STRATEGIC HEALTH POLICY INTERNATIONAL
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Covenant Traditions in Healing: History and Modern Application[1]

The Medicine Trail is a manner of approach, an attitude, like a color of dawn,
something that reaches out to touch things any way it can, unformed,
created only by the desire to connect.[2]
—Stan Rushworth, on Cherokee Healing

Covenants... sacredness... healing. These are emotionally charged terms. I can imagine they rarely find a welcome home in the business of health care today. After all, healers don't have time for something new. Tiimes are tough, there are patients to satisfy, budgets to balance, and financial losses and premium increases to explain. If it's not the latest accreditation group, quality group, or Government Accounting Office (GAO) study group coming to visit, then it's the Inspector General knocking at the door. Healers have a business to run—no, a business to save. They don't have time for covenants and sacredness in healing.

As a health care system under stress, it is natural to reject new ideas that sound like impossible new demands. As Americans, we separate church and state, and these words feel church-like in a state-focused, if not state-controlled, health care economy. As clinicians, policymakers, and payers, we separate soul and science, and words such as "sacred" and "covenant" sound too much like soul in an era that demands scientific application to everything pertaining to health care, including the art of medicine. Besides, for many of us in health care, even our own souls have taken a beating in the course of the caring for people. Is this what we signed on for years ago when our education began? How can we initiate a dialogue like this? How can we possibly engage in a dialogue like this? How can we give even more of ourselves to patients, communities, or the world when all we get in return is hostility? How can we heal others when we are suffering ourselves?

Nonetheless, it is undeniable that these "sacred" concepts are rooted in every culture. They are embedded in our language and, like it or not, they frame our debates. Scan the reactions to the American Medical Association (AMA) announcement that it would support unions for physicians who work as employees: covenant was an implied foundation of these comments. Articles and editorials across the country were outraged that physicians would consider violating their oath and subliminally reminded physicians that they cannot dare to do so. No reporter or editorial writer explicitly connects the oath with its traditions and origins in the sacred or in

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covenant. No writer needs to do that. The concepts of covenant, oath, sacred, and healing are so embedded in our traditions that we take them for granted. They are like the ground on which we walk.

Health, healing, holy, priesthood and sanctuary are inextricably linked in our language. “Heal,” “holy,” and “sanctuary” arise from the same ancient root word, “hal.” The term and its usage grew from life experiences and became entwined in our deepest linguistic origins. These concepts reside within the Judeo-Christian influences that dominate our mainstream culture, and they resonate as well with the Islamic, Buddhist, and Hindu views that are increasingly a part of our national consciousness—and certainly a part of our world view. These ideas, as different as they may appear in the nature and expression of their theology, come together in their recognition of the sacred within the healing encounter.

Covenants: Origins and Meaning

It was not only the language of healing that grew from the sacred, but also the structure and relationships within which healing occurred. That structure was provided by covenants. Covenants were endowed originally by the divine on notable occasions and for divine purpose—including health and healing. The most notable of these is found in the covenant between God and Moses at Sinai. It is no surprise, then, that the practices of healing developed in communities alongside the emergence covenants that structured healing and supported the health of people. The elements of covenantal relationships and covenantal thought were embedded in the original medical oaths and remain today in oaths and principles of ethical practice.

Both biblical and ancient secular texts are crowded with examples of covenants and how societies and covenants developed in tandem. Some covenants were between a king and his people, while others were between communities, between fathers and sons, between teachers and apprentices, and between husbands and wives. Early Akkadian and Hittite covenants, among the earliest known, established a “covenant formula,” with essential elements. The obligations for a king’s vassals, the blessings for obedience, and the curses for disobedience were clear. Earlier Hittite covenants not only came from the king and carried the force of his law but were also witnessed by the gods of the society, who were incorporated, by reference, into the agreement. Later, biblical covenants would follow that established rule. These covenants—both ancient and modern—structured the nature of the relationships between the parties in a particular way. We use the term covenant today, but, frankly, we use it carelessly when compared to usage in ancient times from which our current medical ethics grow.

In the context of today’s usage, a covenant is:

An agreement or promise to do or not to do a particular thing; to enter into a formal agreement; to bind oneself in contract; to make a stipulation; a promise incidental to a deed or contract, which is either express or implied; “an agreement, convention, or promise of two or more parties, by deed in writing signed, and delivered by whichever of the parties pledges himself to the order that

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something is either done or shall be done or stipulates for the truth of certain facts.[3] *[270 P. 2d 276, 278]*

Our current usage of the term covenant comes from our current codification of our own laws and distinguishes between several different types of covenants. "Dependent covenants" are those in which the obligation for performance depends upon the actions of another to perform some prior action or meet some condition. "Concurrent covenants" are those in which one party is required to perform his obligation when the other party is ready to perform his. "Independent, or mutual, covenants" are those in which performance must be done, without reference to the performance of the other party. Other specifics in the definitions of covenant relate mainly to issues of land, title to land, transfers of land, and matters relating to estates. These are not the concepts intended in the use of similar terms in the biblical and ancient texts.

In ancient texts, covenants, by their very nature, involve more fundamental elements of relationships. They are mutual, binding, and alter the life and the life-course of any party who enters into them in significant ways. Covenants are typically created between greater and lesser partners—as in a grant of property between a father and son. They reflect the dependency of the weaker party on the stronger party and the superiority of the stronger party over the weaker one. They may or may not bind both parties equally and mutually to a set of expectations, but they are binding and cannot be reversed. Unlike our modern versions in legal definitions, the performance of one is not dependent on the other; nor is it necessarily concurrent with the other or done in isolation from the other. In ancient times, a covenant was a serious matter. Once established, it determined the actions of both parties from that point forward, no matter what. And there is more.

Unlike contracts, covenants are forever. As a result, they transform the identity of the parties. Covenants are not highly detailed. They do not anticipate each of the possible aspects of the relationship over time; to do so within a covenant would not be possible. Because covenants act within relationships and between ever-evolving parties, the nature of the covenants themselves is a moving target. As the parties to the covenant grow and change, their obligations evolve. In covenants, the giving and receiving is endless and goes deeper over time. The parties to a covenant are continually mutually responsive and alive within the covenant. Medical ethicist William May said it well:

A contract has a limited duration, but a religious covenant imposes change on all moments. A mechanic can act under a contract, and then, when not fixing a piston, act without regard to the contract: but a covenantal people act under covenant while eating, sleeping, working, praying, cheating, healing, or blundering.... Initiation into a profession means, in effect, that the physician is a healer when healing and when sleeping, when practicing and when malpracticing.[4]

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Two Types of Covenants: Covenants of Grant and Covenants of Obligation

Covenants are of two types: "covenants of grant" and "covenants of obligation." These distinctions are important in health care because of the way in which medical oaths were structured. Understanding medical oaths in the context of these types of covenant points the way to possible solutions to a number of dilemmas we face in health care today.

