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The Goal of Therapy

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Most physicians begin practice with a lofty therapeutic ideal which is gradually eroded by compromise, rationalization, and the demands of reality. How much erosion occurs seems highly variable from one physician to the next and from one therapeutic experience to another.

When I was asked to make this presentation, I began to appraise my own therapeutic goals and recognize their variability from time to time and patient to patient. I have begun to come to grips with some of my own compromises and rationalization techniques as reality tempers idealism.

During the preparation of this presentation, I have interviewed several physicians and patients regarding their therapeutic goal concepts. These interviews have brought to light a rather remarkable diversity of expectation.

A rather disturbing factor which became apparent during the interview process was the rather judgmental authoritarian role assumed by many physicians. This physician role assumption often engenders anger and frustration in patients. These patients are then made to feel dependent and helpless by their relative ignorance of their own health condition. They often continue in a frustrating and unsatisfactory therapeutic physician-patient relationship rather than hazard the rejection or abandonment which might result from their expressions of dissatisfaction. Either they will follow orders or pretend to do so in an attitude of troubled but quiescent conformity.

I believe it is a valid assumption that patient negativity militates against the mutually held goal of optimal health. Therefore, this type of relationship is self-defeating, to some extent, in every case.

The existence of these facts requires that the dedicated and ethical physician assume a posture of continuing self-appraisal as well as continuing evaluation of patient response to therapy. The physician must be constantly observing and reaching for subtle signs of patient dissatisfaction, frustration, and bewilderment.

The goal of therapy: the physician's perspective. Before describing my personal therapeutic goals, I should like briefly to describe some of the events which led to their formulation.

My first experience in patient care was as a "medic" in the US Coast Guard. We were intensively trained in "crisis intervention" medicine. The total experience was disease- and injury-oriented, frequently in life-and-death situations. Gradually, irrepressible questions began to arise regarding this simplistic approach to the treatment of patients/diseases. Questions such as "What makes one patient regain health while another does not?" were largely ignored and evaded by the military medical establishment of that generation (the 1950s).

The teaching was that the patient could only regain health if we took the proper steps to "kill the disease" or "correct the injury." Self-healing abilities were not even considered. To question this philosophy was tantamount to blasphemy. However, it became apparent to me that human biological systems do indeed possess

some "mysterious powers which enable people to heal themselves."

It was this irrefutable observation which ultimately led me to the Kirksville College of Osteopathic Medicine and to Fellowship in the American Academy of Osteopathy.

During my years at Kirksville, I became a teaching fellow in biochemistry under the tutelage of Stacey F. Howell, PhD. Dr Howell convinced me that every clinical disease or syndrome must have an underlying molecular lesion. The most effective therapeutic efforts must necessarily be aimed at the primary molecular dysfunction. He insisted that the physician's basic duty is to uncover the molecular lesion and to determine its cause. The causes of molecular dysfunction might be internal or external; they might be physical, chemical, nutritional, genetic, stress-induced or whatever; in any case, the biochemical lesion cause must be identified before treatment can be intelligently instituted. All other forms of treatment represented to Dr Howell a degree of compromise and were evidence in favor of physician failure and/or ignorance on the part of medical science.

Philosophically, Dr Howell was truly osteopathic. He felt that bodily ills will correct themselves once the causes for molecular dysfunction are favorably modified. Dr Howell's goal of therapy was always correction of the cause of molecular dysfunction so that the human body may heal itself.

For a time, it was difficult to envision how osteopathic manipulative treatment could favorably influence molecular function. Dr I.M. Korr, who advocated the favorable influence upon homeostatic mechanisms of manipulative therapy, made this synthesis possible for me. Dr Korr has illuminated mechanisms whereby osteopathic manipulative procedures can and, do favorably influence autonomic nervous (as well as all nervous) system functions. Armed with these concepts, it becomes a simple task to conceptualize the improvement of molecular lesions via the nervous system as a result of osteopathic manipulative treatment.

Once out into the real world of private practice, it became apparent that identification of the "molecular lesion" was not always possible. It also became apparent that the "hands on" manipulative approach did several things. I did not understand these things, but they were all good.

