

National health policies for improving the care of the surgical patient

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Dr. Mahorner, Fellows of the College and Guests:

The privilege of addressing the Fellowship on this occasion has been, by tradition, the special prerogative of the President. It is a once in a lifetime opportunity to which each has dedicated himself with all his energies. When I read the inaugural addresses of my predecessors, I can hear the sound of their voices. In every instance they have the ring of sincerity and reverberate with the high purposes with which their professional pursuits and their personal lives have been imbued. Collectively these statements reflect the history of the College and many of its aspirations. Some have been addressed especially to the new Fellows just inducted; others to the entire Fellowship. My own remarks are intended for you as Fellows, rather than as Initiates.

We are obviously in the midst of immense social changes, which are affecting many parts of our society. The traditional patterns of our own professional lives will be affected by these changes in a variety of ways.

Awareness of these changes led Dr. Preston A. Wade to call a planning conference at Oakbrook, Illinois in 1966, which in turn led to the establishment of a Committee of Surgical Services under the chairmanship of Dr. Robert M. Zollinger in 1966. This committee organized a major conference in Chicago May 28, 1967 which was addressed by Dr. Phillip Lee and other government representatives.

In the past five years the critical discussions at meetings of the Board of Regents, and I believe also at the Board of Governors, have focused increasingly on the needs felt by America for new programs of health care. A second

planning meeting was held in Phoenix, Arizona in 1968. In July, 1970 a study of surgical services was undertaken by a committee headed by our then first vice president, Dr. Francis D. Moore. This group joined forces with a similar committee of the American Surgical Association, appointed by Dr. William D. Holden to conduct the Study on Surgical Services for the United States (SOSSUS) with the aim of providing facts for decisions which are in the process of being made in Washington. Dr. George D. Zuidema serves as chairman of the joint study.

Because of the very real possibility that Congress will launch legislation in this current session, and reach a series of decisions prior to acquisition of these facts, a subcommittee on pending legislation was formed in May, 1971 under the chairmanship of Dr. William A. Altemeier. This committee may have to speak for the College when certain of the pending bills come up for hearings. Obviously this is a heavy responsibility, as it is never possible to have an exact consensus among 32,000 Fellows on all of the questions which could arise at committee hearings.

It is therefore very important that each of you who has not done so respond to the questionnaire which was sent to the Fellows early in September, 1971. Your responses may be used to help define the stands taken by committee spokesmen at legislative hearings.

Two questions come to the fore: (1) What can our College, or any professional organization, do to shape national health programs? and (2) If we could do what we wanted, what would be our proper role?

In my opinion, the answer to the first question is closely tied in with the answer to the second. Clearly the elected representatives of the people of the United States are not going to allow the suppliers of surgical services to dictate the terms on which these services are to be supplied. We have never asked for that. On the other hand, the representatives must depend on those who have the pertinent knowl-

In brief . . .

This is the Presidential Address delivered by Dr. Rhoads following his inauguration as fifty-second President of the American College of Surgeons during convocation ceremonies in Atlantic City October 21, 1971.

edge to advise them on how their chosen objectives are to be achieved. Most, but not all, of the people who have this knowledge are within the medical profession.

The more I have pondered the question of what our proper role in guiding federal legislation is, the more I come back to the College's primary objective: the improvement of the care of the surgical patient. I believe that if the role of this College in advising those in government is aimed at this, our basic objective, we can be of maximum benefit to our fellow citizens and to their elected representatives. Furthermore, as the latter have reason to gain confidence in our motives, our advice is likely to carry real weight.

We do not face government sponsored medical care without some experience. Many of us have worked for the Veterans Administration or have taken care of patients under Medicare. In the VA pattern, the patient in general does not have much choice of hospital, nor does he have choice of physician. At times, in the past, the medical service of VA hospitals has not been a very enthusiastic one, nor one to which many veterans turned if they could afford private care. However, the alignment of VA hospitals with medical schools has provided the hospitals with enthusiastic trainees and teachers which, for the time being, has improved the situation significantly. With the advent of Medicare, which does afford the patient his choice of hospital or physician, a significant falling off of demand was noted in the urologic service of our VA hospitals, where many of the patients are over 65.

