STRATEGIC HEALTH POLICY INTERNATIONAL

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Covenants: Crafting New Covenants for Today's Health Care Ventures[1]

Health policies are rarely derived from explicit and systematic analysis of the moral values that shape them. Much of the art of national and international politics consists in structuring decision-making in such a way that value issues are not confronted. The aim is to keep peace between, and within, divergent belief systems. However, once framed, a health policy unerringly reveals the values that drive a society; and these cannot escape examination retrospectively.[2]
—Edmund Pellegrino

Coming Full Circle

My exploration of covenants began in Greece in 1984, where ethicists and academics, government representatives from many nations, theologians from the world's religions, and experts from the clinical and scientific disciplines of medicine and public health engaged in a dialogue about health policy and human values.

The group explored how ethical and religious values affected the health policy decisions of the world's nations. Dr. Pellegrino was one of the medical ethicists whose observations shaped the discussions. It was at that meeting that he made the comment quoted above. His reflection was true to the exploration of national health policy at that time, and it remains true in health care practices and national health care policy today.

The policies that have shaped the nation's care over the important and fast-moving decades of the last half-century did not explicitly address the covenant relationships among those who were a party to them—or should have been. As a nation and within our clinical relationships, we did not confront the values that framed the foundation of the healer-patient relationship. We did not examine the responsibilities that patients and communities had towards themselves and each other for the quality of their own health and healing. Yet, it is possible, now, to look back and retrospectively assess what happened to the covenants that were the basis for the health and aspects of personal and community life. It is possible to determine how and when covenants went missing and how policies and practices might have been enriched if covenants had been engaged.

What if we engaged in covenant-building?

- We might not have left so many of our dying in intractable pain and hounded so many of our healers for treating them.

- We might not have neglected the perspectives of the animal rights activists so long that some would resort to extreme positions and strategies, threatening researchers and leaving potentially solvable disease problems suspended in damaged labs and destroyed data.

- Had we felt the reciprocity in the healer patient relationship, we might never have transformed our insurance systems into no-fault financing systems, removing much of the incentives for patient self-care and prevention.

- Had we acknowledged the obligations of communities, we would not have allowed our public health infrastructure to crumble or become so eager to assume that healers, captive to capitation payment systems, would absorb the increasing costs associated with social problems.

- If we recognized the importance of the covenantal trust between patient and healer, we might not sell and resell encounter data without the knowledge of either, or for a purpose to which neither had explicitly agreed.

- If we and others were globally in an international covenant of caring, we might have approached the problems in pharmaceutical donations differently—not as a rationale for pummeling the donors, but as an opportunity to save lives and improve health systems.

- Had we as Americans been willing to participate in clinical trials, people in developing nations might never have been pressed into service as research subjects.

- Had we come to peace with profit- making ventures and private investment in health care, we might now have more venture capital available to develop the new drugs and technologies the world needs for healing.

If covenants of obligation become more explicit in our relationships, we might more satisfactorily resolve the problems we face in health care today:

- If traditional healers—allopathic physicians—were "in covenant" with other healers, would they be more willing to embrace nontraditional healers and methods and bring them into their practices, and would clinical practice become more integrated? Would they be more accepting of direct-to-consumer advertising as an educational and compliance strategy with an appropriate place in health care? Would they be more open to nurse practitioners who provide care to the uninsured who lack access to care?

- If alternative healers were "in covenant" with patients, would they more carefully limit the claims associated with their practices to those truly demonstrated as valid, avoiding the potentially ineffective and potentially harmful approaches that may be philosophically attractive, but not genuinely beneficial to health?

- If the news media were "in covenant" with patients and communities, would they improve the quality of information dissemination and reporting and develop methods to ensure accuracy in reporting on the health care arena?

- If communities were "in covenant," would they comprehensively address the social problems of racial, ethnic, and gender bias that drives violence and higher utilization of health care? Would they protect the young and the old with safer streets? Would they work toward cleaner air and living conditions to prevent asthma disability? Would they address the problems of unemployment and poverty that create health risks?

- If citizens of the nation "in covenant" with each other and our healers, would we be more inclined to contribute to tax-supported or other health care financing pools to pay for care for those who cannot afford it? Would we be more willing to adhere to lifestyle and health care practices that control costs? Would we be willing to require that each of us do so? Would we require that, much like children who receive immunizations for school entry, the elderly be likewise immunized against preventable adult diseases to be eligible for Medicare coverage?