Covenants of grant describe a unidirectional relationship, in which one party establishes a relationship of giving—a promise, for example, with no requirement that the other party return the favor. This was the type of covenant between the Hebrew God of the Old Testament and Noah. In this covenant of grant, God promises that He will never again destroy the earth by flood. Noah and his family do not promise and are not expected to perform anything in return. Although they are invited to "Be fertile and multiply and fill the earth" (Genesis 9:1), they do not promise to do so, nor are obligations imposed on them to do so. The only promises are made by God. These promises are numerous, and they are significant. And yet, for all the consequences of the promises, Noah is not expected to reciprocate:

> *God said to Noah and his sons with him: "See, I am now establishing my covenant with you and your descendants after you and with every living creature that was with you: all the birds, and the various tame and wild animals that were with you and came out of the ark. I will establish my covenant with you, that never again shall all bodily creatures be destroyed by the waters of a flood; there shall not be another flood to devastate the earth." God added: "When I bring clouds over the earth, and the bow appears in the clouds, I will recall the covenant I have made between me and you and all living beings, so that the waters shall never again become as a flood to destroy all mortal beings." (Genesis 9:8-17)*

This type of covenant of grant is similar to the one that currently exists between patients and managed care physicians. Stronger parties—the employer, Medicare, and Medicaid, working with managed care companies—arrange for physician care for the weaker party, the patient, at the time of an illness. The physician provides a prescription to relieve the symptoms or treat the disease. The weaker party—the patient—is under no obligation whatsoever. He may choose whether or not to arrive at the appointed time for the visit, whether or not to give the physician complete clinical information, to consent to diagnostic tests, to take the prescription, or to abide by the advice given. Like Noah and his family, the patient does not need to promise anything in return.

The second type of covenant is a covenant of obligation. The best-known covenant of obligation in the Western religious world is the one described between God and the chosen people of Israel. It was to become the central organizing principle of the relationship between God and man, first in the Israelite tradition and, later, in Christianity. This covenant was engaged at Sinai:

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Moses went up to the mountain of God. Then the Lord called to him and said, "Thus shall you say to the house of Jacob; tell the Israelites: You have seen for yourself how I treated the Egyptians and how I bore you up on eagle wings and brought you here to myself. Therefore, if you harken to my voice and keep my covenant, you shall be my special possession, dearer to me than all other people, though all the earth is mine." (Exodus 19:3-5)

The God of Moses grants the covenant, binds the human partners to obligations—to God and to each other—and describes retributions for their failure to perform. In the chapters of Exodus that follow and throughout the book of Leviticus, mutual obligations are detailed. The Israelites are instructed on virtually every aspect of their individual, family, and community lives. Faithful adherence to those requirements brought territory, prosperity, fertility, and special favors. Failure to perform would bring punishments, such as the extended stay in the desert

Unlike a covenant of grant, a covenant of obligation established reciprocal duties and requirements for each of the parties to the covenant. There was no escaping the covenant. There were no exit clauses. No party could "buy out" the rights, obligations, or prerogatives of the other. Thus, care from God was linked to loyalty to God. This relationship with God also spilled over to frame the relationship between men. It was in specifying this covenant that the melding of the sacredness of the healing gifts from the divine are united with the sacredness of the expectations of the covenant between God and man and between men. It was a critical framing of the oath and ethical perspectives of healing and medicine today.

In this biblical example, as well as in other covenants, the formation of the covenant is preceded by the receipt of a gift. According to Professor May,

"... gifts precede the promise—just as the gifts of courtship precede a marriage vow, and in the Scripture of Israel, the exodus precedes Mt. Sinai. The Jews bind themselves to God at Mt. Sinai as those who have already received an astonishing gift, the deliverance from Egypt. A covenantal ethic positions human givers in the context of a primordial act of receiving a gift not wholly deserved, which they can only assume gratefully. God tells the Israelites: When you harvest your crops, leave some for the sojourner. For you were once sojourners in Egypt. Givers themselves receive. Benefactors ultimately benefit."[5]

Professor May, in his work on this type of covenant—the covenant of obligation—and its relation to the medical profession, notes that a gift is also present here. Physicians receive an education, which is a gift from predecessors who came before and learned the skills to impart, and from the communities who supported the educational institutions within which the learning occurred. Gifts come to patients as well: they receive the care and healing. The two—physicians and patients—step inside the covenant.

Medical Oaths and the Covenants of Hippocrates and Maimonides

Notions of covenant appear in the two best-known ancient medical oaths. The most widely known and used is the Oath of Hippocrates, which is an artful combination of both types

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of covenants. In this oath, healers—in this case, physicians—enter into a covenant of obligation with fellow members of the profession. They do this by promising to share their knowledge and goods with each other, and to care for each other and their families as if they were one family. Then, they enter into a separate covenant of grant with patients. In this other type of covenant, they swear to do good for the patient, protect privacy and confidentiality and practice ethical principles. The gods witness the covenant agreement, the terms of which are specified, and the rewards and punishment for failure to perform according to the covenant are invoked:

> *I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement the following Oath:*
>
> *To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my art and my life. I will not cut for stone, leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasure of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.*[6]

Lesser known is the oath crafted by Maimonides in the twelfth century, which he presented in the form of a prayer. Jewish communities viewed medicine as a divine calling. Doctors were given a special protecting angel, and religious authorities directed that a doctor should always be called in time of illness. Unlike others in the community, physicians were allowed to work on the Sabbath, because saving a life was an important task for the community and blessed by the divine. Maimonides was explicit in his view of how physical and spiritual health was linked. This is a mission statement to which to aspire, even today (some might say, especially today):

> *The purpose of the practice of medicine is to teach humanity the causes of ill health, the correct hygiene, the methods of making the body capable of useful labor, how to prolong life, and how to avoid disease. It thus directly elevates the*

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human being to a higher moral plane, where the pursuit of Truth is possible and where the happiness of soul is attainable.[7]

The alignment of natural and spiritual concepts is evident in this physician's daily prayer. This is also the first appearance of a covenant of obligation between the physician and patient. Maimonides' prayer calls the patient into a covenant of obligation by requesting that patients have confidence in the physician and his healing art, that they comply with the directions and prescriptions he offers and that they not take advice from potentially harmful quacks and uninformed family members. Maimonides speaks to reciprocity in the physician-patient relationship that is ignored by Hippocrates. He steps out beyond the Hippocratic Oath, and its description of the more limited covenant of grant between patients and physicians. Maimonides prays:

All-bountiful! Thou hast formed the human body in Thy complete wisdom. Thou hast united it in ten thousand times ten thousand parts that function continuously to preserve the harmony of the beautiful entity, the mortal integument of the immortals. Ever they are active in complete order, harmony, and unity. The moment, however, that frailty of matter or passions disturb this order and disrupt the unity, the forces engage in conflict and the body is reduced to its dust. It is then that Thou sendst to man beneficent messengers, the diseases, who announce to him the danger and urge him to avoid it.

Thy Earth, Thy rivers, and Thy mountains are blessed by Thee with healing substances: they can heal. They assuage the suffering of Thy creatures and heal their wounds. Thou hast granted man the wisdom to unravel the secrets of his body, to recognize order and disorder; to draw the substances from their sources, to seek out their forces and to prepare and apply them according to their respective diseases. And Thy eternal foresight has chosen me to watch over the life and health of Thy creatures, and I now go forth to follow my calling. Stand by me All-bountiful, in this great undertaking so that I may succeed, for without Thy aid, man has no success even in the most trivial things.