Touching the patient during the application of osteopathic manipulative diagnosis and treatment:

1. Rapidly establishes a highly desirable level of rapport between patient and physician;
2. Provides the physician time to ponder the patient's situation without appearing puzzled or confused;
3. Improves the physician's palpatory skills, thus facilitating the more accurate and rapid physical diagnosis of visceral problems as well as a more concise evaluation of the extent and seriousness of injuries;
4. Gives more and more information regarding the patient's general health and emotional status as the physician's skills are sharpened by experience;
5. Provides an excellent modality whereby neuromusculoskeletal system problems can be diagnosed and treated, be they primary or manifestations of other disease processes;
6. Provides a basis for the evaluation of treatment effect and for prognosis;
7. With experience, gives the physician increased confidence in the correctness of his or her evaluation of the patient's condition, thereby reducing physician self-doubt, anxiety, and stress;
8. Somehow improves the patient's ability to become healthy and stay that way in a holistic sense.

Medical science has the most difficulty accepting this last statement. "How can osteopathic manipulative treatment improve the general health of the patient?" "What is general health?" "What is resistance to disease?" We don't know. These questions conjure up different answers and images for all of us. However, we have all seen the results of varying levels of general health and resistance in humans, animals, and plants. Last spring I attended a meeting of a group of farmers. Slides were shown of corn plants on an experimental farm. These plants were made healthier by the proper administration of trace minerals. The yield per acre was greatly increased by this improved nutrition. No insecticides were used. The corn was healthy. It resisted disease and insect infestation, and it even overgrew the weeds. Herbicides were not required. What is this mysterious power that healthy corn plants possess which protects them from diseases? Is it general health, resistance? We cannot scientifically define it as yet, but the effects of its presence seem obvious.

On educational television in East Lansing recently, there was a program which covered the effects of speaking kindly to plants. An astonishing phenomenon occurred. The plants which were gently asked to grow did so at about twice the rate of the plants which were asked not to grow. The plants were grown in glass compartments so that even the carbon dioxide exhaled by the speaker was ruled out as a variable. The experiments were repeated several times always with the same result. Science is presently at a loss to explain this phenomenon. However, both of the above examples strongly suggest that many as yet unknown factors are at work in growth, health, and resistance to disease.

A search of the literature will reveal many more examples similar to those given. I would simply pose the questions: "Does touching the patient in a gentle caring way contribute to the positive physiological effect of treatment?" "Is some of the beneficial effect of osteopathic manipulative care imparted by the necessity to touch the patient?" "Does this touch communicate to the patient some of the same positive effect as does speaking to the plants?"

Recently, I attended a conference in Boston devoted to "holistic" medicine. The well known and highly respected microbiologist Rene Dubos was one of the principal speakers. Dr Dubos, after years of study and research, clearly stated the conviction that the future of health care is in the treatment of patients rather than diseases. He now firmly believes that certain unknown phenomena related to general health and resistance can produce recovery from insult or disease, and that the presence of a pathogenic microbe is to be regarded as a symptom of a physiological malfunction or weakness in the human body. Dr Dubos no longer feels that pathogenic microorganisms cause disease in healthy bodies, but that the pathogens are opportunists taking advantage of biological systems which are in less than optimal condition. The obvious conclusion to be drawn from these remarks is that human beings possess remarkable inherent powers for health and recovery.

Physicians must learn to do things to patients which will enhance the levels of good health and concern themselves less with specific disease processes. I believe osteopathic physicians who use their hands in therapeutic endeavors do exactly that. Dr Dubos' stated convictions are well tuned to the osteopathic philosophy.

Delores Kreiger, RN, PhD, was also a speaker at this fascinating symposium. Dr Kreiger is the originator of the "therapeutic touch" techniques used by an increasing number of nurses across the country. She is on the faculty at New York University and teaches a graduate level course in "therapeutic touch" to

registered nurses. She has trained over 2,000 RNs in these techniques to date. Dr Kreiger has done some controlled clinical studies which show elevation of leukocyte count, reduction of fever, improved sensory perception, and a heightening of subjective well-being as a result of her "therapeutic touch." Dr Kreiger's technique simply involves placing her hands on the patient at some strategic location and literally "willing" a general physiological improvement without the use of words. Her cue that the technique has been effective is a relaxation of the respiratory effort with a reduction of rate followed by a sigh, a general flushing of the complexion, a generalized relaxation of tissue tonus, and a barely perceptible fine perspiration. She states that if these physiological changes occur, the patients will almost invariably remark that they feel better. This physiological change described by Dr Kreiger sounds remarkably like the "still point" described in cranial osteopathy. Recently, Dr Kreiger has found that her hands need not be applied directly to the patient's skin, but that her "therapeutic touch" can be effective through several layers of clothing.