- If patients and communities were "in covenant" with our healers, would we be more willing to see our own role in shaping the status of health? Would we recognize that our own behaviors and the health of the communities we live in also play a role in the quality of our lives, the status of our health, and the cost of our care?

- If citizens of the world were "in covenant" with each other, would we more actively address the risks of disease transmission in travel and immigration? Would those in developed nations reach out to those in poorer countries with health and economic aid, recognizing that when one nation is at risk, the world shares in the consequences?

Whatever the problems in the headlines today, in the years to come the challenges for health care will become greater. The public may focus on the immediate concerns of cost, quality, and access to care, but those in the healing enterprises know that there are a number of fundamental questions that have only begun to emerge:

- How will we support the academic health centers that train new healers and research disease without full funding of biomedical research projects or the patient care dollars to support the effort?

- How will bioethical and biogenetic decisions be made as the science and technology of health care outstrip the capacity of this nation to address its values and craft legislation accordingly?

- How will the healing and health care financing needs of an aging baby-boomer society be met?

- To what degree will alternative therapies be legitimized, not through research but due to patient demand and willingness to self-pay? Will the impact of these therapies be positive on healing, health care costs, and mainstream clinical care?

- What is the likelihood that the nation will be confronted with emerging infections, increasing antibiotic resistance, and bio-terrorism? To what degree will those factors change the safety of cities and threaten the public's health?

- How will the growing number of clinical and pharmaceutical solutions to lifestyle desires, choices, and problems be financed?

- How will those sectors outside health care, particularly those in the financial and electronic commerce industries, affect the course of healing?

These issues are all the more complex as the nation faces the realities of post-terrorism planning and health preparedness funding. Now, more than ever, the nature of the relationships we have with each other—and with those throughout the world—are critical to our health and healing. Now, more than ever, we should commit to the development of the covenants that were the roots of the healing enterprise from its formation.

Only One Step along the Way

In this paper, I want to outline the principles that are relevant to health care today to help us craft a covenant-centered future.

Principle Number One: Covenants Flow from the Senior Party and Are Preceded by Gifts

Before inviting someone into a covenant, gifts are given. We cannot deny that we are among the most gifted and privileged of all the people in the world. We enjoy the freedom that democracy and capitalism ensures. Our healing enterprise grew from both and the risks taken by healers—and investors—who willingly invested in building our collective healing capacity. Because of them, the resources have been plentiful and gifts have flowed abundantly. The nation has developed extraordinary scientific and healing resources and possesses the talent and the technology to shape a better health future for all people—not just for the "insured" patients or for those living in our country, but also for people lacking the resources for care here and overseas. It has crafted the sciences and the systems that make a difference in our own lives and the lives of others.

For all the complaints about the state of health care today, we should not ignore the reality of the gifts we have received from our healers and should acknowledge that we have asked for and have received the most well endowed health care system on the globe. For all the problems in health services, there remain more opportunities than there are obstacles. Our healers have given gifts to us as individual patients, as well. They have studied hard, worked

long hours, taken personal risks, contributed their talents, and produced many of the miracles that were asked of them.

These gifts, given and received, form the basis of the early covenants that were established here and that should evolve into the basis of new covenants of obligation. It was healers, through their oaths, who invited us into covenants and, by virtue of their expertise, remain the senior parties today. It is the healers who should now take the lead in proposing the new covenant. There are some who may believe that healers are no longer the senior parties or, by virtue of the current patient-empowered climate, should not retain the rights of such expert positioning within the proposal of covenants. For all the faults of healing in health care today, however, our healers remain the most skilled of all the parties at living within the covenants of the oaths they have taken. Unlike the rest of us, they understand covenants in a way that patients and communities do not. They are, therefore, the best teachers and leaders into a covenant lifestyle that the future demands.

Principle Number Two: Covenants Do Not End

When covenants are embraced, it is not the end of the story. The beginning of a covenant can be dated; the end cannot. Covenants are established and they evolve. They should not wither. They do not die. There is no "stepping outside" of the covenant for a vacation or a "break." Covenants, established by our forbears in healing, have framed relationships between healers and patients for generations. Healers passed down their healing ethic to subsequent generations of healers, sharing even the specific oaths to serve patients. As oaths are revitalized today, healers are signaling to the patients and communities that the covenant created thousands of years ago is still the basis of the healing relationships by which healers themselves wish to live.

