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From: The Task of Medicine. The Henry J. Kaiser Family Foundation,

Chapter Thirteen

You will have to forgive me for the presumptuousness of referring to myself as "post-Flexnerian." When I'm finished, you might want to classify me "pre-Flexnerian," or worse, simply obsolete. However, I claim to have had a Flexnerian medical schooling—there was not any other kind when I attended from 1947 to 1952. I enjoyed medical school immensely and remember myself as a willing and basically uncritical student who was eager to do anything that my teachers assured me would make me a better doctor.

As a freshman, I read a novel about medical students at Johns Hopkins, Miss Susie Slage's, that fired my romantic imagination about medicine in a way that has carried throughout my professional life. That book was the first I ever heard about Osler, Welch, Halstead, and Kelly. Medicine has been my mistress now for 40 years, my source of personal identity, my window into the mysteries and secrets of human life, my benefactress in more ways that I can count. It's been a grand affair that still has power to charm.

Yet, in many ways, I am disenchanted, perhaps even apostate from Flexnerian medicine and its fierce, single-minded commitment to the most infinitesimal dimensions of human biology. The basic medical sciences, which Flexner loved and trusted so much, seem marginal to a great deal of what I find myself doing as a physician. I should acknowledge that I never really conquered the basic formulas of biological energy transformations. No shiny charts of metabolic pathways adorn my office walls; I display no icons to electron microscopy, DNA chemistry, immunogenetics, or cell membrane transport. I have never spliced a gene or created a
monoclonal antibody. Receptors are as fantastic to me, and as much to be taken on faith, as electrons, quarks, and black holes. I would not recognize cyclic AMP if you showed me a gallon of it.

I am shame-faced about these lacks and tremendously grateful to the discoverers of such knowledge, but in all honesty, I do not believe that learning the basic sciences over again in their modern form would add much to my functioning as a physician. Besides, I have had to learn a great many non-Flexnerian things in order to practice medicine. Therefore, I am no longer a completely faithful worshiper in the temple of Apollo, sometimes I bow at other altars and sacrifice to other gods.

Let me illustrate. The residents said that a recent lecturer in our department was fantastic. I had to hang on by my fingernails to keep from drowning in a torrent of data about the newest drugs for hypertension and heart failure. What they seemed to revel in, and asked good questions about, I had to clutch at, straining to recapture every fragment of memory about the pathophysiology and pharmacology of hypertension. Mute, I sat at the end of the lecture, my head swirling with visions of molecules being cleaved and reassembled, enzymes activated and blocked, four kinds of adrenergic receptors agonized and antagonized, individually dissected renal tubules catheterized and perfused. Clearly, I was not comfortably "at home" in the geometric molecular world of renin, angiotensinogen I and II, prostaglandins and bradykinin, even though my medical career spans the entire history of modern antihypertensive pharmacotherapy.

I remember when no treatment was truly effective—barbiturates, bromides, nitrates, thiocyanates, and veratrum alkaloids—and recalcitrant hypertension was treated surgically by thoracolumbar sympathectomy. I remember the first excitement generated by hydralazine and ganglionic-blocking agents, powerful but dangerous, and the remarkable boon to office treatment when thiazides and rauwolfia alkaloids became available in the 1950s. Things are certainly better now, but I have seen therapeutic fads come and go, official recommendations revised repeatedly, educational campaigns for physicians and patients rise and decline, yet hypertension remains a major health problem and seems likely to continue.

There is a gap between what the molecular pharmacologists know and the conquest of hypertension. Perhaps the obsolescence of my generation is part of the problem, but perhaps there is a human dimension to the treatment of hypertension that the pharmacologists overlooked or that their science is powerless against.

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Is there a sense in which the war against hypertension capsulizes both the strengths and weaknesses of Flexnerian medicine? It does not assuage my conscience to think so, but it puts things into a better perspective. If pharmacology is necessary but not sufficient, there is surely some legitimacy in asking why and in thinking about what sufficiency requires.