Inspire me with love for my art and Thy creatures. So not permit that thirst of grain and greed for fame interfere with my calling, for these are enemies of truth and philanthropy, and they might also lead me astray in the mighty enterprise to further the weal of Thy creatures. Preserve the strength of my body and soul, so that they may be indefatigable at all times to help and to stand by the rich as well as the poor, the good and the bad, the enemy as well as the friend. In the sufferer always let me behold only the human being.

Enlighten my understanding so that I may grasp what is present and correctly surmise what is absent or hidden. Allow it not to sink, so that my judgment may not fail to recognize what is evident but also that it may not overestimate itself and see what cannot be seen. For fine and imperceptible are the boundaries of the great art, and of watching over the life and health of Thy creatures! Let not my

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intelligence be abstracted. At the bedside, let no extraneous matters rob my spirit of its watchfulness. Let them not disturb in its quiet labors. For great and holy is the search for the preservation of life and health of Thy creatures.

Grant my patients confidence in me and my art, and imbue them with obedience to follow my precepts and directions. Ban from their bedside all quacks and the army of advice-giving relatives and too-wise nurses, for they are a terrible band, who, through their vanity, harm the best intentions of the healing art and frequently cause the death of Thy creatures.

If wiser artists seek to improve and instruct me, let my spirit be thankful and obedient; for great is the field of the art. When, however, conceited fools berate me, then let the love of the art steel my spirit and insist on truth, regardless of age, fame, or standing, for to retract in such a case would mean death and disease of Thy creatures.

Grant to my spirit, gentleness and calm, when colleagues, vain of their years, repulse, scorn, or sneering try to correct me. Let this also be to my advantage for they know some things that are foreign to me and their self-conceit shall not offend me; they are old and old age is not the master of passions. For I too hope to be old before Thee, All-bountiful!

Grant me contentment in all things, safe in the great art. Permit not the thought to awaken in me: You know enough; but grant me strength, leisure and the urge always to enlarge my accomplishments and to add to others. True art is long, but man's mind penetrates even farther. All bountiful, Thou in Thy mercy hast chosen me to watch over the life and death of Thy creatures. I now go forth in the pursuit of my calling. Stand by me in this large undertaking, so it may be successful, for sans Thy help man is not successful, be it in the most trifling matter.[8]

The *Prayer of Maimonides* is not commonly part of the oath taken by modern physicians, and more modern forms of the Hippocratic Oath have emerged. One such standard revision is:

I do solemnly swear, by whatever I hold most sacred, that I will be loyal to the profession of medicine and just and generous to its members. That I will lead my life and practice my art in uprightness and honor. That into whatsoever home I shall enter, it shall be for the good of the sick and the well to the utmost of my power and that I will hold myself aloof from wrong and from corruption and from the tempting of others to vice. That I will exercise my art solely for the cure of my patients and the prevention of disease and will give no drug nor perform any operation for a criminal purpose, and far less suggest such thing. That whatsoever I shall see or hear of the lives of men and women which is not fitting to be spoken abroad, I shall keep inviolably secret. These things I do promise and in proportion as I am faithful to this oath, may happiness and good repute be ever mine, the opposite if I shall be foresworn.[9]

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The *Islamic Code of Medical Ethics* provides a physician's oath that is similar:

I swear by God the Great; To regard God in carrying out my profession; To protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety; To keep people's dignity, cover their privacies, and lock up their secrets; To be, all the way, an instrument of God's mercy extending my medical care to near and far, virtuous and sinner, and friend and enemy; To strive in the pursuit of knowledge and harnessing it for the benefit but not the harm of mankind; To revere my teacher, teach my junior, and be brother to members of the medical profession joined in piety and charity; To live my Faith in private and in public, avoiding whatever blemishes me in the eyes of God, His apostle, and my fellow Faithful; And may God be witness to this Oath.[10]

Regardless of the particular form—old or new—the oaths in use in medicine today abide by the elements of covenants established many millennia before. Whether ancient or new, the oaths are witnessed by the gods and specify the duties of the greater partner (the physician) to the lesser partner (the patient). They create loyalty to their more knowledgeable partners (teachers), describe standards of conduct, and invoke rewards and (though less so in modern times) penalties for the quality of the performance.

Did the oaths influence the practice of medicine in those days? It is hard to know. Do oaths influence the practice of medicine today? The Foundation for Medical Excellence, with funding from The Robert Wood Johnson Foundation, studied how oaths and ethical norms governed medical practice in 1997. In results presented at the Institute of Medicine (IOM) in 1998, the investigators noted that there was widespread familiarity with medical oaths, that physicians referred to the oaths frequently, that the oaths influenced their practices (particularly when the physicians were women), and that ethical beliefs and integrity in practice were a critical concern.[11]

Another recent phenomenon is also instructive. In 135 of the 145 U.S. medical schools, first year medical students are now "cloaked" in "white coat ceremonies" in which they swear to an oath. Some schools use the traditional *Oath of Hippocrates*, others update it or use other versions, such as the one by Maimonides. Columbia Professor Arnold P. Gold, whose leadership resulted in the first of these ceremonies, has noted that taking the oath at the start of medical training is a return to the ancient apprenticeship days of medical education and that it is embraced enthusiastically by students.[12] The ceremony has been promoted as a return to the humanity of medicine at a time when the profession feels its professional values are being assaulted from all sides. It is also an unmistakable return to covenant. This movement has expressed itself in greater involvement of students in the development of oaths. The Student *American Medical Association* and the *Association of Academic Health Centers* have weighed in with encouragement for oath-taking and for developing student versions of oaths.[13] In one particularly innovative style, the oath is structured as a dialogue between the swearing class and the patients they serve. It contains the essential elements: the class swears by all they hold sacred, recognizes the gift of medical education, and enumerates the duties they will perform and

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the ethics they will hold dear. This style of covenant also includes some implied obligations on the part of the public, most notably to be “partners in care.”[14]

These oaths were historically structured as covenants and remain so today, even in recent, very modern interpretations. The dominant oath taken today remains the *Oath of Hippocrates*. It is a covenant of obligation, but only among the members of the profession of medicine who take the oath as well. Unfortunately, in most oaths, patients are not yet a party to any covenant of obligation with their physicians. Furthermore, communities are not called into the covenant in the way that the ancient Hebrews were called to act as a group to ensure healthy and viable people. Rarely are the specific duties or obligations of patients mentioned, nor are patients held accountable for their behavior. Patients are not asked or required to take a vow. They are not called to act in any particular way. They will not suffer the consequences of any failure to comply with a physician’s orders. The Hippocratic Oath, if it describes a covenant between physicians and patients—and I believe it does—describes a covenant of grant. Is this distinction important? I believe it is.