There are no exit clauses in covenants. There are no buy-out provisions in covenants. To paraphrase Professor May, once a person abides in a covenant, he does not step outside it. Do it well or do it poorly, do it awake or do it in sleep, the covenant role endures. Just as healers practice their skills and are available to patients at all times, so, too, should patients and communities practice their roles continually. Healthy behaviors are no less a concern when buying groceries, driving a car, or watching television than they are during office visits to the physician. Once engaged in a covenant of obligation, healing should be "top-of-mind" for patients and communities, not just for the healers who serve them.

Principle Number Three: Covenants Change Over Time

At the beginning of a covenant, it is impossible to know where the relationship will lead and what the covenant relationship will require of its parties. It is this element of evolution that distinguishes covenants from contracts. Contracts spell out every step and, even at the beginning, define the end. Covenants, by definition, cannot do this. It is impossible to say how each party will influence the other and how the needs and demands upon those involved will change.

At present, many of the parties to healing are re-examining the nature of the healing enterprise and the relationships involved. It would be wise for all concerned that this examination results in new covenant of obligation relationships among the many healers in

health care today, between healers and patients, and between healers and communities. When the newly defined healers I have enumerated accept their responsibilities to the covenant, they will be more likely to shape positive health care climates. When patients and communities accept responsibilities and obligations, they will help carry the load that has been shouldered so predominately by healers. The relationships that create healing and quality health care outcomes will become the shared responsibility of everyone. Currently, some of the players central to the healing enterprises are able to ignore their roles as healers. In the future, having accepted a covenant of obligation, none of the parties will be able to shift their responsibilities to others and expect that healing will simply be "granted."

Coming into Covenants of Obligation

Covenants of obligation address the challenges of this new era. The existing covenants of grant should be replaced with the more mature covenants of obligation. We as a nation are not satisfied with the health care services we receive. We want more and better care. We demand new advances in research, and we are worried about how we will pay for it. The old covenants of grant that existed between healers and patients have run their course and are no longer sufficient for our health care challenges. The old covenants of grant did not effectively engage all those involved in healing. They did not engage the patients and the communities that are such an important determinant of health today. In order to satisfy the nation's wants, we must acknowledge that all those who "practice" within the healing enterprise—healers, patients, and communities—achieve health and healing within mutually supportive relationships.

Each party must feel obligated to the other. Each party to the covenant must be willing to reciprocate with the other in the healing process. Each must be willing to do his part in finding the best solution to the important lifestyle, policy, political and business decisions that are pending at the beginning of the new millennium. These solutions will shape the future of our health and that of other nations, as well. None of us—healer, patient, or community—can expect that health care will be healed unless we all participate.

None of us can expect that the world will be healed unless we reach out to make it happen. In the case of global health, we are the superior parties. We have the wealth; we own the technology. We have the talent, the incentives, and the resources to invite the world into a covenant of obligation for the healing of all. In this way, we can contribute our assets and elicit from them the mature response of interdependence to create the healing climate for their nations, and thereby, for the world. None of us can expect to be insulated from the consequences of our behavior—whether that behavior is our personal health practices or our policy positions on helping the needy nations of the world. Whether we are patients, healers, or communities, whether we are rich nations or poor ones, we cannot shun the opportunity that a covenant of obligation in healing can create. Mutual obligations will benefit us all.

If covenants, particularly covenants of obligation, are to be the order of the future, how will this be accomplished? Who will be party to these covenants? What processes and documents will frame them? How will those who wish to engage in covenants prepare for them and execute

them? Will everyone embrace covenants? Can they be required to do so? What about those who may reject the invitation to join in covenant, and what are our responsibilities to them?

Creating covenants of obligation will require six essential conditions. Some of these are obvious and will be familiar to those who have tackled any new program and or project. Some are well-honed skills of healers, patient advocates, and community leaders. These skills draw upon the leadership development, strategic planning, policymaking and other processes already used by those in the health care community.

