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Kevin O'Rourke

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by

Kevin O'Rourke, OP

The author is Director, Center for Health Care Ethics, Saint Louis University.

Few occupations are subject to public scrutiny as is the provision of health care. The public assumes that a high degree of competence, service and altruism is characteristic of personnel and institutions who provide health care. And why not? Providers of health care promise to "put the patient first." But several indications and trends raise the question of whether the patient truly is being put first. Can the traditional ethics of health care, the behavioral pattern, which my colleague Griffin Trotter, M.D. calls the "grand tradition", survive?[1] In order to consider this question analytically, we shall consider the basic elements or core values of the "grand tradition", the contemporary trends which threaten these core values and offer some suggestions designed to preserve the "grand tradition".

I. Traditional Ethics of Health Care

In this portion, I shall use the term health care to designate the practice of medicine by physicians but also to include indirectly other persons offering of health care: nurses, allied health care professionals of all kinds, hospital administrators and trustees. It is my firm conviction that physicians are the center of a health care team, but it is also a firm conviction that other members of the health care team are often overlooked or de-emphasized when focusing upon the ethical standards and behavior of health care personnel.

What are the traditional core values of ethical standards proper to providing health care? These standards are often expressed in such phrases as "putting the patient first", caring for the whole (entire) patient", or

"offering health care with no concern for power, position or wealth, but only for the good of the patient." The source of these overarching behaviors and value statements is the physician-patient relationship. Intrinsic to this relationship and indeed at the heart of the relationship, is the promise made by the health care professional to offer help to the patient as he or she strives for an important personal good.[2] Why is this promise at the heart of the medical relationship? Because the essential quality needed for a health relationship is trust. Trust is not engendered unless the patient is convinced that the professional is devoted above all to the patient's benefit. At the heart of the physician-patient relationship there is an altruistic promise which engenders trust.[3] Because of this altruistic promise some refer to the physician-patient relationship as a trusteeship, or as a covenant.[4] Others object to the use of this term on the grounds that the word covenant offers an added impediment to a clear understanding of the physician-patient relationship and the depth of the commitment resulting from the relationship. While the term covenant has merit, it does reflect some religious overtones, and while religion may strengthen and enrich the commitment of the health care professional, the physician-patient relationship can stand alone as the source of ethical analysis. With this in mind, I believe the term profession expresses more clearly the nature and value-centered obligation resulting from the physician-patient relationship.

Of course, the term "profession" does not convey clear connotations unless more accurately defined. In contemporary times the term profession is used for any prestigious occupation. It is a symbol rather than a reality.

Moore and Rosenblum described accurately the modern concept of profession:[5]

1. Professionals practice full-time occupations.

2. They are committed to a calling; that is, they treat their occupation "as an enduring set of normative and behavioral expectations."

3. They are distinguished from the laity by various signs and symbols and identified with their peers – often in formalized organizations.

4. They have esoteric but useful knowledge and skills through specialized education, which is lengthy and difficult.

5. They are expected to have a service orientation so as to perceive the needs of a client relevant to their competency.

6. They have autonomy of judgment and authority restrained by

responsibility in using their knowledge and skill.

These descriptions are satisfactory insofar as present day professions are concerned, but in the *classical* sense of the term, profession has a more restricted meaning. In this sense of the term, professions were concerned directly with improving a person's well-being; with improving the person as a person.[6] In other words, the service offered concerned a good intrinsic to the patient or client as person. Moreover, the good concerned was so important that it should be available to all, even those who could not offer payment in return for service. Today, engineering, accounting, business and other arts are considered professions because they involve knowing, doing and helping.[7] But the goods they offer can be achieved without the presence of the person, and without any change in his or her character or function. In the long run, contemporary professions help people to a better life, but their immediate objective is *productive*, not personal.

Even if one resists the distinction between professionals and professions in a *classical sense*, one would have a hard time denying that the goals sought by classical professions in the sense have distinctive qualities. The classical professions improve the person qua person; that is, they improve the character of the person. The classical professions demand cooperation on the part of the person being served. More importantly, they demand an intimate knowledge of the client on the part of the professional.[8] Moreover, insofar as the goods of the classical profession are concerned, they are so important that they should be available to all, even to those who cannot pay for the service. Thus we refer to some of these goods as "rights": education, police protection, and a fair hearing in court are rights; they should be available to all. Our country, mainly because it is so wrapped up with the profit motive, has not made the same declaration in regard to health care – though six years ago we almost recognized it as a right.