**Extra-Flexnerian Knowledge**

Let us withhold concluding, for the moment, whether I am pre- or post-Flexnerian—I have surely disqualified myself as Flexnerian—yet I do claim to be a physician in good standing. My license has never been revoked, and I see patients almost every day. I sincerely hope that I am not an imposter, a fraud, or a hopeless anachronism. Your judgment about that may depend upon whether I can go beyond my disenchantments and deficiencies and say in a more positive way what I know and do with and for patients. I hope that this will be more than an exercise in self-justification, since the issues being raised affect all physicians, especially those in direct patient care.

Since there is no orthodox Flexnerian science of the mind, much less of the self, the family, or the community, I have had to learn what I know about these from other sources. Patients, never merely bodies or disembodied spirits, present themselves to physicians in exasperating wholeness, not realizing what dichotomous dilemmas they create for their physicians’ science. They do not come in battalions, but one by one, always with connections to others, to society and culture, which are also present by proxy and which cannot be ignored with impunity. A small proportion of patients are the bearers of well-defined Flexnerian diseases; most bear illnesses, the fear of disease, or simply questions about their health. I see very few who have no clinical concerns, no matter that they scheduled their appointments for “check-ups,” whatever that turns out to mean.

I know that diseases, illnesses, and clinical problems occur within circumstances, contexts, and social systems that give meaning and to some extent definition to their forms. I have not only to do with pathological lesions that occur within the patient’s skin, i.e., within tissue, but also within the self, and in the interstices of personhood. The late Michael Foucault correctly identified the beginning of scientific medicine with the concept of tissue, and Flexnerian medicine has exploited that understanding brilliantly; but post-Flexnerian medicine must go beyond the geometry of
tissue to psychic and social spaces where much of modern disease, illness, and malaise reside.

Moreover, I know that illnesses of all sorts, not just mental disorders and behavioral problems, are not only matters of facts having logical and mathematical connections, as Flexner supposed and wrote, but they are also expressions of nonrational, irrational, and even absurd dimensions of human behavior. Simplistic notions of unitary causality will not suffice when the patient’s actual historical existence must be taken into account. I get little explanatory power from the atomic theory, the cell theory, or the germ theory, when what John Whitehorn called “man’s pathogenicity for himself” is the problem. Does anyone believe, for instance, that either the causes or the effects of AIDS have a Flexnerian solution, another magic bullet or vaccine, that will leave man’s sexual behavior untouched?

Knowing the Patient

If there is one respect in which post-Flexnerian epistemology differs most from Flexnerian, it’s in the relative importance of vision and hearing in knowing the patient clinically. Both, of course, are important and it seems a little silly to contrast them were it not for the fact that modern science seems preoccupied with visual imagery as the best and most valuable data. One chairman of a department of biochemistry was quoted as saying, “Life can be explained through biochemistry.” Even with allowance for legitimate pride and homiletic extravagance, such an idea is fatuous. Walter J. Ong, professor of English at St. Louis University, has pointed out that:

... the greatest shift in the way of conceiving knowledge between the ancient world and the modern world takes place in the movement from a pole where knowledge is conceived in terms of discourse and hearing and persons, to one where it is conceived in terms of observation and sight and objects. This shift dominates all others in Western intellectual history.

To which Norris K. Smith, professor of art and archeology at Washington University, St. Louis, replies that science, through its preoccupation with observation, has come to worship the ideal of impersonal objectivity to the exclusion of other forms of knowing. He stated:

... let me suggest that in our day the most insidiously idolatrous kind of image-making ever known is also the commonest—to wit, photography. I find the notion ineradicably fixed in my students’ minds that a well-focused camera reveals to us the truth about
things—what my very worst students refer to as "reality as it really is." ... The camera is widely thought to "see" with impartial accuracy, but in fact cannot see at all; for seeing is not a matter of optical mechanics; it is rather a process that involves our whole mental and spiritual being.¹

The spoken word is the royal road to human understanding in medicine. It is the difference between "knowing that" or "knowing how" and "knowing whom" or "knowing whether." It is the difference between medicine as sophisticated veterinarianism and a distinctly human science and art. It is the difference between significance and meaning, observation and understanding; between a well-functioning TV set and its program, a word processor and a novel.