First, there must be an intention to develop and enter into a covenant of obligation. Being in a covenant is no accident. It will not occur because one "just happens" to be in a particular job or position in the health care arena, because one has made an appointment to visit a healer, or because one is a resident of a community. Compare it to a wedding and a marriage. A marriage does not "happen" because a man and a woman show up in church at the appointed hour. The marriage covenant is struck because both parties have committed to going forward in their relationship over time. Particularly on the part of the party who first proposes the marriage, or covenant, the intention must be clear—it must be intentional. As the expert party who makes the proposal, healers must have the intention to form covenants with each other, with their patients, and with communities. Without that intention, the next steps cannot and will not be taken.

The second essential condition calls for a purging of the immediate past, a clearance, or "letting go" of any biases that might interfere with new styles of relating. This includes releasing the prejudice, ideas, likes and dislikes about the past relationship. Emptying out will free the mind and the heart to consider new ways of relating to the covenant in general and relating to the parties who will become part of the covenant specifically. This will not be easy. Large numbers of interlocking contracts are in place in health care today. These contracts are layered over old, dysfunctional covenants of grant. Biases among patients, healers, and communities are strong, and many of them are negative. It will not be possible to engage in covenants if we continue to believe that patients are irresponsible and ignorant, healers are greedy and unethical, and communities are disengaged and disinterested. New covenants require new ideas and a past that is purged, resolved, and left behind. New covenants require a fresh start and a clean slate.

A third essential condition prescribes that covenants must be rooted. The best roots for grasping covenants of obligation are those from the ancient past. Today's health care ground is, frankly, not sacred enough for a covenant of obligation to be proposed, root, and grow again. Our ground has been eroded and is no longer fertile soil in which to plant a practice as paradigm-shifting and potentially radical as a covenant of obligation. As the modern scientific era and the wealth of the nation produced its fruits, the old covenants of grant could have matured into covenants of obligation. They did not. Instead, the existing covenants of grant began to break down, burdened by new, complex, and interlocking contractual arrangements that characterized changes in health financing over the past 50 years. New players in health care, policy, politics, insurance, advertising, media, and electronic communications did not recognize themselves as healers, did not embrace the healer's covenant or adopt healing roles. Patients and communities did not mature into accepting responsibilities for the state of their own health. The confluence of these factors in this modern era limits our ability to mature our healing covenants toward those of

obligation to one another. Perhaps by returning to the sacredness of healing and the interdependence of the relationships, the roots of healing can take hold again in fertile soil.

New covenants must be connected for the fourth essential condition. Interconnections with those in the covenant of obligation are essential to maintaining it. Hippocrates was wise in holding physicians accountable to one another in a covenant of obligation. Those relationships of obligation supported the difficult demands of research, learning, and practice. The obligation to one another ensured that no physician was left without peers in the demanding arenas of science and skill that were called for in healing. This should stand as a lesson for those developing and engaging in covenants of obligation today, whether patients, healers, or communities. Maintaining and restoring health, and treating and healing disease cannot be accomplished without the connections to other patients, healers, and communities. Each party to the covenant will perform better within a covenant and will meet his obligations more completely if he reciprocates with others in peer relationships. Much as healers gain support for the demands of their roles by connecting with other healers, so, too, will patients gain support by connecting with other patients and communities. Each party will do well within covenants if he contributes something to the healing of others, for it is frequently in giving that we receive the most.

The fifth essential condition demands that those who develop and work within covenants must pause from time to time to reconsider the relationship. The work of health care is demanding, and recreating covenants will make the tasks of healing even more so. This call for covenants is intended to ease the crises we will most certainly face without them, but covenants are hard work. They require near constant attention to the ebbs and flows of human relations. Covenants are not intellectual constructs, but heart-focused, soul-driven lifestyles. Covenants are not only for the good of the patient, but for the good of the healer as well. Overworked, stressed-out, and unhealthy healers cannot give what they do not have. Patients whose lives have been altered by disease or who face critical disease crises need the pause to sort out what changes they want and are willing to seek from their healers. Communities and nations, too, will change as economic circumstances, employment, immigration, and disasters take hold. Covenants are destined to change. It is, therefore, important that from time to time the parties to the covenants reconsider and recommit to them. This takes an occasional pause to reassess their workings to determine if changes are needed. Some couples do this within marriage. They reassess their relationship to determine if changes should be made. Not a bad idea for covenants in health care, either.

The sixth, and final, essential condition asks that covenants cause the parties to stretch into and beyond their capabilities in creating, sustaining, and healing their health and the health of others. If we are to embrace an idea as fundamental and radical as covenant, we should set our sights high. We should call out the best in ourselves as patients, healers, and communities. We should seek the best within the relationships we have.