The Emergence of Contracts within the Medical Covenant

Physicians face a daunting task in the United States to provide clinical care under a Hippocratic-style oath. They practice within both types of covenant simultaneously. The covenant of obligation among members of the profession promotes progress in the healing arts and sciences. It facilitates the development of new knowledge. It also creates a fraternity and provides the support to sustain a difficult life of practice.

But by virtue of the Hippocratic oath, healers also practice within a more limited—and for them, more demanding—covenant of grant with patients. Physicians provide, but patients are not expected to reciprocate. There are clearly some returns for physicians that derive from patients—primarily income and respect—but the patient is not, by covenant, engaged in joining the healing venture. Healing is treated as if it were the domain and responsibility of the physician alone, acting within the scope of his knowledge and skill and with the help of the divine. Without the reciprocal obligation of the patient to likewise participate in the healing, it is little wonder that the physician would need to rely on the assistance of the divine. Unlike the values suggested by Maimonides, patients are not enjoined to follow the prescriptions of the physician or to avoid the bad advice of family and friends. Unlike the modern covenant-dialogue between physicians and the public, there is no recognition that health is a partnership. If patients were engaged in a covenant of obligation rather than the more limited covenant of grant, they would be more likely to follow directives and assume more personal responsibility for their care. As it is, the physician-patient relationship does not call upon them to do so. To complicate matters for the physician today, the covenant is established with patients, but the process of providing care and the payment for care is established by contract with other parties acting on behalf of the patients’ and others’ interests. Physicians, acting within covenant, cannot abandon patients. Individual clinicians cannot abandon individual patients, and the profession as a whole cannot turn back several millennia of calendar pages to abandon society.

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The emergence of contracts has complicated the demands of healing for any of the healing professions that take, and feel bound by, the covenants as they are intended to function. A contract is defined as:

> *A promise, or a set of promises, for breach of which the law gives remedy, of the performance of which the law in some way recognizes as a duty. [1 Williston, Contracts §1.] The essentials of a valid contract are "parties competent to contract, a proper subject matter, consideration, mutuality of agreement and mutuality of obligation." [286 N.W. 884, 886]; "a transaction involving two or more individuals whereby each becomes obligated to the other, with reciprocal rights to demand performance of what is promised by each respectively." [282 P. 2d 1984, 1088].*[15]

The law specifies several types of contracts. Bilateral contracts are between two parties, cost-plus contracts allow for costs plus a percentage profit, oral contracts require no written documents, and output contracts require delivery and receipt of all the products of the work. In contracts, the exact duties and responsibilities of each party are clearly specified and carefully reviewed by attorneys or representatives of the parties. Contracts contain exit clauses and time limits. They limit the rights of the parties in explicitly described ways. Contracts assume at the outset that each of the parties acts solely from self-interest. In that case, it is in the "interest" of one party to guard against the "self-interest" of the other by building in carefully described requirements. Contracts require payment for the expected performance. In contracts, non-performance is anticipated and, therefore, legal enforcement provisions and penalties are built in. Contracts can be enforced in courts.

As a party to a contract with health plans and payers, the physician becomes a contractor. A contractor is defined as "one who is a party to a contract; also one who contracts to do the work for another."[16] A physician is considered to be an independent contractor, or "one who makes an agreement with another to do a piece of work, retaining in himself control of the means, method, and manner of producing the result to be accomplished, neither party having the right to terminate the contract at will."[17]

Acting within a covenant, as May has said, requires that a physician live within a "24-7" lifestyle. Being "on covenant" is much more difficult than being "on call" in a physician's practice or "on contract" with a payer. There is no time off from the covenant. There is no time outside the covenant. There is no canceling a covenant. For each of the twenty-four hours of the day and each of the seven days of the week, physicians are bound by the covenant in Hippocratic Oath, with obligations to fellow healers. They are also bound by the covenant in the Hippocratic oath to "grant healing" to their patients. They receive support from fellow healers, but there is no such reciprocity on the part of patients. Regardless of the time of day or particular activity, a healer is a healer—whether in relationship to fellow healers or to patients. Regardless of what the office schedule or managed care contract reads, physicians are always "on call," if you will, in the context of the covenant.

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In addition to the parameters of covenants of obligation and grant, today's physicians also practice within the context of a contract. Contracts specify, in greater or lesser detail, how the physician will carry out the covenant. Increasingly, those contracts are specific about how the physician will be expected to practice. Few contracts recognize the comprehensiveness of the binding covenant relationships within which physicians practice, nor could they. As a result, the compensation for performance under the contract is inadequate for the level of responsibility that we expect from these healers as they practice their arts. And then it gets worse. The accelerated introduction of new medicines and technologies places additional demands on physicians who must work under capitation contracts and live within the covenant. How? Physicians, obligated under covenants to provide care, must adopt the new technologies they feel are viable for healing patients. Yet no contract recognizes the increased costs associated with those innovations. As a result, the physician is left in the untenable position of failing to treat for lack of resources, yet living and working constantly within the covenant. The "market" today does not recognize or value that the modern healer/physician lives a demanding, unrelenting, obligation to patients. Is this a realistic or fair and reasonable expectation in today's world? Is it any wonder that physicians, in particular—though they have not been the only healers to feel the tensions of managed care—have bristled under the demands of managed care? Regardless of the circumstances of the contractual relationships, they were still obliged by their covenantal ones. Is the nature of covenant antiquated? Is it outdated in today's pursuit of health and healing? I think not.

Engaging Covenants in Health Care Today

Although they have ancient roots, notions of covenant and sacred origins of the healing arts are not outdated. They continue to be central to healing enterprises today. This is a critical time to be more explicit about these foundations of healing and return to them in whatever ways possible to address the health care needs of the nation. Doing so will help us come to grips with the challenges and maximize the opportunities in health care today. Failing to do so will stretch our healers to the breaking point and will fail to recognize that patients and communities, who heretofore have been passive recipients of healing largesse, must become more engaged in assuring their health. Covenants should be central to each of the practices within health care and must be among the fundamental considerations of everyone in healing endeavors. "Everyone" means every individual patient, scientist, clinician, health care executive, government bureaucrat, legislator, employer, and community.

This notion is not new. It was proposed by Dr. Donald Berwick, president of the Institute for Health Care Improvement, and others in a *British Medical Journal* editorial, "An Ethical Code for Everybody in Health Care," published in 1997. In it, Dr. Berwick notes the dilemmas created because important leaders and stakeholders have not adopted ethical codes. This is worse than it might seem, as ethical codes translate into standards and norms of practice. In an informal survey of attitudes, for example, he found that 83% of the health care executives who responded indicated that a surgeon who develops a new technique to reduce hospital length-of-stay and control post-operative pain is ethically obligated to share his discovery. Only 56% believe that an HMO with similar insights is likewise obligated. Do we really want the corporate healers to abide by different ethical standards?[18]

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Everyone should be invited into a covenant—a covenant of obligation, that is. For some, particularly physicians, this will mean re-engaging, re-invigorating, and re-inventing the covenants they have held for so long. For others, particularly for patients and communities, this will entail crafting a covenant where no explicit covenant has existed in the past. For still others—those who support clinical care in the health care infrastructure of research, education, management, advertising, legislation, and payment bureaucracies—this will require a radical recognition that they, too, work within the same healing enterprise as clinicians, have the same responsibilities to patients, and, therefore, should be brought into covenants with each other and with patients. At the heart of the crises in health care today is an opportunity to design symmetry and synergy in the relationships between healers and patients, among healers, and within communities.