Paying Homage

I owe to Adolph Meyer the simple but profound idea that the physician must come to know the patient's name and the experience of life that the name stands for. ² I owe to Samuel Novey the equally profound idea that the patient's history is invented as well as discovered.³ L.J. Henderson (yes, of Henderson-Hasselbach equation fame) taught me that the doctor and patient comprise a social system, a dyad, if you will.⁴ Harry Stack Sullivan was my source for understanding the structure and process of interviewing.⁵ From George Herbert Mead⁶ and Talcott Parsons, I have come to know the deeper dimensions of what Henderson meant by social system, the nature of the sick role, and the motivated character of symptoms.

Michael Balint,¹¹ to me the greatest in this list of teachers and the only one I ever met face to face, legitimized my life as a post-Flexnerian and gave me the courage and the tools to practice in that style. Among many things, he taught that patients turn their problems into illnesses, and that the physician's task is to turn illnesses back into problems.

Martin Buber persuaded me that the highest form of human communication is the life of dialogue between subjects, not monologues between subjects and objects; that dialogue creates the possibility for genuine response to the other and sometimes "inflicts destiny upon us."¹²

Leston Havens wrote that the first great task of medicine is to create a relationship with the patient and the second is to learn how to hear what that relationship reveals.¹³ From Edmund Pellegrino, I learned that the practice of medicine is foremost a
moral enterprise in which "wounded humanity" seeks help from another.\textsuperscript{14}

This short list of teachers and ideas by no means exhausts those to whom I owe homage. Let's consider it a symbol of a body of knowledge without which I could not possibly be a physician, one that could enrich any medical curriculum and move it beyond Flexnerian epistemology.

What I Do

Insofar as I am aware, I see run-of-the-mill patients who are not selected by their demographic characteristics, the nature of their clinical problems, or by my special interest or skills. Even if this is not literally true in all respects, I think of myself as a generalist who takes on all corners in the belief that I can offer them something, if not definitive care.

My understanding of the generalist's role is precisely this; not that I must know or be able to do everything, but that I have a legitimate clinical interest in anyone who seeks my services. Not only that, but I also try to acknowledge whoever accompanies the patient to my office. I do not exclude from my rooms family members or friends who show an interest in the patient and to whom the patient appears to reciprocate. There is always time later when the patient can be seen alone. These others often turn out to be important sources of information or play crucial roles in the outcome of the visit.

Without intending to exaggerate, romanticize, or sentimentalize my work with patients, it must be obvious by now that my chief sources of knowledge about patients are the spoken word and the doctor-patient relationship. I try with everyone to form a therapeutic alliance, though I do not always succeed. Failure in this provides painful but important opportunities for learning.

Patient Dialogue

So I begin and end every consultation with a patient with conversation that in its best moments becomes dialogue. I come to know patients, bit by bit, only as we disclose ourselves to each other in a trusting relationship. This is the reverse of the way we come to know the natural world; we gather facts and then we trust their orderliness and come to say that we know an object. In truth, we know \textit{about} the object, we know \textit{that}. Such knowing will not do in human relationships, whether of friends, lovers, or parents and children. Here we have to trust first and later come to know whom.

These ideas lend meeting of patient as a golden, almost savagely vivid when anything pities, or impatient the first few minutes know.

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Balint wrote ab illness before consult being organized or is nature of complaints purpose.\textsuperscript{17} Sometime emphasized the un complaints and failed to
These ideas lend an aura of mystery and expectancy to the meeting of patient and physician. Rarely do I fail to feel it. There is a golden, almost sacred moment at the beginning of each interview when anything is possible if I do not, by my biases, preoccupations, or impatience, distort or misguide it. A tone will be set in the first few minutes that determines what I am likely to come to know.