Too often in health care we have limited the capacity to do better, believing that we cannot, or that others around us cannot, successfully perform to the goal. Yet, the history of health care is one of remarkable progress on all fronts. New funds have appeared from private, public and commercial sources to build the infrastructures wanted, healers have adapted their

practices to what the nation wanted, and new medicines have spilled out of pipelines with increasing regularity. Today, there is tremendous wealth and diversity in personnel and resources. The health workforce is one of the best-educated groups of all the sectors of the economy. It is already bound by covenant. These resources are not some albatross around the neck of the nation, but the wings that will enable us to soar to new heights of healing. Covenant may well be one of the flight paths towards the change we so desire today. As we work toward creating these new covenants within this country, we should stretch all the more, to reach beyond our borders. It matters little for us to enjoy health here if we will fear our global neighbors for the pathogens they may harbor in a handshake. Global covenants of healing are one signpost on the path to world peace.

Who Should Create New Covenants of Obligation?

Donald Berwick, of the *Institute for Health Care Improvement*, says that all those who "shape the experience of patients and the social investment in care" should be party to the ethical ideals of healers.[3] I agree. Even though he is referring to "ethics" and I to "covenant," our perspectives are so similar as to be indistinguishable. I'll be more specific. Everyone who works in a professional or volunteer position in a healing enterprise should define him- or herself as a healer, should be a party to a covenant, and should adopt a covenant of obligation in relation to the patients they serve. This is independent of the education or position of those healers. It is independent of whether the healer serves one patient or a million patients. It is independent of whether the service is clerical or clinical. It is independent of whether the patient served is a single individual or the collective whole. As a result, I include physicians and policy makers, surgeons and clerks,[4] legislators and litigators, advertisers, marketers, and e-commerce entrepreneurs. I also include newscasters, insurance company clerks, and pharmaceutical sales representatives. These individuals form the initial covenants of obligation—those that exist among healers and are at the foundation of all the other covenants. They are the senior parties who will invite each other and others—the patients and the communities—into the reciprocal relationships that will create the new covenants of obligation that I propose.

The creation of these covenants will not happen by myth or by magic. The identity as a healer, the intention to create covenants and act within them, will not ensure that these covenants arise full-grown like some goddess of old from the head of her father. The creation of these new covenants of obligation will emerge from a new generation of leaders in health care who may now be appearing on the scene. These are leaders worthy of being nurtured by the rest of us. These are leaders whose intentions will span beyond the limits of the sitting president and congressional majority.

These leaders will, first of all, heal health care. They will help create the sanctuaries of tolerance for bringing today's healers together to search for their commitment to covenant. Once they are united in trust, they will use that emotional glue to approach patients and communities. Since patients carry with them the vestiges of the covenants established throughout history, they will be inclined to welcome the invitation to participate.

What Will a Covenant of Obligation Look Like?

A covenant of obligation will be an explicit statement of relationship. It will be reciprocal. I have only been able to locate one healer with a clear statement of such a covenant. It was developed by the staff and patients of Indiana Health Centers, Inc.[5] This healer is a Community Health Center (CHC) composed of clinical sites and satellites. It is a safety-net provider established to care for the uninsured, the underinsured, and those lacking access to care. As such, it is dedicated to serving those too often at the margins of our communities. If healers can create covenants of obligation within these settings and amidst the resource constraints of caring for the poor and the disadvantaged, we all can.

Their covenant of obligation addresses access, affordability, quality convenience, prevention and dignity. It says:

Each Indiana Health Centers person promises...	**Your responsibility is...**
...to provide quality to keep you healthy	…to schedule and keep your services appointments for immunizations, annual exams, WIC and cancer and other screenings
...to provide quality nutrition and WIC services, as well as quality medical care when you are ill, and to have a medical provider you can reach by telephone when we are closed	…to call us when you have a health problem or nutritional concern
…to be open at times that work for you, including evenings and weekends	…to let us know if our evening and weekend hours work for you
…to make every attempt to honor appointment times	…to make appointments whenever possible, to make appointments at convenient time, to make every effort to be on time for an appointment, and to call if you can't keep your appointment
…to take a personal interest in your health and keep all personal information private	…to give us accurate information about you and your health, and to make sure we can always contact you if necessary
…to treat you with respect and courtesy	… to treat us and other clients with respect and courtesy
…to ask for and consider your input	… to complete the client satisfaction survey
… to keep the cost as low as possible	…to pay your fees for medical services when due, to tell us if you have any insurance coverage, to take advantage of any health insurance program you might qualify for, to provide us with accurate financial information
…to refer you to other services that would be helpful	…to consider using the referral and let us know if it works for you
…to offer many services that help you stay well	…to use as many of our services at each visit as possible