It is too soon to evaluate the Medicare program fully in terms of life expectancy for those reaching 65, though such figures should be forthcoming before long. It is clear to most of us, however, that it is a tremendous advantage to be able to go ahead in obtaining the studies, the hospitalization, the intensive care, and the consultations that are indicated in the management of those who are 65 years of age or older, and to do so without the obstacle of unmet costs.

In general, our other relationships with the patient and his family under Medicare have been unchanged with one or two exceptions. One of these relates to discharge from the hospital. Today the elderly patient, and especially his busy relatives, would like him to stay on a few days longer; whereas in the past, when

the cost fell directly on them, they could hardly wait for the day of discharge. It sometimes places a strain on the doctor-patient relationship to be accountable for the early discharge of such patients.

Just as Medicare uncovered a fairly large latent demand for medical care in persons over 65, so I think we may expect the release of an important new demand by those under 65 if medical services became available without an economic impediment. As medicine places more emphasis on the preventive aspects, and surgery is increasingly shown to be dependent for its success on early diagnosis, public education becomes critical. Without successful school systems and a substantially increased health content in the curriculum, a substantial percentage of the population will fail to utilize even the best, the closest and the freest of health services. This educational process must be continued as people age.

Continuing education is essential for the physician; it is equally important for the patient.

To make medical care completely free, however, when even more basic health needs, namely food, shelter and clothing, are not free seems somewhat illogical. Much could be said in favor of providing universal employment and a reverse income tax for the support of the unemployable. Then something could be charged for medical care, except in the case of emergency. In essence, however, medical care must be available for all, and all should be educated to take advantage of it in a timely manner.

From these concepts, a number of obvious problems emerge. One is high cost, and in relation to the high cost one must list: (1) too short a supply of physicians; (2) the difficulty of drawing adequate numbers of people into the medical profession, due in the main to limitations on medical school admissions; (3) the duplication of highly specialized facilities among competing hospitals; (4) the reluctance of medical organizations to make good use of auxiliary personnel, and (5) the influence of the risk of malpractice suits on the costs of medical care, a subject to which I will return later. There is the unwillingness of physicians to serve in remote areas or unsafe areas in city districts, the over-emphasis on curative medicine, the under-emphasis on preventive medicine, and the under-emphasis on early diagnosis.

This means that public health programs for prevention and ambulatory care facilities for early diagnosis must be financed just as adequately as hospital care. Indeed, part of our present high costs are undoubtedly due to the fact that insurance has been provided for inpatient service and not provided in an equivalent way for out-patient service. But health

maintenance organizations (HMO's), which pay bonuses to physicians if they decrease utilization of hospitals, seem to me to place the physician in conflict of interest. I do not believe that he should profit by early discharge, nor should he be in a posture in which a resisted discharge order might even seem remotely to be motivated for the profit of the physician. I, therefore, think we should reject this "quickie" solution to the reduction of medical costs.

About two years ago, the Association of American Medical Colleges and the AMA published a joint statement to the effect that medical schools should accommodate all students who are well qualified and who seek admission. I do not believe that we are doing this. I do believe that additional opportunities must be created for students to go into medicine. Medical education, per se, for these new recruits should be adequately financed directly, and not through research and research training grants or any other subterfuge. More overall planning for numbers of specialists, numbers of specialized facilities, etc. will be necessary. A variety of inducements will be required to balance the system geographically. The manpower crisis in medicine is a very real one and is perhaps best solved both by educating more persons to be physicians, and by supplementing the efforts of physicians with less thoroughly trained personnel who are either prepared as physicians' assistants or who are graduates of nursing programs with additional specialized training.