Over 5,000 years ago, the Yellow Emperor of China, in his *Handbook of Internal Medicine*, stated that all disease was the result of an imbalance of vital life energies. The whole of traditional Chinese medicine, which included acupuncture, herbs, diet, alleviation of stress, moderation of life-style excesses, and, yes, manipulative therapy, was aimed at the return to health by the correction of imbalances of these vital life energies. Physicians were compensated only while their patients remained in good health. Illness was considered due to physician failure. Ill patients were treated by their physicians at no charge. One might say that this situation motivated physicians to keep patients well, but since patients had to pay only while they were well, I wonder if this did not motivate psychosomatic illness in some patients. In any case, it is obvious that in 3000 BC the Chinese recognized what Dr Dubos has recently become convinced of, what Dr Kreiger has been teaching at NYU, and what caused Andrew Taylor Still to found osteopathy.

Even Louis Pasteur, a well-recognized principal in the microbial theory of disease, observed that there was a factor of general health or resistance which determined those patients who would be taken ill and, when ill, which would recover.

Osteopathic experience supports the tenet that "hands on" manipulative therapy does, indeed, facilitate the human ability to regain and maintain general health and resistance. Restoration of motion is the general goal of most manipulative technique.

Mobile patients seldom get sick. It would also seem that patients who are touched by caring hands do better than patients who do not receive this attention. Therefore, one might say that osteopathic manipulative treatment not only corrects specific somatic dysfunctions and mobilizes, it can also afford the benefits of "therapeutic touch." I wonder if "therapeutic touch" does, in fact, mobilize.

The above rather diverse examples and opinions suggest that caring and compassion are beneficial to all living systems. Computerized and scientific diagnostics and therapeutics largely omit the benefits obtained by patients from the sense that the physician cares what happens to them. These benefits would seem to be truly physiologic rather than purely psychologic (if there is such a thing as "purely psychologic").

The physician's therapeutic goals are frequently quite divergent from those expectations of benefit held by patients; only communication between these two principals can resolve this discrepancy and create mutual understanding.

After interviewing over 20 physicians from rather diverse backgrounds and areas of practice, I should like to share with you some of their summarized statements which I feel are representative of the different points of view.

A rather typical answer to my inquiry regarding the goal of therapy was to make the patient feel better first, and then to discover the cause, if possible, but in any case to continue whatever therapy made the patient respond the best and feel as well as possible. Further questioning revealed that these physicians were typically more or less willing to continue symptomatic and palliative treatment while procrastinating in the search for the true etiology. These physicians were usually too busy to render more than superficial care. Improving health and patient education seldom were given serious consideration. They all practiced under the DO license; however, adherence to the microbial theory of disease seemed the rule rather than the exception.

Another rather popular answer was the "prevention of disease." These physicians usually thought more deeply, but most considered disease prevention in terms of nutrition, vaccines, and exercise programs. Concepts of general health and general resistance ranged from in-depth and very detailed to quite vague. Most would rely, to a greater or lesser extent, upon external agents and devices to protect the patient. This group also included several physicians who commonly prescribe antibiotics in order to prevent infection.

A smaller group of physicians, most of whom are oriented toward manipulative therapy, usually quite emphatically talked about treating the patient and not the disease. Some of the descriptions included such phrases as "improve physiological resiliency" and "the restoration of maximal physiological and functional capacity with mandatory patient participation." This group was much more considerate of the importance of good health and musculoskeletal mobility, but few of them were very concerned with the understanding of patient expectation.

There was a very small minority of physicians who immediately and spontaneously discussed the patient's needs, feelings, and expectations. One of this group would work out a problem list with the patient, and assign and negotiate which problems would receive attention and in what chronological order. This same physician emphatically stated that of primary importance was a relationship which allowed the physician to confess his ignorance and say "I don't know" *pro renata*.

Another of this group stated that it was his habit to discuss a problem list, the therapeutic approach, and expectations for outcome on the first visit and before embarking in a therapeutic program. If he and the patient could not come to a mutually acceptable treatment plan, there were no further visits. In my opinion, this approach may not serve those patients who might benefit from gentle persuasion and education. Its efficacy depends a great deal on the patient's sophistication and previous education.

There are three physician responses which were uniquely stated and which I feel are worthy of passing on to you at this time.

The first of these describes an improvement of the inherent strength of each patient by mobilizing each articulation of the body. The concept is that each disease, dysfunction, or physiological weakness has its correlate in a specific joint immobility. The returning of all joints to normal mobility is all that can be done. This physician has tremendous faith in the healing power and homeostatic mechanisms of the human organism.

