



Three decades
of service
in public health:

An interview with C. Everett Koop

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Author's note: I recently had the opportunity to interview former U.S. Surgeon General C. Everett Koop, MD, FACS, in his home in Hanover, NH. The house contains many photographs of him with presidents and policymakers, reflecting how much Dr. Koop has influenced public health decisions for nearly three decades. Dr. Koop's distinguished career in public service began at age 65 after an equally distinguished career as a pediatric surgeon. Today, at age 91, Dr. Koop continues to affect our nation's health care policies.

Dr. Koop's accomplishments are varied and impressive. Born in Brooklyn, NY, he attended Dartmouth College, received his medical degree from Cornell Medical College, and completed his postgraduate training at Boston Children's Hospital and the University of Pennsylvania School of Medicine where he received a doctor of science degree. Dr. Koop spent 39 years de-

voted to surgical care, serving as professor of pediatric surgery and professor of pediatrics at the University of Pennsylvania, as well as surgeon-in-chief at Children's Hospital of Philadelphia. His public service career began in 1981 when he became the Deputy Assistant Secretary for Health, followed quickly by his appointment as the U.S. Surgeon General, a position he held until 1989. Dr. Koop has been the recipient of many awards and honors, including the Public Health Service Distinguished Service Medal and the Presidential Medal of Freedom.

In the interview that follows, Dr. Koop focuses on his thoughts about the future of the nation's health care system and surgical care. He provides his thoughts about reforming our health care system, including defining the current challenges, roadblocks to avoid or overcome, and his thoughts for improving the system.

Most stakeholders agree that our current health care system is facing dramatic challenges. What do you see as the biggest hurdles we need to overcome in improving our nation's health care?

The first thing that comes to mind is the famous adage that the best health care in the world will not help unless you use it. We have the best health care in the world if you can access it, but we do not have the best health care system.

Before I move on, I should take a moment to note my biases, which are twofold. I was a surgeon, and we [surgeons] think differently and approach problems differently. Beyond that, I was a pediatric surgeon, which always slants my thoughts toward the needs of children. I believe that, as a nation, we are very free with our rhetoric about children's health but low on action. There are still children in our country who went to bed hungry last night and are part of a subset who have not seen a doctor in the last year. It is these same children who will likely not be able to gain access to the best health care in the world should they become sick. It is against this background that I do most of my thinking.

We have a saying in this country that "you shouldn't fix what isn't broken." Our health care system is broken. The current system is not really a health care system at all; it is a "sick care" system. We do not invest in keeping people healthy but instead wait until they become ill. Smoking is not the leading cause of death, but it is the leading cause of preventable death. The discrepancy in what we spend on preventing smoking-related disease and on caring for it is enormous. In our country, we have to change the way prevention is viewed to truly reform the health care system.

People need to understand that the choices they make before they turn 65 will greatly impact their life after 65. A focus on preventable disease can greatly enhance quality of life for seniors and reduce the cost of aging. I mention aging because [seniors are] becoming the largest cohort of our population. I would love to see the baby boomers who thought they would be forever bungee jumping and skydiving carry that same enthusiasm into becoming the elderly-well instead of the elderly-sick.

We have a terrible health care burden to bear

that has not struck people in their hearts and souls the way it eventually will. We hear all of the health care statistics but do not change our behavior. To continue with the smoking example, we know that globally a billion people will die a smoker's death in the 21st century. It is a staggering number that is not really being internalized. Suppose that the same statisticians announced that a billion people will die from terrorist attacks in this century. We would be willing to completely change our lives to avoid that tragedy. The significance of the health care problems has not sunk into our nation's psyche. We do not have a critical mass of people in trouble so that we are all compelled to take action.

I do believe that eventually there will be a critical mass of people who have such considerable access-to-care problems that the country will want to make significant changes. What I have learned from dealing with the public is that an event will come along and change the trajectory of public opinion on a given topic. That event will undoubtedly come in health care, and we must be flexible and ready to react.

Suppose you had the power to redesign the U.S. health care system. On the basis of what you have learned throughout your career, what characteristics would you include in the new system? What challenges would you address?

Whatever the future plan, it will be far better if it is a public-private partnership. It cannot be designed with the old "medicine rules all" philosophy or the government taking over with socialistic medical management. In addition, I do not think that all change has to be enacted through the legislature. I think a president who is impassioned about health care could have enormous impact on the system through Presidential Order or moral persuasion. That being said, there is no such thing as "Republican health" or "Democrat health"; there is only our nation's health, and that must remain the focus.

Health care should be universal. The person with the poorest financial background should be entitled to the same care a millionaire can receive. We may not be able to change [the circumstances that] made a person poverty-stricken, but by grace we should provide the equal care. Many people say that we should not be taking

care of those people who are not taking care of themselves. As an American, we do not have the right to health care granted by the Constitution or Bill of Rights, but I do believe that we have the moral right to care. I hope that thinking about care as a moral right makes people think about what role they should play in the system.

To get to some detail, the amount of paperwork that providers are asked to complete is daunting. I think there are 142 forms that can be filled out by a provider who has cared for an insured patient. A surgeon in Maine must have three office staff because of all the paperwork, while a surgeon in Canada might have one member of the office staff. The amount of money spent on administrative expenses for health care could be greatly reduced. I believe that this is an area in which the government could get involved and standardize the submission of information.