Seeking covenant alone will not resolve all of the issues we must address to achieve the promises of the healing arts and sciences today, but it will help tremendously. Failure to do so will surely contribute to the further decline of the healing enterprise; hence embracing covenant in the fullness of its potential should be considered as an important step in advancing the health arts and sciences. Failure to do so will ignore the fact that we can no longer afford business-as-usual tweaks to financing formulas, more burdensome regulations of providers, and hand-wringing over patient noncompliance. There are too many diseases to treat. An aging population is destined to have more of them than ever before, and this shrinking globe is bound to bring more of them to our shores.

The concept of covenant, itself, is not radical. It is really quite conservative. To recreate and enliven covenants in health care would be restorative and potentially healing for individuals, for the system, and for society as well. It is precisely the notion of covenant that would enrich health care relationships and allow us to craft the public policy debate on more fruitful ground.

Without such a restorative attempt, we will continue to drift in a direction that strays from its sound origins and is likely to collapse under the weight of its own conflict and confusion. This conflict should be resolved by returning to the foundations of our relationships as healers and patients. This confusion should be addressed by engaging each other in dialogue about what we value within health care and how we will pursue it jointly as patients, healers, and communities.

Each of us, at one time or another, participates as a patient in health care today. Even healers become patients, since—as in ancient times—today's healers turn to other healers when they are in need of care. We have the incentive, then, to take an especially close look at the role of patients in the process of healing, including the most important health care measures of all—those practiced by patients between clinical visits, when the critical prevention and treatment regimens are managed at home. Further, we are all, patients and healers alike, members of communities whose decisions about safe water and food, traffic safety enforcement, unemployment, poverty, warfare, and tax-supported health care will impact on our ability to be healthy.

There is no room in this discussion for old professional jealousies, territoriality, secret incantations of science, and mystical methods of clinical discernment. There is no room for

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segmenting health and healing from other aspects of our lives, social systems, and economics. This is a time for entering the heart of the conflicts that drive us apart to find the values that bring us together as individual patients, healers, and communities—not only in this country, but throughout the world. This should be done by addressing health care covenants at the three levels at which they are broken, weak, or unformed: first, among those who are healers; second, between individual healers and patients; and third, among those in communities at the local, state, national, and even international levels.

Covenants of Other Healers

The model covenants were created for physicians in the Hippocratic Oath and prayer of Maimonides, and it is the physician oaths that are best known. But others in the healing professions take oaths as well.

> Pharmacists swear:
>
> *At this time, I vow to devote my professional life to the service of all humankind through the profession of pharmacy. I will consider the welfare of humanity and relief of suffering my primary concerns. I will apply my knowledge, experience, and skills to the best of my ability to assure optimal drug therapy outcomes of the patients I serve. I will keep abreast of developments and maintain professional competence in my profession of pharmacy. I will maintain the highest principles of moral, ethical and legal conduct. I will embrace and advocate change in the profession of pharmacy that improves patient care. I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public.*
>
> Nurses take the Nightingale Pledge:
>
> *I solemnly pledge myself before God and in the presence of this assembly:*
>
> *To pass my life in purity and to practice my profession faithfully; I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug; I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling; With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.*
>
> Associates of the American College of Healthcare Executives pledge to:
>
> *Abide by its Code of Ethics; Contribute to the advancement of our profession by exemplifying competence and leadership in healthcare management; Commit to lifelong learning by maintaining a personal program of continuing education; Contribute to the improvement of my community's health status; Enhance our profession through leadership in a wide range of community and professional*

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activities; Uphold and further the mission of the American College of Healthcare Executives to advance healthcare management excellence.

To engage new covenants with patients and communities, healers today should re-engage their own covenants first. This should be done in several ways. To begin, those healers in medicine, nursing, and pharmacy with existing oaths should revise and expand their oaths. It is unlikely that, under examination, they will choose to abandon the covenant of obligation that they feel now toward each other. It is likely, however, that they will need to reconsider how those obligations flow to those who are in other related healing professions. For example, it is unlikely that physicians, nurses, or pharmacists will decide that they will no longer impart their skills to the younger generation of students, interns, and residents learning in the ranks behind them. Even those healers who are uninvolved in formal medical education have the opportunities, and use them, to impart their knowledge to the young.

It is likely, however, that they may consider broadening their view of peer relations to other professional groups who have recently emerged as having particular specialty skills or who have demonstrated the ability to enhance patient healing. Pharmacists come to mind. Recent advanced education, coupled with computer information systems and a plethora of new medicines, have made pharmacists a more important addition to the clinical care team. No longer relegated to counting pills, pharmacists increasingly use their clinical acumen to counsel physicians and patients on appropriate prescribing, dosing, and compliance with medicines. As a result, they are no longer subordinate to the prescribing clinician; they are capable clinicians in their own right on whom physicians and patients are heavily dependent. Pharmacists are the only healer today capable of monitoring the increasingly common and potentially deadly practice of patient self-medication with combinations of prescriptions, over-the-counter, and herbal remedies. It would be a missed opportunity for all involved to neglect to marry the professional covenants together in such a way that the obligations do not flow freely between the two.

Critical to all the covenants of the healing professions, the elements contained therein should provide the structure for a true covenant of obligation with the patients they serve. It is the stronger party, after all, who creates the relationship and its requirements and invites the other to join. By virtue of the knowledge of the professional and the vulnerability of the patient, it is the professional who must take this first step. This step will involve determining how responsibilities of the patient should be engaged to optimize the healing encounter and support the health of the patient throughout life—on those days when patients are healthy and on those days when they are not.

Having accomplished this task, healers with reinvigorated covenants should lead the dialogue with others in health care who support clinical care and healing. Where necessary, this may mean engaging the others in an oath similar to the one offered to health profession graduates generally. At graduation, some schools offer a more general oath for those entering the healing professions, including those in health administration, public health, and management:

I will devote my professional life to the service of humankind through my chosen profession. I will consider the welfare of humanity and relief of human suffering

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as my primary concern. I will apply my knowledge, experience, and skills to the best of my ability to assure optimal therapeutic outcomes for the patients I serve. I will keep abreast of developments and maintain professional competency in my profession. I will maintain the highest principles of moral, ethical, and legal conduct. I will embrace and advocate change in my profession that improves patient care. I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public.