The second of these three physicians attempts to discover the external counterpart for each complaint or physiological dysfunction. His goal of therapy is to educate the patient regarding the internal and external correlates, to assist the patient in the modification of the disturbing factors, and, ultimately, to achieve patient acceptance of responsibility for the favorable modification of all identified disturbing factors.

The third of these physicians gave perhaps the most well-rounded therapeutic goal description I encountered. He gives serious consideration to his own concepts and abilities as well as to patient expectation, education, and the assumption of responsibility for self-help. First, he would gain patient confidence, then he would attempt to convert all negative patient feelings to positive, attempt to make the patient as comfortable as possible, treat his own findings as they are discovered, induce patient understanding of the problems and their causes, and finally gain patient acceptance of responsibility for a fair share in the therapeutic endeavor.

It is only fair at this juncture that I attempt to describe my own therapeutic goal concepts. Ultimately, I would attempt to achieve, by any means possible, complete physiological freedom to move for all body components. This includes such gross structures as bones, joints, muscles, connective tissues and viscera, as well as all body fluids through all membranes and compartmental boundaries. Microscopic and submicroscopic particles and energy parcels should all be free to move as the body and its homeostatic mechanisms direct. I cannot attempt in good conscience to direct any of these movements, but only to improve their freedom of mobility. I am, at the present time, firmly convinced that the key to good health and to the adaptive qualities of resistance is free mobility so that all body mechanisms are readily able to respond optimally to both internally and externally induced stresses, insults, and perturbations. I do not recognize the physiologic and psychologic as separable.

I recognize that this ideal goal is perhaps seldom, if ever, achieved; but for myself, an attainable goal leads to complacency, which I consider as one of the deadly sins.

This desirable state of mobile freedom cannot be achieved in the presence of self-destructive patient feeling or action, nor can it occur when pain and/or fear are paralyzing a portion of the physiology. Requisite to working toward this ideal goal is complete patient cooperation and mutual understanding between patient and physician. Therefore, maximal patient comfort and positive feelings are mandatory.

I firmly advocate flexible compromise, as needed, on the part of the physician early in the therapeutic endeavor. However, no matter how remote the goal seems in the beginning, nor how severe the compromise, the ideal goal must always be retained at some level of physician consciousness.

In practice, I have extensively used a wide spectrum of therapeutic modalities in working toward the ideal goal. These modalities include such acceptable approaches as pharmacotherapy and surgery, and such controversial approaches as acupuncture and hypnosis. Through these experiences I have finally discovered that I am most comfortable using my hands in the osteopathic manipulative approach, and more specifically in using the craniosacral approach to the whole body for the diagnosis, treatment, and progress-evaluation of the patient. Other therapeutic modalities are used largely as enabling measures (or symbols of treatment), all of which are intended to move toward body mobility. Mandatory in the use of this approach is the firm belief that the human body will respond the most effective and efficient way, given the freedom to move.

These remarks clearly point to the fact that physicians' goals are widely variable and do indeed reflect the basis for some of the internal disagreement within our own profession.

It is at this juncture that I feel obligated to identify some of the negative physician goals which, from past observations, are unmistakably present and which have been identified, either explicitly or implicitly, during several of the patient interviews.

A significant number of physicians "need to be needed." In order to fulfill this need, they consciously or unconsciously create patient dependence. This personality quirk can insidiously develop and become part of our motivation as practicing physicians. We must all be continually alert to the danger that this neurotic need may creep into our lives and influence our judgment. It is most likely to happen when we begin to believe our own "press notices." It will cause us to encourage excessive utilization of medical care and facilities and to use subtle scare tactics with patients rather than encourage the patient to learn techniques of self-help, so that they can gain command of their own situations.

A far worse negative goal of therapy is the creation of patient dependence for purposes of financial gain by the physician. A population of uninformed and fearful chronically dependent patients, who believe that their physician is "keeping them going" or "alive," offer a very comfortable level of financial security to the parasitic and unethical physician. I am sorry to say that I have seen this type of physician in action more often than I care to admit.

In either of the above cases, the patient is victimized physiologically, emotionally, and financially.

In order to restore your optimism following that unpleasant note, I would like to quote the answers of an ex-director of a free clinic who will enter MSU-COM shortly as an osteopathic student. I asked her about her goals for the patients while serving as director of the free clinic. I know her statements to be true because I observed her actions in dealing with thousands of pleas for help over a four-year period of time. Her responses were three:

1. Let the patient know someone cares;
2. Help the patient feel better;
3. Improve the patient's health and living standards wherever possible.