Conversation and dialogue do not allow me to escape the fact that in some respects the relationship between physician and patient is ambiguous, ambivalent, and even adversarial. I do not agree with Thomas Szasz that the physician's traditionally assumed benevolence towards the patient is actually fraudulent and that self-interest or interest in objective truth always takes precedence over interest in the patient's welfare. Neither do I agree that the physician's proper role is that of expert, whose primary duty is to tell the truth, letting the chips fall where they may.

I acknowledge, however, that the patient's interests and the physician's are sometimes obscure, lack congruence, and may even be conflicted, especially now that so many physicians are employed by others than the patient. This is an important moral problem that needs constant attention, but is not necessarily the most important way in which physicians and patients fail to understand each other or have common goals.

A Real Relationship

The spoken word is notoriously subtle and testimony is not the same as evidence. Pauline Bart has noted unique ethnic and cultural qualities of "vocabularies of complaint." If patients couch their complaints in concrete terms, physicians are apt to respond in concrete ways. Balint and others have taught me that complaints are often "tickets of admission" to the physician's office, and Feinstein emphasized the importance of the "iatrophic stimulus" as the reason for the visit that may lie behind the stated complaint. Moreover, the meaning and purpose of the complaint may not be entirely clear to the patient.

Balint wrote about the time when the patient is alone with the illness before consulting a physician, the time when the illness is being organized or is in gestation. Parsons described the motivated nature of complaints, that they serve a more or less well-defined purpose. Sometimes I think that physicians have overemphasized the unconscious or metaphorical character of complaints and failed to explore fully their conscious elements.
A great deal of attention has been paid in recent years to the quality of the physician's communications to the patient, especially as this has become formalized in the legal doctrine of informed consent. Our ancestors also emphasized the need for clarity and full disclosure on the part of the patient, and this idea was contained in the earliest Code of Ethics of the AMA in a section entitled "The Patient's Duties To The Physician." This section has been omitted in recent versions of the code.

John Berger, in his penetrating study of the British general practitioner John Sassall, described the transformation that occurs in the professional lives of many physicians from "life saver" to "healer," wherein the key is the physician's capacity and willingness to use his or her own imagination to encounter the patient's. This is a non-Flexnerian skill in that its subject matter is not the law-abiding regularities of nature, but the caprices of culture as assimilated by the individual. W.R. Houston, quoted below on the placebo effect, also noted that the physician does not necessarily believe what the patient believes about the illness.

The physician-patient relationship is at least as complex and ambivalent as any other intimate human relationship. It takes time and energy and delicacy to cultivate. Like marriage, it is not a state to be entered into lightly or unadvisedly. So I always begin by believing the patient and taking the complaints at face value, even if, later, I have to confront the incongruities. I am not a surveyor, a poll-taker, an interrogator, or a prosecuting attorney; I do not merely collect data toward which I am affectively neutral or a dispassionate observer. Often I must disclose myself in the process of coming to understand a patient. There is no way to keep the meeting completely safe for me if it is not equally safe for the patient. Both must take the risk of getting to know the other when medicine is practiced in the most effective way.

Therapeutics

I have a small repertoire of technical and procedural skills, and I use a small pharmacopeia of drugs. I have no confidence in a purely objective therapeutic that works regardless of who applies it or in what context it is applied. W.R. Houston wrote, in the 1930s, that the placebo has always been the norm of medical practice, and while I do not self-consciously use drugs as placebos, I certainly try to maximize the placebo effect of myself. He also wrote, "The faith that heals, heals not through argument but by contagion." Michael Balint also wrote lucidly about the doctor as a "drug."