Finally, the most dominating characteristic on core value of the ethical physician is competence. Competence follows from the promise to help a person strive for health and represents a needed explication of a quality found at best implicitly in the *Hippocratic Oath*. Jonson best describes this quality mentioned by an earlier generation of American ethicists.[9]

> The ethics of competence, fully understood as mastery of the science and skills of diagnosis, therapy and prevention of disease, together with an appreciation of the personal and social aspects of the patient's health and disease, are the glory of modern

medicine. They are the standard to which all physicians must be held - the goal of medical education and the expectation of the public.

In sum, the traditional health care ethic:

1. Is characterized by a promise to help individual patients strive for important personal good. Namely, optimal physiological and psychological function.

2. This promise is not qualified by providing for the well-being of the provider, rather, the promise is made to all in need. It is altruistic.

3. Is characterized by competence; that is, by knowledge, technique, and empathy.

4. Seeks to know the patient as person; that is, concerned about all human functions and their integration, realizing that the patient is more than a biological case study.

These ethical standards are often expressed in codes or oaths particular to specific sections of the health care professions, for example, for physicians by the AMA; for nurses by the ANA; and for psychotherapists by the APA. The most famous oath for physicians, the *Hippocratic Oath*, has been developed over the centuries.[10] The latest contemporary version of this oath used at many medical school graduations is a bowdlerized version of the original, omitting prohibitions against abortion.[11] Even in this reductionist version, it does not insist forcefully enough upon competence as a significant foundation for health care ethics, but does underline the view that physicians treat persons, not diseases, and bespeaks altruism on the part of the caregiver.

II. Contemporary Attitudes and Situations Which Threaten the Traditional Ethics of Health Care

The traditional ethics of medicine which I have outlined has never existed without opposition. This opposition has resulted from other schools within the practice of medicine, as well as from movements within society at large. When we speak about a traditional ethics of medicine we do not assume that the "grand tradition" is unchangeable for all time. But we posit that the traditional ethic expresses most clearly, if not completely, the basic standards, which protect and promote the physician-patient

relationship and which best promote the health of individual patients. Basic ethical requirements may not be subverted or ignored without destroying health care as a profession. However, as we shall see, the traditional ethic of health care can be developed without being destroyed. Development may bring about greater ethical sensitivity that will lead to the expression of new ethical norms.[12]

Insofar as the traditional ethics of medicine are concerned, I shall consider and evaluate three challenges. One of these challenges, I believe, results in a healthy development of the "grand tradition", but I believe the latter two challenges subvert and destroy the "grand tradition". Thus, they must be resisted and rejected if health care is to survive as a profession.

1. The first challenge is that of social justice. The traditional ethics of health care have arisen from the promise of the professional and the needs of particular persons. In describing the needs of particular persons we realize that the social function of the person must be respected by health care professionals. For example, in treating a particular patient, the family of the patient usually must be considered as well. The needs of a family will often influence the choice of treatment of a particular patient, especially at times of serious illness or impending death. Does Mom want to be sustained in her last days by a respirator that would impede communication with the family, or does she wish to allow death to ensue without the respirator because this form of therapy impairs her social function. Thus, the traditional medical ethics recognized the social needs of individual patients to some extent.

But the challenge of social justice is much more explicit and extensive than the responsibility to be aware of the social needs of the singular persons. The challenge of social justice to health care professionals is a concern for the health care of society qua society. Thus, health care professionals must be concerned with general programs to prevent disease and with the provision of health care for all. Pellegrino aptly expresses this new challenge:

> The physician's sense of responsibility toward his patient is one of the most admirable features of medicine and must always remain the central ethical imperative in medical transactions. But, it must now be set in a context entirely alien to that in which ancient medicine was practiced. In earlier eras, the remote effects of medical acts were of little concern, and the rights of the individual patient could be the exclusive and absolute base of the physician's actions. Today, the growing interdependence of all humans and the effectiveness of medical techniques have drastically altered the simplistic arrangements of the traditional ethics....