Or, if necessary, this may entail developing an oath more specific to the needs of the particular responsibilities of the profession within health care. It is less important whether the oaths in health care are general or specific. It is critical that there are oaths, and that they are pledged and lived by those engaged in healing enterprises today. By everyone, I do mean everyone. On this list, I include without hesitation everyone providing health care products and services for the benefit of people's health. I also include those who facilitate the delivery of healing products and services. This directs every individual engaged in healing—physician, nurse, technician, scientist, administrator, manager, marketer, insurer, legislator, regulator, or government bureaucrat—to become a party to a healer's covenant. This also includes pharmaceutical and medical device companies, e-commerce health care ventures, architects designing health care and living facilities, wholesalers managing the supply chain of goods, and telecommunication and financial service companies providing information and financing products. Everyone who participates in or supports healing enterprises is acting as healers did in the past. They are simply doing it in more sophisticated ways and to larger numbers of patients. Our societies are more complex and sophisticated today and so, too, are our healers.

Those who now seek to enter the healing arena in the family caregiver, alternative, or complimentary arenas of practice should be a party to the healing covenant. My mother is healthy and active today, but what happens when she needs more care than her twice-yearly checkups and daily prescriptions, and my brothers and I have to turn to an eldercare consultant, a nursing home, a home-care agency, a physical or speech therapist, a surgeon, a hospital, a hospice, and each other for her care? Whose patient will she be? She'll be our Mom, for sure, but she may also become our patient, along with other medical entities and individuals who help us care for her. Her physician will see her less often and will have less impact on the quality of her life and her health than the rest of us. All of us who care for her, whether we are her children or her home health aides, would become parties to the covenant that will care for her. All of us should be willing to embrace the ethics and the values that healers have through the ages, for that is what we will become.

In my view, a covenant of care would extend to those who do not currently see themselves as part of the healing enterprise. Take, for example, those who watch and report on health care and medical issues, or who manage health-related Internet sites. The *Boston Globe* recently announced that in the interest of public health they would no longer run tobacco advertising. They join a small, but growing group of newspaper publishers, including the *New York Times*, *The Christian Science Monitor*, the *Seattle Times* and the *San Jose Mercury News* who have made similar pledges. Additional steps might now be taken in their reporting and advisory editorial content. A Canadian medical journal study found recently that advice in 50%

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of medical columns directed at the general public was inappropriate and 28% was dangerous to the point of being potentially life-threatening.[19] Similar studies should be undertaken to assess the accuracy of health advice on television network news and talk shows, and the media should be responsible for its health content. Our weather is provided us by meteorologists accredited by the American Meteorological Society. Why not some similar assurance for our health information? Beyond the dangerous is the inflated or the incomplete, as well as the unbalanced view. According to a recent study conducted by the *National Council on Aging*, nearly one in four news stories about research and older women omits critical information. Internet health care providers add to the mix and add greatly to the confusion. Modern patients risk receiving the wrong information, becoming overwhelmed with variously accurate and inaccurate information and being underserved by it. There is a positive side and evidence that the media can act as healers. For example, 240 affiliates of the ABC Radio Network will soon launch a partnership with the Department of Health and Human Services. This effort will reach over 90% of African Americans in the U.S. with information about local care providers, public health issues, and ways to improve health. The project will be supported by an Internet website and will attempt to "Close the Health Gap" and reduce the disparities in care that so many African Americans face.

Leaders in health care can make great strides in reclaiming the positions they have lost over the past fifty years by initiating a dialogue to shift the paradigm back from contracts to covenants, and from covenants of grant with patients to covenants of obligation. These shifts must go beyond the mere mission and vision statements created in corporate climates of medicine. They must reach back to the foundations of care laid down in early civilization and project ahead to the needs of healing today and in the foreseeable future. Those forebears of modern healers may have lacked the scientific basis for their practices and cannot guide us today in the technical aspects of care, but they had a clearer perspective on the importance of the climate within which care should be delivered. Whatever they lacked in science, they possessed in soul. Whatever we have gained in data, information, and knowledge in the past several centuries, we seem to have lost in wisdom. Has science has placed such a mountain of information in our path that everything we know is becoming a barrier to treating and healing in ways that are more fundamental, perhaps lower priced, certainly more satisfying, and perhaps more effective?

In the early 1980s, former President Jimmy Carter posed just such a question to a group of public health experts. He posited that we did not solely need more research to improve the health of most Americans. He believed that there was already substantial knowledge that we were not using in the best ways for the benefit of the nation. He wanted to know what could be done with existing knowledge to improve health and how he could best help in any such venture. The deliberations on his question were not easy, because the targets of opportunity were so numerous. In fact, he was right. We already know what we need to know to prevent and treat a vast majority of the diseases in this country, and certainly to prevent and treat diseases that are most costly. To answer President Carter's question, public health experts assessed disease and risk-factor categories for him. He was advised on conditions such as obesity, smoking, alcoholism, and accidents to determine how to change behavior. Should he have looked at the nature of the relationships instead? That is, at covenants? If the physicians who know the road to good health and the patients who are asked to walk it day-by-day had better relationships, would

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behaviors change? Would risks be reduced? Would the results have been more productive if his advisors had approached the underlying nature of the care-giving paradigm? Where would we be today if covenants had been considered in the early 1980s?

Crafting Covenants between Healers and Patients

The model covenants created among healers should then be used to construct a covenant between individual healers and patients. These covenants should be developed initially by groups of healers and patients working together and then modified for the particular practices in health care where they need to be applied. The nature of the relationship and responsibilities of healers and patients within primary care, for example, may be specified somewhat differently than the nature of the relationships in critical care. The ease of access that patients expect for a preventive care visit is different than the access expected for a suspected heart attack or stroke. The parties to the healing of a child will be different than for an adult engaged in self-care. The case of an asthmatic child, for example, involves more than just the patient, parent, and physician. The school is involved as well, and in today's climate of "zero-tolerance" drug policies, asthmatic children who cannot carry inhalers are likely to be less compliant with drug dosing regimens and suffer more attacks. Likewise, the healer's expectations of the patient differ. Healers anticipate that patients can follow the directions for the tablet medicines they prescribe with relative ease, but caring for a home-infusion drug delivery system is altogether different. Physicians and pharmacists anticipate that patients and families providing for high levels of care will need additional training to assure compliance and proper use. Responsibilities, as well as rights, of each of the parties may vary by the type of care and need to be explicitly recognized.

With examples and models of healer-patient covenants in hand, each individual clinical healer should invite each patient into the covenant in a new way, building on the longstanding covenant of grant with patients, and encouraging and even requiring them to participate in a matured covenant of obligation. This covenant would establish the basis for reciprocity and mutual obligation that is so desperately needed now. This reciprocity should go beyond bill paying and social courtesy. Most physicians I know would gladly forego a good restaurant table for a more satisfying practice of the medical arts. It should promote the active participation of patients in the remedies that will promote and restore their health. It would involve those elements of lifestyle and personal responsibility of the patient and their families that would support the continued health of the patient, whether through prevention, treatment, recovery, or maintenance activities. Maimonides, for instance, included patients in his covenant, seeking their compliance with his remedies. He also included their families, hoping to protect patients from the bad advice of meddlesome relatives, and warning that their intervention could result in the patient's death. That was a beginning. On that foundation, a paradigm can be built to include patients within a modern covenant of obligation. From the paradigm will come the practices that will, over time, create new insights into the care of individuals and communities.