Such notions may be obviated by scientific means, but those means are mostly to be found in the quantification of the patient's experience, not in the reduction of the patient to a collection of measurable variables. For the most part, my medicine as given by medical schools is unsatisfactory. For example, I am always certain that something I am about to do, such as ordering a test, is necessary, but I am more likely to believe this if the test is given as a routine measure, or if I have been trained to accept such a test as part of my practice. The placebo effect of a test is vastly more powerful than the placebo effect of a drug, because the patient is exposed to a test of the patient's response to the test.

"First, do no harm"

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Pathologists work well as for a hematologist...
Such notions may well be pre-Flexnerian, but they have not been obviated by scientific medicine.

I consider myself a familiar (in the sense of an intimate, confidential, associate, or spirit) of the human body, especially in its macro dimensions. I have day to day close contact with it; look at, touch, and smell it, probing its intimate spaces, directly sensing its various effluvia. I know its beauty and grotesqueness, its asymmetries, leanness, and fatness, its lumps and bumps, all its orifices. More than that, I know its anatomy uncommonly well. I can tell when it is functioning well and when and in what ways it is impaired. My fingers can usually locate its pain and tenderness and I rarely fail to palpate the part that hurts. I can ordinarily guess what lies beneath its surface, although sometimes I have to resort to endoscopy and the marvels of modern imaging. It might be too much to say that I love the body, but I have great respect for it and for the person whose it is.

My style of medical practice would be impossible without direct access to the living body. I make a point of this only because I sense a trend in modern medicine to distancing from the body, to know it mainly indirectly by means of instruments, machines, or chemical analyses, and to assign unpleasant or routine contact with the body to others. I would not welcome a future technology that obviated the physical examination.

"First, do no harm"

For the most part, I don't hurt my patients. I try not to inflict pain during my examinations and procedures. I'd like to think of my medicine as gentle and nonviolent. I warn patients when something I am about to do might hurt and give them permission to say, "Stop!" Most of all, I try to reduce the risks of causing iatrogenic illnesses. I prescribe drugs cautiously, and in as small doses as possible, warning of possible reactions, and avoiding known interactions.

I am careful about recommending invasive diagnostic procedures, which are so easily available nowadays. The average physician is only a telephone call away from a vast array of tests and procedures that formerly required referral to a subspecialist. Now the subspecialists are likely to refer patients to the same radiologists that are available to me. I can order a myelogram, four-vessel cerebral angiography, or a CAT scan with contrast as easily as a neurosurgeon.

Pathologists will do a bone marrow examination for me as well as for a hematologist. The power to invade the patient's body
is limited only by the physician’s conscience and judgment. The ancient adage, “First, do no harm,” has never been more important.

On the other hand, I am eager to relieve symptoms, pain, and suffering. My risks are on the side of relieving inappropriately, of overusing analgesics, tranquilizers, antidepressants, and the like. I worry a lot about creating drug dependency, and I spend a lot of time talking with patients about drugs and their proper use. Sometimes I have to be confrontational about prescription refills.

Being on the Patient’s Side

I allow a certain amount of dependency upon me. I am not very good at setting strict limits on my time and energy. I am vulnerable to being “conned,” to giving the demanding or exploitive patient the benefit of the doubt. I tend to take the patient’s side in matters of conflict with insurance companies, employers, “the government,” or other bureaucracies. I give permission to be sick, to miss work, to stay home from school, to be excused from gym class. I feel little compunction to protect the system from the patient. Short of direct lying, cheating, or stealing, I am apt to support a patient’s claim for disability, or to word a diagnosis so that the insurance company will pay for a claim.

I do not feel compelled to demand perfection in my patients, to challenge every habit, every compromise, every adaptation to illness. I do not require that they always choose the best. I try to give sound counsel, but I do not break relationships when patients choose not to take it. I respect their right to say no, to give up, even to die. This does not mean that I have no interest in what my patients choose, but that I will try to help them through whatever they choose.

My errors are likely to be those of omission rather than commission, of doing too little rather than too much. I hold on, I wait, I buy time. I know that Mother Nature is on the side of most healers and that many illnesses improve with time. I do not see myself mainly as a disease fighter or a death defier, I do not believe that death is the worst enemy. I feel very badly if I miss a diagnosis of cancer, but I am not willing to organize my entire practice around avoiding these mistakes.

