From the Editors

Changes underway in healthcare delivery throughout the world have a direct and major impact on healthcare relationships. Shrinking resources and expanding demands are straining programs to the limit at the same time that entrepreneurial approaches are on the rise. Changes such as these call into question the goals, functions, boundaries, and even the definitions of how health professionals, patients, and families interact.

For some observers, the doctor-patient relationship represents the last vestige of an ancient craft that should be protected from the infringements of modern concepts such as "autonomy" and "patient preference." For others, the changes represent a chance to instill in this venerable relationship a sense of social justice, concern for the common good, heightened awareness of economic constraints, and the ability to offer healthcare to more and more people. In Part Two of an exploration of the doctor-patient relationship and the roles of the ethics committee, we look at the place of beneficence and autonomy.

In this issue, we also explore some of the changes and challenges facing healthcare relationships in a revised system of care, along with their strengths and weaknesses. For example, should health professionals refuse to treat noncompliant patients to bring about a social good, i.e., reduction of health costs, or is it their responsibility to offer treatment to all patients without regard for the genesis of the illness? What are the obligations of health professionals to society? Are the obligations parallel to those of the patient, or do they come or interact through the care of the patient?

The illustration chosen for this Special Section, William Chandler's painting of Dr. William Gleason, is a powerful symbol for the separation of caregiver and patient. The patient, represented by an extended hand through a drawn curtain, reveals more than the eighteenth century premise that the pulse is sufficient for diagnosis and therapy. By substituting MRI, blood test, or EKG for pulse, the painting also serves as a commentary on our contemporary reliance on the physiological at the expense of the interpersonal. There is a tendency in the history of healthcare to rely, when possible, on dispassionate quantitative measurements rather than on the patient. The warning by Berkeley anthropologist Nancy Scheper-Hughes is a critical one, "All of us can either be open and responsive to the hidden language of pain and suffering or we can cut it off by relegating . . . complaints to the ever expanding domains of medicine. . . . Once safely medicalized however, the buried issues are short-circuited . . . the desperate message in the bottle is lost."

"The desperate message in the bottle" is the real subject of the Special Section, *Healthcare Relationships: Ties That Bind*. In keeping with our view that ethical discussion must be rooted in the

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lives of real people, we begin with an open letter to physicians from Shana Alexander in which the journalist provocatively explains why she trusts her attorney more than her physician. The message from this first-person account is expanded and amplified throughout this issue: healthcare relationships demand much more discussion than traditionally has been the case.

William Atchley has noted that the once popular metaphor for medical care as an orchestra looking to the physician-conductor for guidance, instructions, and decision should be replaced by the more appropriate image of the healthcare team as members of a chamber music group in which the patient also participates. In this model, there is no assigned leader other than the imperative of the evolving disease process; and separate parts are played by the individual specialists as the disease-score requires. The interaction is horizontal rather than vertical in a dialogue of instruments or voices.

As a new system of care emerges, professionals and patients must keep the dialogue going—not just about the services involved but more importantly about the nature of the relationship they plan together. This point is critical. Not only will each encounter differ, but each should involve a more explicit discussion of the values to be protected and the goals of treatment to be accomplished in the relationship.

Realistically, however, that dialogue will take place within a climate of increased bureaucratization and legal dominion that inevitably brings its own pressures on healthcare relationships. The important question that emerges and one that we will continue to address in future issues of *CQ* is "Can health professionals maintain professional flexibility and the ability to treat and tailor care for individuals in an environment where there is greater and greater social, economic, and legal control over the system?"

Beginning in this issue, we are pleased to welcome Kate Christensen's assistance in coordinating the Ethics Committees at Work Department and extend our appreciation to all the Ethics Committees who share their cases and comments with CQ readers.