Other covenants may be stated in different terms because they will be uniquely structured to fit the nature of those within the relationship. The covenant of caring that emergency personnel have with their communities will differ from those that primary care physicians have with patients and families. The covenant that health care trade associations have with their members will differ from those that their members have with the patients and communities they serve. The covenant of state public health officials will be different in times of crises than in times of quiescence.

Some covenants may be totally personal—as between a healer and a patient. Some may be organizational—as between a hospital and a community. Since oaths have been used to structure and define covenants, most parties will choose to state their covenants in that way. Covenants won't be the answer to every dilemma, but they will be the starting point for resolving many. These covenants will probably be short, so that they are easily remembered. It is not the document, after all, that will be important, but the degree to which the reciprocal promises live in the hearts and inform the heads of those who are party to it. These covenants will also provide for some sort of reconciliation process, as everyone is fallible and will fail to live up to the spirit of the covenant on occasion. Building back the trust and reentering the relationship will require the parties to restore their standing in the covenant when it breaks down.

Covenants in Action

Do covenants work? Do they make a difference in practice? For true covenants of obligation, it is not yet clear. So few can be identified, and none is sufficiently longstanding to be measured at this point. Many hospitals and health care institutions now post patient rights and, less often, patient responsibility statements, but the statement of the Indiana Health Centers, Inc. stands alone as a true, reciprocal covenant of obligation developed between healers and patients.

In addition to the covenant of grant established in the Hippocratic Oath, which has been measured and found to have a positive impact on practice,[6] there are three others worthy of note and discussion. One is from a corporation, one is from an association and the other is from an individual.

The first is the Johnson & Johnson Credo. This credo is typical of a covenant of grant, but it is notable because its impact has been measured.[7] It reads:

Our Credo

> *We believe our first responsibility is to the doctors, nurses, and patients, to mothers and all others who use our products and services. In meeting their needs everything we do must be of high quality. We must constantly strive to reduce our costs in order to maintain reasonable prices. Customers' orders must be serviced promptly and accurately. Our suppliers and distributors must have an opportunity to make a fair profit.*
>
> *We are responsible to our employees, the men and women who work with us throughout the world. Everyone must be considered as an individual. We must respect their dignity and recognize their merit. They must have a sense of security*

in their jobs. Compensation must be fair and adequate, and working conditions clean, orderly, and safe. Employees must feel free to make suggestions and complaints. There must be equal opportunity for employment development and advancement for those qualified. We must provide competent management, and their actions must be just and ethical.

We are responsible to the communities in which we live and work and to the world community as well. We must be good citizens—support good works and charities and bear our fair share of taxes. We must encourage civic improvements and better health and education. We must maintain in good order the property we are privileged to use, protecting the environment and natural resources.

Our final responsibility is to our stockholders. Business must make a sound profit. We must experiment with new ideas. Research must be carried on, innovative programs developed, and mistakes paid for. New equipment must be purchased, new facilities provided and new products launched. Reserves must be created to provide for adverse times. When we operate according to these principals, the stockholder should realize a fair return.

In this credo, Johnson & Johnson, as a corporation, holds itself accountable to patients, family members, employees, communities, and stockholders. It grants them quality products, working opportunities, good neighbor relations, and returns on investment. The credo was written in the mid-1940s by the late Robert Wood Johnson, the company's leader, and was the guiding principal of his own management of the company. In 1972 it was the theme of the company's annual report and the basis of a series of meetings for company employees, led by the new chairman, Philip B. Hoffman. The credo formed a number of important corporate decisions, including the decision to maintain the company's headquarters in an urban area and support the redevelopment of the city rather than flee to more desirable settings in the country.