Sometimes I violate a patient’s confidentiality, particularly when the problem involves intimate others. I value openness, seek permission, and try to persuade patients to share their secrets with family members and others who care, have responsibility, could be affected adversely by the illness, or who may be in complicity with the illness. I do worry whether or not healing both occur accept confidentiality or not above using in paternal, so be it; I judgment when I ar

Sometimes I become subjectivity becomes mon sense, it is the get over it, though: relationship, profess Flexnerian ideal of idolatrous delusion between phys

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If the 20th cer surely is that science The biological sciente be kept under civil physician-patient er edge must be temp for its own good, sh larger frame of refer
with the illness. I do not refuse to take a telephone call from a worried spouse or an anxious parent. If I believe that illness and healing both occur within personal and social contexts, I cannot accept confidentiality as an absolute value. On the other hand, I am not above using institutions and organizations. If this sounds paternal, so be it; I am willing to be bound to the same sort of judgment when I am the patient.

Sometimes I become overinvolved with patients and my own subjectivity becomes a problem. Whether one calls this identification, counter-transference, ignorance, immaturity, or lack of common sense, it is the price of doing business. I don't ever expect to get over it, though I don't enjoy the pain of a neurotic or broken relationship, professional or otherwise. I have simply given up the Flexnerian ideal of complete objectivity, which was always an idolatrous delusion wrapped in layers of denial, hiding the distance between physicians and patients.

What's the Point?

Why belabor these points? Not to recreate the mystery and magic of a more superstitious era; not to return to the dogmatism, empiricism, and sectarianism that Flexner so thoroughly despised; not to repudiate the scientific knowledge that has been so arduously and expensively amassed during the past 75 years. Not at all!

The reason is to ensure that the power of medicine does not become demonic, that medicine retains its roots as a servant rather than a master of individual and public good. It is only within the small contexts of millions of physician-patient relationships that are open, safe, and mutually determined that the public has any chance of controlling and protecting itself from its own Prometheus-like propensities. If war is too important to be left to generals, health is surely too important to be left to an impersonal professionalism that is bound to become coercive as it becomes more authoritarian.

If the 20th century has learned anything about science, it surely is that science is not socially, politically, or morally neutral. The biological sciences, no less than physics and engineering, must be kept under civilian control. Such control is an issue in every physician-patient encounter. The pure science of medical knowledge must be tempered by other forms of human knowing, and for its own good, should always be subject to judgment within a larger frame of reference than itself.
Educational Implications

In reciting these claims and confessions about how I practice medicine and what sorts of knowledge I take to be important, I expose myself to criticism from both Flexnerians and those who want to reform that system. To the former, I am hopelessly anti-scientific; to the latter, I lack the courage to be radical enough.

However, my personal characteristics are not the real issue; I am merely one example of a type of professional development that must engage all experienced physicians if they are to fill in the vacuums of their formal medical education. If I am idiosyncratic in my adaptations and compromises, if we all are more or less idiosyncratic in our understanding of the deeper dimensions of the physician's work, it's because our formal systems of medical education have either left this part to chance, deliberately ignored it, or actually opposed it. I tend to believe all three. We would not have participated in the dialogue at Wickenburg if there were not powerful and stubborn forces at work in medical education that keep it focused on producing what a dean of my acquaintance likes to call "superb human biologists," and what I prefer to call human veterinarianism. (No disrespect for veterinary science or animals intended).

Accepting Responsibility

Our medical schools are not weak and ineffectual. Flexnerian reforms created a remarkably effective system of education that is almost impossible to resist. It is elite, lock-step, and overwhelming; if it fails in one or more respects, it is not by accident, but by choice. The benefits of Flexnerian medicine are unarguable, but it has flaws that must be acknowledged and redressed.