Perhaps we could all take a lesson from this kind and compassionate person.

The goal of therapy: the patient's perspective. Over 50 patients were interviewed during the preparation of this presentation. The responses reflect a wide variety of expectations from the therapeutic endeavor. They also reflect some futile hopes by patients who continue to try but who are fighting cynicism with more or less success. Some of these patients are my own; some are under the care of other physicians. The reason for this selection of patient interviewees is to deal at least partially with the fact that specific patient types will seek out and/or remain with specific types of physicians.

A few major points emerged from these interviews which I shall attempt to summarize accurately for you.

1. Relief of severe pain is always an important consideration. Patients often would prefer to be rational, but find it difficult when in acute or chronic unrelenting pain.

2. A majority of patients interviewed want an understanding of the health problems which they are enduring. They would like insight into the cause and the prognosis.

They are often frustrated in their attempts to gain this understanding.

3. Most patients are eager to accept some responsibility for their own health, but they are fearful of doing the wrong thing. They have been made to feel incapable and clumsy by their experiences with our health care delivery system.

4. Most patients can accept pain if they understand why they have it. They are frequently willing to work out acceptable programs which will allow them to return to the mainstream of life if they can achieve moderate comfort and at the same time retain good intellectual function.

5. Most terminal patients seem to accept their condition. They would prefer quiet death with dignity, provided the fear of great pain (beyond their tolerance) is allayed. A few terminal patients were very afraid of death and wanted as many days of life as possible. The great majority of terminal patients want to know and understand their situations. Uncertainty seems less desirable than knowing that life on this earth soon will end.

6. A significant number of patients felt that physicians deliberately created dependence by holding back information and education, either for financial gain, or for other obscure reasons.

7. A significant number of patients felt their physician to be arrogant and devoid of respect and compassion for them as patients. They expressed feelings of resentment during the interviews, but usually were afraid to take action. I believe this type of patient/physician relationship is responsible for the initiation of many lawsuits.

Once again, the fact comes through that patient desires, needs, and expectations are markedly variable. The desirability of mutual understanding and agreement upon the goals of therapy between patients and physicians is apparent. This understanding can be achieved only by open, honest discussion between the parties involved. A mutually acceptable program is essential for the best result. No physician has the right to impose his or her preconceived notions of what is good for the patient upon the patient without true, informed consent and, hopefully, eventual enthusiastic agreement.

It is true that the physician usually possesses a better knowledge of the physiological dysfunction and a better understanding of the possible therapeutic results than does the patient. This circumstance only means that the physician has invested time and effort in the study of the biological sciences. It does not mean that the physician has the right to judge and mandate what is best for the patient as a whole person, a family member, a member of the community, a citizen, and a provider. The patient has a right to understanding and information so that the best goals can be mutually agreed upon and set.

A rigid physician with fixed therapeutic programs and goals has accomplished little when an angered or frustrated patient either refuses his treatment or quietly submits to a program of treatment that has little meaning to him or her as the patient.

I recall (as a new physician) the vitamin B-12 fad. I had many senior citizens who wanted injections of this vitamin for no reason that I could justify. I spent hours delivering lectures on the "true" indications for vitamin B-12 injections. I angered many patients who left my office bewildered and disappointed (without having received the B-12 shot). These people probably got their injections elsewhere. Slowly, I began to realize that one of the "true" indications for vitamin B-12 might be simply the faith of the patient in the treatment. Gradually, I began to realize that I could bargain with these patients. I administered the injection of vitamin B-12, if they would let me

do something that I believed would help them. This approach worked fine. Gradually the requests for B-12 began to diminish. Certainly, this therapy began as a compromise of my ethics, but it established rapport. The result usually was patient satisfaction and benefit. Therefore, there was no compromise in the holistic sense (although third party carriers might not agree).

Now I will further incriminate myself as a physician of compromised ethics: one who has at times gambled that the ends would justify the means. This particular experience occurred while I was rather deeply involved in the treatment of heroin addiction through the Clearwater Free Clinic. It was immediately prior to the beginning of the methadone treatment programs (with which I firmly disagree).

The heroin addict frequently has the program of treatment forced upon him by the legal authorities. There is no room for negotiation and little insight into patient needs or hopes. The rate of failure and recidivism was, and is, extremely high.

When no legal authority is involved, most heroin addicts are told by firm ethical physicians exactly the terms of treatment with little or no consideration for the addict's needs or expectations. Under these circumstances, the addict will usually reject the proposed treatment and simply disappear. No real service is rendered; however, the physician can congratulate himself for "doing the right thing."