This dialogue is needed, particularly in an era in which patients' rights and the allegations of health care failure are so prominent in national policy dialogue. The reciprocity of rights and responsibilities of both parties—healer and patient—must be taken into account. Without defining the relationship—the covenant—in terms that call for patients (as well as healers) to

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take responsibilities as they secure rights, the goal of achieving health or relieving disease will not occur. This, by the way, is not easy for healers to do. Steeped within the covenant of grant that has framed their relationships with patients, the natural inclination of healers is to accept all the responsibility for the health outcomes of their patients.[20] Nonetheless, healers should shake themselves from that habit and initiate this debate. It is increasingly in their interest to do so. In the absence of such a covenant, healers will continue to bear the burdens of patients' failures to engage in responsible acts. To the degree that the healers and their enterprises are capitated, it is the healer, not the patient, who bears the most immediate and identifiable impact. It is true that patients who do not take their medicines eventually suffer the consequences, but healers paid under capitated contracts suffer as well. This is particularly true if their practice patterns, financial performance and public relations are monitored by quality groups, Wall Street, the press, and, in the late 1990s, tobacco-settlement-era trial attorneys. Failure to take medications will lead to longer spells of illness and sometimes hospitalizations. Failure to be immunized will do likewise. Failure to eat well, lose weight, and exercise will increase the costs of preventive care for hypertension. Inappropriate uses of over-the-counter medicines cause overdoses, accidental poisonings, and adverse-event interactions with prescriptions. Self-treatment without learned guidance can cause crises.

Respected health policy observer, Eli Ginzberg, reflected on his own experiences when he asked,

> *What is the most important lesson I derived . . . over a span of 70 years? Americans think of illness and disability as a condition that can be fixed by an expert, in this case a physician. Accordingly, they want more medicine, more research, and more physicians—all with a lower cost and equitable distribution. This was the case in 1930 and it is still the case today at century's end. However, the fact that each individual is ultimately responsible for the maintenance of his or her own health is a lesson that most Americans still need to learn.*[21]

Reaching Out toward a Covenant with Communities

The notions of covenant in healing should extend beyond the person-to-person encounters among physicians and between physicians and patients. Communities themselves are parties to health and should be invited to establish covenant relationships as well. What is a community? A community is any group that assembles itself into a recognizable unit. A community is a group of employees who work for the same employer; it is a town, a county, a state, and a nation. In a shrinking world, with the prevalence of the Internet and the ability of people and diseases to travel the globe within a matter of hours, community extends beyond our borders to include the entire planet. A community is fluid as our affiliations change, and we are all members of multiple communities. Are all communities of consequence to health? Yes, potentially so. Even the Internet, as we now know, is an important community. It does not just provide information to the 60 million Americans who went on-line to search for health information last year,[22] it is a "setting" in which disease can be transmitted. As research has demonstrated, people who search the Internet for sex are a high-risk community with higher rates of sexually transmitted diseases than those who do not.[23]

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What about the covenants among the members of the community? The most stunning advances in health have been made because of community-level action over the past 100 years. Increasing life span and improvements in the day-to-day quality of life were achieved not by medical care, but by the nearly invisible work and unsung heroes of public health. Modern science traces its understanding of public health back several hundred years. Ancient texts trace public health at least as far back as the divine edicts of God to Moses. Our living together, sharing common water, shelter, storage, and sewage enables our sharing of common plagues and bad habits. Our support of the public health infrastructure is, therefore, critical. Unfortunately, our funding of public health is appalling, and our recognition of its importance occurs only when the infrastructure breaks down and diseases break through. Experiences with E. coli contamination of food at state fairs and fast food restaurants rabies exposure of children at petting farms, and West Nile Virus Encephalitis should be enough to raise our awareness about the importance of maintaining the public health infrastructure, even in a highly developed nation such as ours. Experiences with tuberculosis, HIV/AIDS, and bioterrorism should be enough to raise our awareness about the importance of creating global networks of disease prevention and management.

Public health today means more than just the safety and security of the community's infrastructure. It also includes our personal risk-taking behaviors. We increasingly impinge on the quality of each other's lives. We smoke, abuse alcohol and drugs, carry guns, drive fast, forget seatbelts, neglect immunizations, shun pre-natal care, and spread sexually transmitted diseases. When these risky behaviors result in high-cost illnesses and disabilities, we burden the tax-based and employer-paid systems that reimburse healers and health care enterprises for our care. Just as the ancient Israelites learned the interdependencies of personal and public health, so must we today. We must extend our understanding to include the reality that all of the health care we receive—especially when it is paid for in whole or in part through third-party mechanisms—is rarely an individual matter. It is all, now, a community matter.

The *Fordham Institute for Innovation in Social Policy* has reviewed the data of the past quarter century and concluded that the nation's Social Health Index is declining. The American Dream may be easier to realize, but as a nation we "feel worse." Why? The Institute measures sixteen aspects of social health: infant mortality, child abuse, children in poverty, teen suicide, teen drug abuse, high-school completion, average earnings, health insurance coverage, unemployment, poverty among the elderly, highway deaths due to alcohol, the homicide rate, affordable housing, food-stamp coverage, and the gap between the rich and poor. Ever since the mid-1970s, as the Gross Domestic Product (GDP) has increased, the social well-being index has been falling, and the gap between the GDP and the Social Health Index is widening yearly. We must expect that these factors, which are so integrally related to the conditions within communities, do have an impact on health status and on health care. Particularly for those measures that relate to the health and well-being of children and families, the measures have been declining most markedly in recent years.[24] Unless communities address these and other factors, the pressures on health, health care, and health costs will continue to grow. For too many nations beyond our borders, the challenges of poverty-related disease are even more staggering.

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Communities must create the reciprocal relationships that will support the health of all their members, and they must work in partnership with other communities as well. An employer community can hardly expect a healthy workforce if the local municipal community does not support a clean, safe environment. Dealing with the health of communities is perhaps one of the most pressing needs in health care today. Not only do we have individual, private, and confidential matters concerning our own personal and separate health care needs, we also have needs in common with others. The community is the setting in which our needs and those of others are placed in conflict and can be brought into harmony. Increasingly, our communities have neglected this aspect of collective life. Some of our most contentious public policy issues arise from the collective relationships of community, and some of the greatest potential for resolution lies there as well. Some of the most important ways to improve health and reduce health care costs are born within communities. Smoking, food safety, gun control, traffic safety, immunizations, clean air and water, hazardous waste, rabies in urban animals, and pest infestation are community, not just personal health, concerns. Yet resolving each will require larger budgets and less liberty—tough issues for any community. Addressing these tensions will be one of the essential challenges of the next generation. Resolving them will require that the other covenants are acknowledged, in place, and practiced if we are to address the critical challenges that an aging population, advances in medical technology, and patient demand place upon us. Fortunately, a number of communities are leading the way in models that define health in terms that satisfy their needs and that address the social, economic, behavioral, public health, and clinical care imperatives of meeting those needs.