> This social dimension of ethics becomes even more immediate when we inquire into the responsibility of medicine for meeting the urgent sociomedical needs of large segments of our population. Can we absolve ourselves from responsibility for deficiencies in distribution, quality, and accessibility of even ordinary medical care for the poor, the uneducated, and the disenfranchised?....These are vexing questions of the utmost social concern. Physicians have an ethical responsibility to raise these questions and, in answering them, to work with the community to set priorities that makes optimal use of available medical skills. As T.S. Elliot puts it, "What life have you if you have not life together? There is not life that is not in community.[13]

Social justice requires a recognition that the common good must be the concern of every profession and business enterprise in a true community: profit, prestige and power being of lower priority than the common good. In the United States, if people recognize ethical responsibilities at all, they are usually so influenced by individualism that they are reluctant to consider the needs of others.[14] Being devoted to the common good is not a form of socialism. Promoting the common good promotes the good of individuals but in an equitable manner.[15] Many Americans analyze every suggestion concerning the common good and its ethical mandate in terms of the free enterprise system or the tyranny of socialism. The basis for seeking social justice and the common good is found the *Universal Declaration of Human Rights* issued by the United Nations in 1947.[16] Thus, working for the common good of the whole community insofar as health care is concerned is a responsibility of physicians as individuals and as a group. Specifically, physicians as a group have an ethical obligation to work for more equitable health care coverage in the United States. This responsibility devolves upon all the people in our nation but health care professionals bear the brunt of the responsibility because of their prominence in the field.[17] The best way to conceive of this added responsibility is to realize that fulfilling personal and social standards of ethical health care is not a matter of "either-or," rather it is a matter of "both-and." Hence realizing the needs for health care professionals to broaden their ethical vision to include the common good does not imply neglect of the individual or of the "grand tradition." Fulfilling the common good is designed to help individuals fulfill their personal goals in an equitable manner. If physicians as a profession fail to recognize this responsibility, their profession will be considered nothing more than another method of manipulating the public.[18]

2. The second challenge to the traditional ethics is found in society

itself: I refer to the movement known as post-modernism. As one critic of post-modernism opines: "A new world view is emerging, a world view which calls into question all traditional notions of truth, structure and reality."[19] If this worldview continues to grow and is not abated or reversed, not only the traditional ethics of medicine will be destroyed, but also all semblances of common ethical standards for any community will be destroyed. For many of us the notion that there is not objective truth and no common notion of human purpose seems ludicrous, and yet that is the focal point of post-modernism. Jan Francois Lyotard, one of the more influential post-modernist authorities, describes it as "incredulity toward meta-narratives."[20] A meta-narrative common is a set of fundamental assumptions used to verify and relate our common values and experiences to everyday life. Patricia Waugh, another post-modernist writer informs us that meta-narratives have no coherence and are oppressive.[21] The responsibility of post-modernism is to deconstruct all worldviews so that one particular belief or approach is not truer than any other is. What constitutes truth is relative to the individual community. As indicated above, if post-modernism flourishes, health care ethics as well as all ethics will lose its meaning. Hence, it will be just as valid to deny informed consent as to grant it, depending upon the small community to which one belongs or depending upon the attitude of the health care professional. Depending upon the "ethics" of an individual physician or a small group of people, it will be just as ethical to terminate willfully and directly human life as it will be to promote health and fight disease. This is not the place to offer a thorough critique of post-modernism, others have done so.[22] But it is a place to call for common sense in the quest for ethical standards for health care. Human beings are free, and they share common needs, which give rise to common values and common ethical norms. These needs, values and ethical norms are founded in objective reality. Discerning these common needs, values and norms has never been as easy a task because of the complexity of human society and human weakness, but it is by affirming our commonality that we express the worth of our being; not by catering to individualism.

3. A third challenge to the traditional ethics of health care is the changes in health care arising from managed care. Managed care is often described as totally detrimental to patient-centered health care and to the patient-physician relationship because some practices of managed care revise the etiquette of health care as well as some practices assumed to be endemic to health care in the past. But the benefits of managed care must be admitted as well. As a frequent critic of managed care has stated:

> The inherent virtues of managed care have manifested themselves

> in many salutary improvements to the system that might otherwise never have been made. Those include attempts to eliminate waste and redundancy, a greater focus on health promotion and disease prevention, more attention to the management of chronic diseases, a focus on accountability of physicians and health plans on the quality of care, lower hospitalization rates without an obvious decline in the quality of care, heavy investment in patient information systems and control of employer health care costs.[23]

Thus, the limitation of choice in regard to physicians, the capitation of patients as opposed to fee-for-service plans, emphasis upon preventive medicine, the transfer from hospital to out-patient facilities of many medical and surgical procedures, do not of themselves weaken or displace the traditional ethics of medicine. The patient-physician relationship and the needs of individual patients can be fulfilled in a system designed to reduce costs and eliminate overcare from the health care system. A critical look at the excesses of health care provisions in the 1980s indicate the ethical validity of a radical shakedown in attitude and practice.

