I grew up in an apartment off my father’s 28-bed private surgical hospital in New London, Conn. My siblings and I—who awakened every morning to the smell of open-drop ether—all opted for careers in medicine. My sister became a registered nurse, my older brother a general surgeon, my younger brother a urologist, and I a general internist. I retired a decade ago but still volunteer during the summer at a free clinic in Maine and teach during the winter in the New Hampshire-Dartmouth Family Practice Residency in Concord, N.H. So I have a present-day perspective on both the care of underserved patients and the training of new doctors.

I have seen some amazing changes in the 50 years since my own medical training. When I was an intern, patients who’d had cataract surgery had to lie in bed for a week with sand bags keeping their heads from moving to prevent postop bleeding. Then they were fitted with “Coke-bottle” lenses that gave them little peripheral vision. Today, cataract surgery is done on an outpatient basis under local anesthesia, and patients commonly have 20/40 vision a few days postop.

Exploration: In the early 1960s, I got a call from the stepfather of one of our office nurses. He asked me to meet him in the emergency room with his unconscious daughter. She’d suffered a cerebral hemorrhage of our office nurses. He asked me to meet him in the emergency room where we needed more, not fewer, doctors—primary-care specialties—where we need more, not fewer, doctors—orthopaedics, and neurosurgery—and a human cost—damaging the trust that’s essential to a good doctor-patient relationship. In addition, this litigious environment impels doctors to order more tests to protect themselves from suits, further driving up costs.

Care: I could go on and on: The recent cloning of a human blastocyst in Korea threatens to open a scientific Pandora’s box. The barrage of drug ads on TV pushes patients to ask for fancy new pharmaceuticals, when older, cheaper drugs might serve just as well. The trend toward subspecialization is fragmenting our health-care system. The evolution of “boutique medicine” may make top-quality care available only to the well-to-do. Meanwhile, the U.S. still has some 40 million people without health insurance. And amidst all this, we face the menace of new diseases—HIV, SARS, avian flu, and mad cow.

But then I think about the eager young physicians to whom my generation has turned over the nation’s health. The residents I work with are too quick to go from a brief history and a cursory physical exam directly to an order for an MRI or some other sophisticated and expensive test. I urge medical schools nationwide to recruit more retired physicians to do clinical teaching, and my retired colleagues to offer their services to nearby schools. I shudder to think of the waste of valuable clinical experience when a retired physician spends all his or her time playing golf.

Trend: A change I welcome is the increase in the number of women entering medical school—now more than 50% in some schools. I feel they bring a valuable perspective to medicine. The only worrisome effect of this trend, in my observation, is the number of such women who marry fellow physicians (often in different specialties) and the difficulties they experience finding a community that can accommodate both of them. As a result, many of these well-trained women either take part-time positions or leave medicine altogether.

I worry, too, about the environment young doctors face once they’re out in practice. There are barriers today to developing the close doctor-patient relationships with which my generation was blessed. The HMO model now so prevalent pushes physicians (even in academic medical centers) to see more patients in less time—and you can’t develop a close relationship in a 10-minute visit.

Even more disheartening has been the explosion in malpractice suits. This has both financial effects—raising the premiums paid by all practitioners, especially those in emergency medicine, ob-gyn, orthopaedics, and neurosurgery—and a human cost—damaging the trust that’s essential to a good doctor-patient relationship. In addition, this litigious environment impels doctors to order more tests to protect themselves from suits, further driving up costs.

Care: I could go on and on: The recent cloning of a human blastosphere in Korea threatens to open a scientific Pandora’s box. The barrage of drug ads on TV pushes patients to ask for fancy new pharmaceuticals, when older, cheaper drugs might serve just as well. The trend toward subspecialization is fragmenting our health-care system. The evolution of “boutique medicine” may make top-quality care available only to the well-to-do. Meanwhile, the U.S. still has some 40 million people without health insurance. And amidst all this, we face the menace of new diseases—HIV, SARS, avian flu, and mad cow.

But then I remember how far we’ve come since the days of open-drop ether. I remind myself that I never regretted a single day of my career. And I think about the eager young physicians to whom my generation has turned over the nation’s health. Call me an idealist, but I’m sure some way will be found to fix what’s broken in the present, while preserving the best of the past.

As Dr. Steven Schroeder, former head of the Robert Wood Johnson Foundation, has put it: “Don’t let medicine lose its soul!”

The “Point of View” essay provides a personal perspective on some issue in medicine or science. Lena, a 1951 graduate of Dartmouth Medical School, practiced general internal medicine in Concord, N.H., from 1959 to 1995.