The Interdependence of Covenants

These new, modern covenants of obligation extend the reciprocity in the relationships in a number of ways. They extend the covenant of obligation among physicians to include obligations among all healers, between individual healers and patients, and among members of a community. They establish obligations of patients for the first time. They reach out to communities in a new way and call on them to be accountable. They create the foundation on which a new dialogue can be engaged in between healers and patients within a community, a state, a nation, and around the world. The healing enterprise today, now more than ever, depends on the actions of interdependent parties, acting in reciprocity in the context of a covenant of obligation.

As they currently stand, the relationships between healers and patients rest on the patient's dependency on the physician. This is a role patients have been encouraged to assume. Employers and health care financing systems have facilitated that dependency. In recent years, that dependency has shifted from a clinical dependency on physicians (with financial support from third parties) to clinical and financial dependency on the managed care organizations that contract with those physicians. Dependency, however, evokes a parent-child paradigm that is wholly unsatisfactory for the fulfillment of health goals and the development of mature health systems today.[25] Remaining child-like in the approach to our own health and healing deprives us of the opportunity to grow toward a greater potential that accepting responsibility entails.

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This growth process may be painful. Change and growth frequently are. Without a deliberate covenant dialogue, however, we risk taking steps toward change that will be unproductive. We all remember adolescence and the developmental imperative to assert independence. Today's relationships in health care are taking on the appearance of the familiar rebellions of that stage of life. In many ways, patients are becoming independent. We are not taking our prescription medicines, we are ignoring the advice of physicians, and we are turning to alternatives on our own initiative. It is projected that nearly half the population is now using alternative and complementary therapies and that visits for alternative therapies exceed visits for primary care. Counting visits and the costs of products, Americans spent over $30 billion in 1997, paying for it mostly out-of-pocket. We are combining the prescription and over-the-counter medicines in ways that may be harmful. We are venturing into the land of herbals and unregulated, unproven products as if the "natural" is always better than today's health care offerings. We're not reading labels and may be mishandling many of the medicines we take. We trust the anonymous sources on the Internet more than the trained and licensed practitioner in the neighborhood. This type of rebellion may, in fact, be a necessary phase of development in human growth. It would be an unfortunate place for health care systems to get stuck, however. The same foundations of science and education that support traditional, clinical care should support self-care and alternative and complementary medicine as well. If managed care today required patients to use these alternatives without the benefit of the Food and Drug Administration (FDA) or other regulatory agencies' assurances of their safety and efficacy, we, as patients, would object.

Neither dependence nor independence is an attractive or satisfying state for adults. Childhood and adolescence are both necessary stages of human development, but each would be a horrible place to get stuck. Baby boomers are poised to use their political power to demand more from health care, and they should. But they should make those demands with the awareness of their responsibilities. The parents of the baby boomers were given entitlement reassurances through Medicare and employer-based reassurances through health insurance. Both created dependencies on modern health systems that are not capable of meeting the demands of the growing elderly population, which will become increasingly vocal and powerful as baby boomers age. With luck and some hard work, especially on the part of the health care community, we may be able to weather the storms of rebellion of this adolescent period in our national patient-driven maturation. With policy and political restraint on the part of the legislatures, we might succeed in reaching adulthood without institutionalizing the dependence and independence that are most common today.

The aim for individuals, as well as for society, should be to progress toward "interdependence." If healers, particularly physicians, wish to resume the effective and powerful roles that are deeply embedded in our tradition and culture, they must make the first moves toward creating and offering new covenants. They have both the historical and the legal prerogatives to do so. They remain, by law and tradition, the more responsible of the partners—both among healers and with patients. They should initiate the dialogue with each of the other parties involved in the healing enterprise. They must provide leadership.

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When physicians have succeeded in creating a broader group of healers who have adopted and developed practices within covenants, they can then approach the tasks of dealing with patients as individuals and in community. In much the same way that good parents help their children to grow up, the healers of our society should take the initiative to confront the dependencies that they and their forebears have created in the patients they treat. This applies not only to those healers who are directly engaged in patient care, but also to those who are supporting and peripheral in medical care—including those in public health, health care company management, research, or public policy. The inclination of all these healers today has been to take too much responsibility from the shoulders of patients and place it on their own.

As a result of assuming all the responsibility and shielding patients and communities from difficult choices, the health care enterprise today finds itself in constant turmoil. It bears the internal conflicts over the allocation of power and professional practice. It struggles with how best to allocate the scarce resources given to it by the community. Its own identity is in crisis as it is being reformed by forces from the outside. It faces controversy with patients and the broader community on every front. Its costs are too high, its quality too low. More and more of its patients—estimated at upwards of 47 million at last count—have no health insurance. It has become responsible for limiting access and is being sued for succeeding in that responsibility. Its new products and services are perceived as too expensive. Its most valuable practices are second-guessed and underpaid. It is a target of fraud investigations by the Inspector General, the Justice Department, and the FBI. Neither its patients nor its healers are satisfied.

These are crises, but they are also opportunities. It is the opportunities that are the most exciting. We know that much of disease is lifestyle-caused and that a change in lifestyle can improve health. We know we can relieve substantial illness, injury, cost, and suffering through the application of new treatment and care paradigms that create behavior change. We know that we can affect the clinical course of certain diseases by changing patient and family dynamics. We know that working with patients within the healing context can save lives. We are learning that the status and involvement of the patient in the healing process will differentially determine the effectiveness of the drugs we prescribe to heal him. We know that communities that support the health of their citizens can enjoy better quality of personal and collective life. Whether we are pushed by threats or pulled by opportunities into covenants, it is the next worthy trip to take.

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[1] This appeared originally in 2001 in *Covenants: Inspiring the Soul of Healing*. Readers interested in exploring covenants in greater depth can find background in *The Origins of Healing as Divine Gift* which appears in this series.

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[4] William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics,* Philadelphia, PA: Westminster Press, 1983, p. 119.

[5] May, p. 108.

[6] Charles G. Cumston, *An Introduction to the History of Medicine,* London: Dawsons of Pall Mall, 1968, pp. 86-87.

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[15] Gifis, p. 44.

[16] Gifis, p. 45.

[17] Gifis, p. 45.

[18] Donald Berwick, P. Janeway, P. Hiatt and R. Smith, "An ethical code for everybody in health care," *Brit Med J,* 1997, 15:1633-1634.

[19] Frank J. Molnar et al., "Assess the quality of newspaper medical advice columns for elderly readers," *California Medical Association Journal,* 1999; 161:393-395.

[20] This is true in public health as well as individual clinical healing encounters. See J. Katz, "Patient preferences and health disparities," *JAMA,* September 26, 2001, 286(12):1506-1509. This study noted that even patients who tended to avoid care received higher immunization rates when they were cared for within managed care settings. The authors concluded that individual resistance could be overcome with the right (healer) interventions. This, it seems to me, represents the continuing trend of healers to accept responsibility that is better left to patients.

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[24] Elia Kacapyr, "What's wrong with this picture?," *American Demographics,* September, 1998, pp. 18-19.

[25] In *The Physician's Covenant: Images of the Healer in Medical Ethics,* Philadelphia, PA: Westminster Press, 1983. William May describes the model of the physician-patient relationship in parent-child terms.

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