However, one characteristic of many contemporary managed care programs does thwart and destroy the practice of traditional health care ethics. That characteristic is the for-profit investor-owned nature of many health care corporations. In a health care corporation of this type the principal and ultimate goal of the corporation and the people in it is to make a profit for investors. Other intermediate goals such as physician competency or patient care may be expressed as important in the life of the corporation but they are not the ultimate goals. All investor-owned for-profit corporations pay lip service to the traditional medical ethics, but by reason of the nature of the entity, ethics are subservient to profit. To put it another way, quality health care is a means to making money, not the ultimate goal of the corporation. In human affairs we can direct our activity to only one ultimate goal. Jesus expressed this by telling us that "no one can serve two masters." Uwe Reinhardt (whether influenced by Jesus I know not) states the same idea this way: "The mandate of for-profit hospitals is to maximize shareholder wealth without violating the law of the land. I do not like to hear for-profit hospitals prattle about charity care. You cannot count on it. This is not their mission and they will abandon it if the bottom line demands."[24]

The recent exposure of illegal activity on the part of investor-owned health care corporations are not surprising.[25] In the business world, laws do not limit unethical activity because laws in our society no longer speak to the conscience of the administrators. The "ethical" question is no longer "Am I breaking the law", but rather "If I break the law, will the

penalty cost more that the profit made by breaking the law?" When profit for investors becomes the ultimate goal of health care professionals and business leaders, then other goals become expendable because they are no longer at the heart of the health care endeavor. This is true of every human endeavor; if making money becomes the goal of the endeavor, then other values are sacrificed. The perversion of traditional health care ethics, which results from investor-owned corporations, weakens and eventually destroys trust, the fundamental substructure of any physician-patient relationship between provider and patient. If you are caring for me mainly because you are making a profit, I will soon surmise that my overall well-being is less important to you than your profit. I realize that in the present day practice of medicine that profit is a predominant and necessary consideration, but it is the ultimate goal for only a small percentage of persons involved at the various levels of health care. The more that percentage increases, the less likely is the "grand tradition" to perdure. In sum, the for-profit health care corporation endangers the traditional ethics of health care. This disturbing thing about health care today is that not-for-profit corporations often imitate the activities of for-profit entities. Their surplus increases and their charity care decreases.[26] While in theory the difference between not-for-profit and for-profit corporations is quite clear, in practice the difference often is not noticeable.

III. Can the Traditional Ethics Survive?

I mentioned before that the "grand tradition" has often been opposed. I look to "survival" as more than lip service to an outmoded ideal; rather, I would state the "grand tradition" should be conceived of as a set of living values and principles that are fostered and protected by the medical profession itself. These basic principles are akin to the constitution of the United States as a fundamental basis for decision making by the Supreme Court. Thus, in an application of the "grand tradition" to particular cases there may well be a difference of opinion, but there would be no doubt about the core values of the medical profession itself.

In order to protect the "grand tradition," as the identity trait of the health care profession and indeed to dispose for its development further, I propose the following initiatives:

Initiative 1.

Influential individuals and organizations must realize that honoring and living the "grand tradition" gives health care its meaning and fulfillment. These leaders must protect and propagate the "grand tradition."

As mentioned previously the basic principles of the traditional ethics arise from the very nature of the physician-patient relationship. If one is to function ethically as a health care professional, at any level of the profession, one must accept these principles and apply them in accord with one's position on the health care team. In other words, the ethical standards of health care must be accepted as objective norms, as firm and meaningful as the principles of biochemistry or hematology. We admit the core values of medical practice are more difficult to utilize than physical sciences because of the innumerably diverse situations to which they must be applied and the variable circumstances surrounding their application.