The credo was tested most severely in 1982 when a criminal poisoning of Tylenol® resulted in a number of deaths. The company encountered a crisis of unprecedented proportions. No crisis management plan could have anticipated the turn of events and the demands on the company to cooperate with so many government officials, press contacts, consumers and customers. The company and a number of knowledgeable observers credit the credo with guiding corporate actions through the hour-by-hour responses that, within five months, led to its re-launch of Tylenol® into the marketplace, the repackaging of consumer goods to prevent similar tampering, and the recapturing of 70% of the market it had previously held.

In another example, the National Health Council, an association of over 100 health groups, developed concepts of patient rights and responsibilities. The Council is composed of both patient and healer organizations, and these rights and responsibilities were developed through extensive research with patients across the country. This statement, like the one developed by Indiana Health Centers, Inc., moves in the direction of reciprocity between healers and their patients:

All patients have the right to:

1. *Informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.*
2. *Concise and easily understood information about their coverage.*
3. *Know how coverage payment decisions are made and how they can be fairly and openly appealed.*
4. *Complete and easily understood information about the costs of their coverage and care.*
5. *A reasonable choice of providers and useful information about provider options.*
6. *Know what provider incentives or restrictions might influence practice patterns.*
1. *All patients, to the extent capable, have the responsibility to:*
7. *Pursue healthy lifestyles.*
8. *Become knowledgeable about their health plans.*
9. *Actively participate in decisions about their health care.*
10. *Cooperate fully on mutually accepted courses of treatment.*[8]

In the final example, an individual, Martin Wasserman, M.D., J.D., at his swearing-in as Secretary of the Maryland Department of Health and Mental Hygiene, crafted a "Health Pledge to the People,"

- To protect and promote the health of the public by creating healthy people in healthy communities
- To strengthen partnerships between the state and local government, the business community, and all of the health care providers in Maryland
- To build a world class and professional organization grounded in the principles of quality, accountability, cultural sensitivity, and efficiency.

This pledge, particularly the second item, established an explicit covenant of obligation among a broader group of healers and others within the state. The state's Department of Health and Mental Hygiene reached out to form a relationship between community health departments, healers, and communities through businesses. The pledge not only guided the efforts of the state's Department of Health; it was also signed by 24 local health officers and 7 facilities, and it was supported by over 200 quality teams. As a result, the Department of Health and Mental Hygiene was the only department-wide winner of the Governor's Gold Quality Award in 1997, which was based on the Baldridge quality award criteria. No other department in Maryland has won that award since. In addition, the pledge formed the basis for extensive outreach to communities. When the Health Care Financing Administration approved a Medicaid waiver for the State of Maryland in record time, it commented that the state had secured the highest

involvement of the public in any state up to that point. The state continues to involve the public, respecting citizen time by scheduling meetings in multiple locations so that no individual must travel more than one hour to participate.[9]

Evolution of Covenants

Those who engage each other in covenant terms are changed by the nature of their relationships. Much like young couples who marry with ideal expectations and later face difficult realities, each party to a covenant is challenged in ways that would not have been possible had they not entered into the covenant in the first place.

In healer-patient covenants in clinical settings neither party knows, at the outset, how the relationship will unfold. What diseases will befall the patient? What diagnostics or therapeutics will the healer be called upon to use? How rapidly will health care technology develop? How will the interaction between the two parties change each one as they work together over the years for the benefit of the patient's health—and perhaps for the healer's health as well? What will each party teach the other?

In a healer-community relationship neither party knows how the other will be required to change perspective in order to advance the covenant. How will communities respond to a healer's call for better education and social issue management to address, for example, problems of drug abuse, teen pregnancy, smoking, and obesity that drive health care costs? How will healers respond to the problems of violence that lead to increased health care utilization? How will the cost of caring for the uninsured be distributed among the community and its healers during economic recessions and periods of high unemployment?

In the case of the patient-community relationship the evolution is even more uncertain. How will communities be defined? To which community does a patient belong: the one in which they are employed, where they live, or where they worship? To what degree are local employers a part of the community that should be engaged in solutions to health problems? Who will act as the voice of the community and have the "standing" to bring various groups within the community together to improve health? What are the limits of community control in cases where the community also feels responsible for health care? Are there limits to the degree that a community and its healers should feel responsible for individual patients, including those who may not be inclined to practice healthy behaviors or respond within the covenant themselves?