It's time that the nation's medical schools accept responsibility for all their effects, the good and the bad. It has always been amazing to me how medical school faculties can disassociate themselves from the characteristics of doctors and organized medicine that they profess to deplore. There are no physicians who were not first students, few who were not residents for three or more years. There is a direct and continuous connection between what medical schools believe, teach, and approve and the characteristics of medical practice and the behavior of organized medicine. The schools must take the bitter with the sweet and realize that these are two sides of the same coin.

Flexnerian medicine is alive and well in 1987, fueled by the energy of the surgical specialties, transplant technology, immunogenetics, and spectacular advances in body imaging. There is no sign that a "Kuhnian basic medical science thought in some quasi-mechanical" metaphor; power, and medical yet, in the wake of genuine problems with more significant in the technological fix seen

Successes, Advances

Medicine's best which the germ theorist most applicable. Alfi: Western philosophy, particularly the major medi to Lister, Virchow, an infectious diseases have been conquered, and epidemic exposes so Moreover, new pathologists' taxonomies—violence of all sexual problems, abstinence of John Whitehor himself. What a litany.

Some might say not only medical, but a claim on them. It's much, bitten off more can be attributed to confident optimism and methods.

Perhaps hubris is the most egregious, blinds us to flaws, hypocrisy, and obscures our keeps us from seeking medicine.

Medical Schools and

One of the ironies relationships between
sign that a "Kuhnian paradigm shift" is anywhere in sight in the basic medical sciences, even though that has been a wishful thought in some quarters for 20 years or more. The "body as a machine" metaphor seems still to have a great deal of explanatory power, and medical research, in the main, is still committed to it. Yet, in the wake of medicine's conspicuous successes, there are genuine problems with its science that promise to become even more significant in the decades just ahead, problems for which no technological fix seems possible.

**Successes, Advances, Problems**

Medicine's best successes have come in those conditions for which the germ theory, the atomic theory, and the cell theory are most applicable. Alfred North Whitehead once observed that all Western philosophy can be considered footnotes to Plato. Similarly, the major medical advances in the 20th century are footnotes to Lister, Virchow, and Pasteur. No other classes of disease than the infectious diseases and their analogs may truly be said to have been conquered, and even this task is incomplete, as the AIDS epidemic exposes so dramatically.

Moreover, new illnesses that do not fit neatly into the pathologists' taxonomies have emerged as major unsolved problems—violence of all sorts, mental disorders, addictions, stress, sexual problems, abortions, care of the aged, etc., etc.—problems that John Whitehorn said originate in man's pathogenicity for himself. What a litany of unfinished business!

Some might say that such problems are not truly medical, or not only medical, but medicine, in one way or another, has staked a claim on them. It may be correct that we have medicalized too much, bitten off more than we can chew, but even that propensity can be attributed to the hubris of Flexnerian medicine and its confident optimism that every illness can be made to fit its theories and methods.

Perhaps hubris, what theologians call overwhelming pride, is the most egregious flaw in modern medicine. It's the flaw that blinds us to flaws, hides us from the real nature of medical fallibility, and obscures our understanding of the limits of science. It keeps us from seeking and receiving help from sources outside medicine.

**Medical Schools and Universities**

One of the ironies of the Flexnerian reforms is the ambiguous relationships between medical schools and universities. On one
hand, universities became the new proprietors as private, for-profit schools disappeared; but the dream of integrated basic science faculties and interdisciplinary learning was never realized. In many instances, medical schools developed in urban settings at some distance from their parent universities, and all of them showed a remarkable propensity for becoming the tail that wags the dog.

Their independent development was abetted by the power and popularity of medical science plus their ability to generate funds, first from public and private sources, more recently from payment for medical practice. There is a lamentable chasm between the faculties of medical schools and other schools in their universities, which accounts, in part, for the intellectual one-sidedness and academic isolation of medicine from other relevant disciplines.

