost Containment

The fact that caring takes time does not mean that it has to be costly. Indeed, when services are properly organized, medicine delivered in a

caring manner can achieve appreciable savings. The key to economy is to understand that caring is not restricted to (or the sole responsibility of) physicians, but is rather a responsibility of everyone involved in health care delivery: doctors, nurses, social workers, assistants, clinical and office administrators, technicians, attendants, orderlies, aides, and others. In most situations the physician will be the chief architect in creating an environment for caring in his or her office and in the hospital, but other participants carry out the plan.

For example, physicians may need to take the lead in ensuring that caring takes place, but much of the time-consuming and costly detail work involved with caring can be handled by other personnel whose rate of reimbursement is much lower than that of doctors. By personal example and by the values he or she holds, the caring physician creates the setting for caring relationships to develop among the patient, the physician, and the institution. This approach, if designed and implemented with a strong commitment to deliver medical services in a caring fashion, can have dramatic implications for the costs of health care.

In any system modeled on a fee-for-service concept, one can imagine a reimbursement scheme that would pay for an initial visit to permit the physician and other members of a treatment team to become acquainted with the patient, establish communication with him or her, and set the general tone for what is to follow. If responsibility for caring is shared by a team of providers, and this fact is explained to patients early, developing and ensuring a caring relationship can then be shared with less costly personnel. In addition, although subsequent physician contacts might then be of short duration, provision could also be made for periodic longer visits as needed. The patient would then identify with a caring team of which the physician is a principal member. The most costly encounters with expensive personnel could be appreciably reduced, and the number of less expensive personnel working with the health care team could be considerably increased. The nurse practitioner, medical social worker, and medical technician become features of the practice of medicine in a caring environment. The additional time, and thus resources, invested might turn out to be productive in the long run, even in purely economic terms.

Overall, the best approach for fostering caring relationships between providers and patients would be one that makes relevant information readily available to patients, permits the cost of establishing initial "ac-

quaintanceships" between patients and providers, does not penalize patients for changing their health care providers or organizations, and enhances the incentive for providers and patients to cultivate long-term relationships with one another—while reducing the excessive cost of unnecessary procedures. Increasing the availability and quality of primary care by including the time to establish a caring, trusting relationship might increase the overall cost of primary care, but this might be more than compensated by a reduction in the overuse of expensive diagnostic and therapeutic services.

Conclusion

The likelihood that caring relationships will develop between caregivers and their patients depends on administrative and organizational features of the settings in which medicine is practiced. Humane care derives largely from the structure of human relationships and collegial arrangements, and if humane norms are widely shared and supported by everyday attitudes and routines, we have a great opportunity to improve the quality of the caring environment and, in the long run, to reduce health care costs by encouraging physicians and patients to work together in a mutually rewarding relationship.

We have suggested a number of administrative and financial arrangements that we believe will enhance the likelihood that medical services will be delivered to patients in a humane and caring manner. We conclude that if caring is to happen on a widespread basis, however, it will come about because of multiple changes throughout the entire health care system and not by manipulating a single lever in one segment of it. Changing the kind of people we recruit into medicine would surely help, but only a little bit. Changing medical education and training will also help, but only to a small extent. Similarly, altering organizations and administrative procedures will help, as will recruiting administrators who understand the purpose of medical services, but only to a certain degree; this is the case with funding as well. For caring to become a central feature of the medical landscape in our society, changes must begin to occur in all of these sectors, with each influencing changes in the other.

Consistent with this point, caring is best understood as a general qual-

ity that must infuse all aspects of medical care. It is applicable across all specialties and roles within the health care system. It is not as if the ingredients of caring that we have enumerated would apply to some specialties and not others, or only some of the time or in certain settings and not the rest. Caring must become a concern to everyone providing care to patients, whether directly or indirectly, and in all situations in which care is given. Caring is an issue that extends beyond individual providers to include organizational settings and administrative procedures, the manner in which technologies are used, the way in which health care is funded, and the elements of health care that are emphasized.

Medicine is a multifaceted practice in the modern world. It has scientific and economic aspects and must be related to societal needs as well. Our analysis, however, leads us to the conclusion that beyond all of these things, medicine is fundamentally the *art of healing*, and therefore a calling. By this we mean that it is a practice organized ultimately around certain intrinsic values. These values dictate the goal of healing, which is to deal with and be responsive to human suffering in a compassionate way, not merely to eliminate pain in this or that part of the body. Furthermore, it is the dedication to restore and maintain health, and to offer this gift to society.

In a society like ours, divided on values and accustomed to viewing most social problems as an exchange of commodities, the calling of medicine may be the last real ethical frontier. We still have some consensus about the aims of medicine and how in fulfilling these aims we should relate to each other. Hence the revitalizing of the conception of medicine as a calling has significance even beyond the functioning of the practice itself. For ultimately, the caring attitude and behavior that should be a hallmark of medicine might also serve as a model for other services critical to maintaining the fabric of our society.

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