After some negative experience in dealing with heroin addicts in this way, I began to recognize the almost certain guarantee of treatment failure which was implicit in my role as the authoritarian, judgmental, self-righteous, law-abiding physician. It began to dawn upon me that the addict, by his own or her very presence, was really asking for help. The plea was perhaps timid, tentative, full of suspicion, and frequently well camouflaged with bravado and/or pseudosophistication. However, in reality the addict wanted help but was very afraid of the conditions and circumstances surrounding the treatment. In fact, the addict was frequently afraid to relinquish control of his or her treatment program. I decided to compromise. First, I asked each addict to describe to me how we should proceed. We negotiated an agreement for a treatment plan (I must admit that the addicts almost invariably got the better of me during negotiations for the first few weeks of treatment). As mutual goals and trust gradually were established, I found that the addicts soon (voluntarily) began to place rather severe restrictions and demands upon themselves.

The most popular treatment was a withdrawal program of Dilaudid taken orally. The addict was allowed to negotiate his or her dosage. With this input into their own programs, approximately 70% were successfully withdrawn. We found at least 50% of these addicts to be reliable, resourceful, and trustworthy after withdrawal. Many of them continued voluntary work in the Free Clinic long after they were drug-free. Understand that the majority of our addicts were not from the ghetto but from upper- to lower-middle class homes. Most were either in high school or junior college. The successful treatment of a ghetto population may be an entirely different matter.

Recently, a student related to me her first experience in patient management. It took place at her preceptor's office. The patient was a moderately obese-middle-aged caucasian female who requested "diet pills." The student examined and quizzed the patient and found the real reason for the "diet pill" request was for the mood elevating effect. The patient had been recently widowed. "Diet pills" were the only thing that would keep her going. The student refused the request and the patient left in tears of anger. The preceptor congratulated the student for uncovering and thwarting this potential case of drug abuse. I simply asked this student, "Was the patient benefited by the visit?" "How do you know?"

Is this what the practice of health care is all about? Should a physician do the "right" thing at the expense of patient benefit? What of compassion? I do not advocate the misuse of harmful and/or addicting drugs. I do advocate compromise: in temporary and extenuating circumstances the ends do, indeed, justify the means. Rejected, angry patients are benefited minimally, if at all. They are frequently damaged by the experience. The temporary use of almost any modality is justified if it is used to gain trust, understanding, and rapport, or if it represents a symbol of treatment to the patient. I believe every patient is either overtly or covertly asking for help (even the addict who has come apparently to "rip you off"). Physician and patient can agree to disagree only after achieving mutual understanding upon rational ground.

Certainly, we have all experienced patient encounters wherein we are convinced that nothing positive can occur. Under these circumstances, the physician certainly should not attempt to be someone he is not. To do so would only result in unconscious rejection, error, and at least partial failure. Open discussion with the patient regarding these circumstances is the only ethical and effective way of handling the situation. The patient must be referred if the negative feelings persist after discussion. Only an egomaniacal, self-appointed deity will attempt to treat a patient whom he truly dislikes or disrespects.

Each physician must personally decide to what extent he or she is in the profession to serve the patient, and to what extent he or she is self-serving. Then the physician must decide the degree of compromise, with his or her personal goals and ethics, which is acceptable in order to meet patient needs and expectations. No one told you it would be easy. But remember, helping the patient is the real goal.

I shall now present for your consideration my own interpretation of the humanistic and realistic goals of the therapeutic encounter between the patient and the dedicated physician.

The goal of therapy is a realistic and acceptable compromise between patient expectation and physician ability. It must be flexible enough to accommodate change in expectation and ability as new diagnostic information is uncovered and therapeutic responses occur. The goal is, therefore, dynamic. It is the result of a continuing process of negotiation, education and discovery.

The intelligent identification and definition of each current goal requires:

1. Patient-physician rapport, understanding, and dialogue;
2. Patient recognition of the professional, ethical, and human limitations of the physician;
3. Accurate recognition and periodic rearrangement of priorities for the problems, with negotiation as needed;
4. Physician recognition and realistic appraisal of the etiologic internal and external factors (the physician must appreciate the patient's real ability to modify any, all, or none of these factors).
5. Patient education in etiologic factors (including their abilities to change these factors), in present health strengths and weaknesses, in the probable consequences, and in the realistic options.
6. Definition of patient and physician responsibility in the collaborative therapeutic endeavor, including identification of, and training in, self-help techniques.