The overuse of diagnostic testing and therapies is a serious problem in our country. I am sad to say that I have sat in many hospital meetings as an outsider and listened to the medical staff being encouraged to use the laboratory more frequently because the fees are the difference between coming out in the red versus the black. We need a better understanding of what care is appropriate and why.

As an example, for your grandmother who is confined to a wheelchair because of her bad knees, there are options for her care. She could have steroid injections every few weeks to relieve her pain, or we could give her a new pair of titanium knee replacements. We can spend a few thousand dollars on steroid injections or we can spend \$100,000 for the surgery. We decide to go forward with the knee replacements, only to find out that she has neither the muscles nor the will to use them. This is to say that we have amazing technologies available to us in this country, but it is not always appropriate to use them. As providers, we stress the options available, but we do not stress the appropriateness of those options.

I would also institute a medical board to oversee health care. It would be composed of physicians, but also other health care stakeholders because they have a broader view of the system. The board would not have the authority to decide what care should be offered but would establish the gold standard for care. As an example, the

board would examine reasons why some specialties are overcrowded while others are shrinking and further examine if this is in the best interests of patient care. I would want to see this board protected from political influence. Perhaps it should be modeled after the Federal Reserve Board.

Federal health care spending continues to rise exponentially, with many policymakers looking for opportunities to slow that growth. What are your thoughts about the amount of spending on health care in the U.S.?

My earlier comments can serve as evidence, but my answer is that we are spending more money than the results would justify. There are many places to trim spending without reducing quality. However, we will have to make compromises, and compromises always hurt somebody. That is a hard path for legislators to go down.

As policymakers search for methods to curb spending and growth, many point to the lack of research that clearly defines proper care. Do you think we should be spending additional dollars on research?

I think research pays off, but research is another area in which aspects could be corrected. I do not think that researchers are out to fleece the government, but as with many facets of health care, [the researchers] are entering a system in which money is customarily wasted so there is little guilt. There are plenty of research projects that we all hear about for which it is hard, by any stretch of the imagination, to see how they are improving human welfare. There is money wasted in research, and we could be getting more for our current research dollar.

In a recent presentation, you talked about your concerns regarding changes in the doctor-patient relationship. Could you talk a little about that now?

I think one of the most sacred things in medicine is the relationship between doctor and patient. That relationship has been talked and written about since the days of Hippocrates. I have given hundreds of lectures about the doctor-patient relationship because I think it inspires medicine to continue and evolve over the gen-

erations. It is this relationship that encourages people to act compassionately and in the best interests of society instead of for personal aggrandizement.

Having said that, I am disappointed that the doctor-patient relationship has waned. I am very upset when I have patients come to me and tell me stories that smack of arrogance by the physician. My current position allows me to do quite a bit of traveling, and I have the opportunity to talk to both patients and physicians. When I talk to patients, they say, "You know, Dr. Koop, the whole thing that is wrong with our health system is that medicine has become a business instead of a profession." And then I will be at a medical school talking to the faculty, and they will say, "One of the problems we have is that we don't treat each other the way we used to. I wonder if we couldn't find a way to sharpen our sensitivity to the way we interact?"

It is clear to me that both sides are feeling the same problems. My fear is that as older physicians who remember a closer doctor-patient relationship retire, they will be replaced with physicians who have their eye on the business aspect of care. As much as we talk about the relationship and have regular training programs, it seems to be an area in which we have to continually be educating ourselves just to keep the relationship at a functional level.

Professional liability is a major concern for surgeons in the current health care environment. Do you have any thoughts as to how the current system could be reformed?

I began practicing medicine in a very nonlitigious time, but ended in the middle of the legal environment we live in now. When I ended my clinical practice, I was paying roughly a quarter of a million dollars a year in malpractice insurance. The policy I bought when I started my practice, the same year that I joined the American College of Surgeons, was \$15/year. Of course, it had limitations, including no more than \$1,000 paid out per incident with a total limit of \$5,000.

Part of the solution is patient education, specifically around the fact that many things that happen to patients are uncontrollable and do not represent negligence on the part of their physician. I think as patients learn more about

medicine, it makes them better patients in some respects and more dangerous in others as they know a little and assume a lot.

When I talked earlier about the fading doctor-patient relationship, I was really talking about the roots of the problems that lead to malpractice. There is nobody that has better control over malpractice than the physician. The skills that lead to success also lead to arrogance, which leads to malpractice cases.

How do you think professional organizations such as the American College of Surgeons could be most beneficial to health care?

I think the important function of these organizations is the leadership symposia they provide. This allows knowledge to pass down through the generations of surgeons. It is important for new members to understand what sacrifices it took to get the profession to its current position.

Dr. Koop resides in Hanover, NH, and is the senior scholar of the C. Everett Koop Institute at Dartmouth College. The mission of the Institute is to promote the health and well-being of all people. For more information on the C. Everett Koop Institute, visit <http://dms.dartmouth.edu/koop/>. For more information on Dr. Koop's papers and presentations, visit <http://profiles.nlm.nih.gov/qq/>. □