No Easy Answers

By now, some readers are hoping for some final answers, and perhaps some easy answers, at that. However, this book was not intended as a scholarly analysis of the history of medicine, the ethics of medical care, or the theology of covenants. It was not intended to describe each of the health care or global issues of the day and present an analysis complete with prescriptive solutions. In fact, discussing such a scholarly analysis of even one of the dilemmas discussed here would require several volumes, as the field of global political and health care publications readily demonstrates.

This exploration was intended to be a practical approach to some selected issues for healers, patients, and communities interested in understanding and influencing the important decisions in the public policies of tomorrow's health care. It was intended to raise the questions to frame discussions for those who are parties to the covenant. Each of the issues we face in health care today is a long-term work in progress. Each one is complex enough that none is likely to be resolved in the near future. Considering how covenants can help may lead to solutions is the next important step along the path of healing health care. Pausing to develop covenants where they are most needed may be the best prescription for the maladies that ail our failing health care system.

In this work, I did not intend to tinker at the margins of new health care financing proposals. There are very talented and dedicated people in the policy arena and health care enterprise who are crafting the incremental changes that will make health care accessible and affordable for decades to come. I cannot contribute to those efforts except by raising issues of covenant and suggesting that mutual obligations among all the players within health care will help. This book is, instead, intended to radically challenge the nature of the relationships that are the foundations of health care today. On a new footing in relationships, the payment and financing issues can be more productively and easily addressed.

Furthermore, I did not intend to tinker with the margins of health care companies. To do so would not help the future, it would harm it. Investors have long recognized that the health sector contributed to the economy in a number of ways. Health care has produced a growing number of jobs for an expanding workforce and kept the nation in the forefront of development as well. Health care was founded on solid science and increasingly productive, exportable technology. Demand-driven care has been good for health care. New technologies replaced old ones with greater effectiveness and, over time, efficiency. Health care contributed not only to national pride, but to a favorable balance of trade.

Nor did I intend to shoot at a single, clear target with magic bullets. The targets in health care are too numerous, too fast moving, and there are no magic bullets. I did not intend to offer specific solutions or to propose changes to "fix" health care—save one. It is my contention that if health care is to be healed, everyone involved in the healing enterprises of the day—the healers themselves, patients, and communities—must enter into new and reinvigorated covenant relationships, and we in the U.S. must reach out to the world. In the course of my work on this topic, I posed over three hundred questions. Yes, there have been precious few answers. But there are ways to reach toward those answers and find the right ones. The best way, I believe, is to reach back into the roots of healing and covenants—specifically covenants of obligation. What better time than now?

[1] This appeared originally in 2001 in *Covenants: Inspiring the Soul of Healing*. Readers interested in exploring covenants in greater depth can find additional background in *The Origins of Healing as Divine Gift* and *History and Modern Applications of Covenant Healing Traditions* which appear in this series.

[2] John H. Bryant, and Zbigniew Bankowski, "Health Policy, Ethics and Human Values—An International Dialogue," XVIIIth Council for International Organizations of Medical Sciences (CIOMS), Switzerland: CIOMS, 1984, p. 7.

[3] D. Berwick, Janeway, P. Hiatt, and R. Smith, "An ethical code for everybody in healthcare." *Brit Med J*, 1997, 315:1633-1634.

[4] In one study of routine neonatal circumcision, 63% of parents did not discuss the procedure with any medical professional prior to admission to the hospital for childbirth and 20% were confronted with the decision at that time. Of those parents delivering male children, 37% discussed circumcision with a medical professional, 9% with friends, 20% with the hospital admissions clerk, and 34% discussed it with no one. A.J. Herrera and J.B. Trouern-Trend, "Routine neonatal circumcision," *Am J Dis Child*, 1979, 133:1069-1070.

[5] Lynn Clothier, personal communication.

[6] J.A. Benson, "Contemporary Use of Oaths and Covenants." Paper presented at the Institute of Medicine, Washington, D.C., October 13, 1998.

[7] L. Foster, "The Johnson & Johnson Credo and the Tylenol Crisis," *New Jersey Bell Journal* Reprint. Copies of this reprint, as well as a copy of the Credo may be obtained through the Johnson & Johnson Corporate Communications Department at 732-524-0400.

[8] *Putting Patients First®: Patient Rights and Responsibilities*, Washington, D.C.: National Health Council, 1995.

[9] Martin Wasserman, M.D., personal communication.