While the leaders of the AMA or the National Institutes of Health are often considered the leaders of the medical profession, I believe that the VPs, deans and chairmen of departments in medical schools are much more significant. If these persons speak out to insist decisively that the "grand tradition" is at the heart of medical education, residency and practice, then the continuance of the "grand tradition" is possible. Certainly the type of emphasis I suggest requires more than reciting the *Hippocratic Oath* at the time of graduation. It will require a consistent emphasis upon the specific ethical standards mentioned above and their application. Because of its emphasis upon competence, the traditional ethics is not soft science, rather it requires a comprehensive knowledge of human physiology and psychology and the techniques to apply this knowledge effectively.

How is this conviction concerning the importance of the traditional ethic to be communicated to the health care community? Fifteen years ago, Peters and Waterman wrote *In Search of Excellence* and questioned how core values are communicated to people in the business world.[27] Their conclusions apply to the profession of medicine as well.

a) "Figure out your value system; what are the basic beliefs and overriding values; what gives you the most pride; put yourself ten or twenty years in the future; what would you look back on with greatest satisfaction?" (p.279)

b) "Values are not usually transmitted through formal written procedures. They are often more diffused through more subtle means; specifically through stories, myths, and metaphors (p. 282-283), and by the adherence to values by leaders at all levels of organization." (p. 287)

c) "Be convinced that profit is a natural by-product of doing something well, not an end in itself. This is almost a universal trait of successful organizations." (p. 289)

Just recently, another popular book outlining the path to success in business corporations, *Built to Last*, [28] has demonstrated that successful enterprises are more interested in service for the common good than in profits.

The problem of developing a value-centered culture has been analyzed and commented upon by social psychologists and business experts, yet I believe *In Search of Excellence* and *Built to Last* provide thorough theory and examples pertaining to this quest. Applying these lessons to medical schools and residency programs is not beyond the competence of our present leaders. But they will have to *revise their priorities* in order to protect the heart and soul of the profession. They will have to insist upon personal conscience as the basis for making the "grand tradition" an integral part of the decision making process. Renewal in the formation of physicians will not result merely from curriculum renewal. It will require an emphasis on the traditional ethics, the aforementioned modern additions to this tradition, and the methods of instilling the "grand tradition" in the hearts and minds of health care professionals. There is simply too much money associated with the provision of health care to depend upon the law to bring about adherence to ethical norms.

Pellegrino maintains that periodic evaluation of competency also contributes to ethical development and is another effective method of sustaining a commitment to ethical medicine. "A profession sensitive to its ethical responsibilities cannot tolerate fading competence even for reasons (such as age or illness) beyond the physician's control."[29] The essential requirement is that the competence of each member of the profession of health care is the responsibility of all.

For those who do not respond to positive encouragement some negative strictures are needed. In this regard medicine has been reluctant to discipline its own. Should medical discipline boards be composed only of physicians as, for the most part, they are now? The discipline of priests was enhanced immeasurably when lay people were added to groups analyzing complaints against sexual aberrance on the part of the clergy.

Initiative 2.

A second imperative for fostering and developing the "grand tradition" is the rejection of the investor-owned health care corporations. There is need for severe changes in the provision of health care. All agree on this. But it is only by insisting that the ultimate goal of health care is the benefit of individual patients and that this benefit should be available to those unable to pay for it, will the profession retain its meaning and focus. There is not time in this paper to develop the theoretical arguments against investor-owned health care enterprises; the late Cardinal Bernardin and

others have expressed eloquently the main arguments against investor-owned health care corporations.[30] But let me point out that even investor-owned health care corporations say they will care for the poor. Thus, they acknowledge the need of care for the poor but set up a system, which is diametrically opposed to care for the poor. The activities of Columbia HCA have demonstrated the validity of these arguments. Clearly, when profit dominates a person-centered enterprise a perversion of value occurs. Let us not be led astray by belief that the free market system will solve our problems. The free market never cares for the poor, underprivileged or aging. We must remember that there are some human goods that are beyond price; they will never be achieved as a result of the free market system.

Conclusion

Is there solid hope that the traditional ethics of medicine with its needed additions will survive into future generations of health care professionals? Not without a renewal of effort on the part of the leaders of the profession. Certainly there will always be a "faithful remnant" who preserve the "grand tradition." But for the "grand tradition" to flourish in the future and predominate in the profession of health care, I believe that a rebirth of ethical awareness and commitment is necessary in the profession of health care.

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