Oddly enough, the basic science departments in medical schools are the most isolated from academic social sciences and the humanities, and the basic science faculties are the most resistant to curricular changes that might repair the deficiencies of Flexnerian medicine. They fight tenaciously for their piece of the curricular pie, object to the early introduction of clinical information, and oppose elective courses or volunteer learning experiences on the grounds that any infringement on the students' free time is a threat to their immersion in the basic medical sciences. Small wonder that physicians have become more expert and less learned than Flexner would have liked.

The first two years in medical school are not unlike a horse race in which students, like thoroughbreds wearing blinders, run as fast as they can toward a finish line that includes passing an examination (NBME Part I) having a built-in failure rate of 11% to 13%. One wonders, in view of declining applications to medical schools and the skyrocketing costs of tuition, how long it will take medical students to realize that they now have the power to demand something different and better. There can be little doubt that Flexnerian medical education for 75 years has been run by a feudalistic bureaucracy.

What all this means to me is that no superficial changes in the education of physicians are likely to produce broadly literate physicians who are better prepared to deal with the clinical problems that are already apparent and that will be even more important in the 21st century. It also means that Flexnerian medicine, like dogmatic medicine and empiricism before it, is not likely to be able to heal itself.

Conclusion

Unfortunately, contributing to the need for privatization of medical education of a narrowly and management of medical corporations moral in defense contracting complex can be no more than the military-industrial complex. From where I sit, medical educators, the recognition and structures that were contained in the postwar period are now breaking up as the proper object of knowledge science to include others will continue to bepers. Its costs beyond all call equally available to the

I do not expect a grinding halt. Perhaps professionals should have a place in the curriculum to exclude all other educational curricula. Flexner likened the medical school to an engineering, but with more individuals. I prefer creativity and intuitive thinking the relations between different models for future development.

We need a theoretical framework comprised of an elite in science designing all our roads; of all our industrial professionals who are committed to applied medical science
Conclusion

Unfortunately, current changes in medical practice will not contribute to the necessary reforms. The industrialization and privatization of medicine are no reforms at all, but the mere extension of a narrowly conceived scientism into the organization and management of medical practice. We have no reason to hope that corporation morality in medicine will be any better than it is in defense contracting or on Wall Street. A medical-industrial complex can be no more self-regulatory and socially responsive than the military-industrial complex that President Eisenhower warned us about so presciently.

From where I sit, the philosophical beliefs and attitudes of medical educators, the problems of clinical practice, and the organization and structures of medical care have common root defects that were contained in Flexner's famous report. They are the preoccupation with the human body as the only proper object of medical knowledge and the faith in experimental biology as the solution to all problems of health and illness. Until we take the whole human person in his or her social and cultural dimensions as the proper object of knowledge, until we expand our notions of science to include other forms of rationality than the logical, we will continue to depersonalize and fragment medical care, increase its costs beyond all calculation, and fail to make all its benefits equally available to the whole population.

I do not expect that Flexnerian medicine will come to a grinding halt. Perhaps a minority of physicians and other professionals should have a primary commitment to it, but it should not be allowed to exclude all other forms of knowing and it should not dominate the entire medical profession and the schools that produce the professionals.

Flexner likened the thinking of a physician to that of an engineer, but with more urgent decisiveness for the life and death of individuals. I prefer to believe that a physician also needs the creativity and intuitiveness of the novelist, but be that as it may, the relations between physics and engineering might be a good model for future development of the medical sciences.

We need theoretical physicists, and I would not mind if they comprised an elite in status and pay, but I would not want them designing all our roads and bridges or overseeing the manufacture of all our industrial products. Similarly, we need human biologists who are committed to the canons of positivist science, but the applied medical sciences cannot be based entirely on that. Physics
had to confront its moral limitations in the Manhattan Project, and it has never been the same since. Scientific medicine is headed for the same impasse. Let us hope it sees itself clearly before we are all ushered into a “brave new world” that none of us really wants.

References
4. Ong W. Quoted in No. 17.