An enormous barrier to this line of development lies in professional liability. Not only are partially trained individuals more likely to make some kinds of mistakes, but they are at a disadvantage in defending themselves and the physicians to whom they are responsible in the case of unhappy occurrences that are not their fault.

I believe the present pattern in professional liability, which has led at times to liability insurance premiums consuming more than ten percent of the patient's fee, increases the cost of medical care in a number of ways. First, it has led the physician to expand the records so that it takes more time to write and to read, and is more expensive to store; secondly, it increases the demand for laboratory tests and X-ray examinations and decreases the interval between one set of tests and the next. Professional liability is, as I have emphasized, a major block preventing the transfer of appropriate responsibilities from the doctor to a well-trained assistant who is not an MD.

A new system for handling malpractice should be evolved which recognizes that the physician does not charge in terms of the lifetime earnings of the patient he may save, and cannot be expected to be responsible for the

lifetime earnings of those patients in whom the end result is unexpectedly unfortunate. One expense of the system is the legal fees of the plaintiff's lawyer which, under the contingency fee system, are often one third or more of the patient's potential lifetime earnings. A sounder arrangement would be some form of insurance for every physician against all premature catastrophes, plus a liability on the part of the physician for clearly defined sins of omission and commission adjudicated in terms of his scale of charges, probably under a ceiling such as the Warsaw Convention provides the international air carriers. Such a reform would enable young doctors to go into practice sooner, older doctors to stay in practice longer, and would not only reduce the enormous cost, now over ten percent of gross in some specialties, but would also save an enormous drain on the time of doctors in proliferating records, in worry and concern about medico-legal matters. Most particularly, it should permit medical judgments concerning the number and variety of expensive tests ordered to return to normal levels.

How much can the cost of fine medical care be reduced by better organization? Undoubtedly a number of valid economies can be introduced. On the other hand, the purpose of medical research is to find new ways of keeping people in health. The new ways are often expensive. The survivor of a series of five potentially mortal illnesses will usually have consumed much expensive medical care which would not have been consumed had the treatment of the first illness failed and he had died then. In 1920 the insulin bill for the United States was zero. In 1970 it was estimated at \$100 million for insulin and insulin substitutes. Therefore, we must look primarily at the productivity of the patients salvaged in order to realize the value of medical care. It is unwise to promise the public that the kind of care they want will be cheap because the system is changed.

What concern should we have for our own monetary compensation? While this is not the mission of the College, it is unrealistic to suppose that we have no concern for it as individuals. So far as academic medicine is concerned, the brilliant study of the problem by James V. Maloney, Jr., which appeared in the July 1970 issue of *Surgery*, clearly demonstrates

the reality of the economic motivation of both surgeons and non-surgeons in patient care and teaching. It is reasonable to presume that the economic factor operates just as strongly outside of academia as within it. The implications of Maloney's study for the design of a national health system are far-reaching. From the point of view of the public, the recompense and working conditions of surgeons must be sufficiently attractive to draw able students into the field. Otherwise everyone is the loser.

In contemplating the remuneration question, I am partly reassured by the history of the two major controversies between the American Medical Association and the public, namely Blue Cross and Medicare. In both situations the public very generously overrode medical objections to changes that were clearly and predictably beneficial to the profession in a financial sense. Why did the doctors object? Many feared loss of freedom, including freedom to serve the patient in the way that seems best for him, freedom to improvise when the routine methods of care do not meet the problem, freedom in teaching and in research, and freedom to select where one lives and one's pattern of work.

Some of the medical plans now under study obviously threaten these freedoms. How can they best be preserved? I believe they can best be preserved under a pluralistic system, and that they would be least likely to survive under a single monolithic plan. The doctors' freedoms are indissolubly associated with the patients' freedoms. The patients' freedoms should include choice of physician, not only at the primary level but at all levels. They should include the right to a choice of hospital, the right to a system in which he is not only guaranteed the essentials of excellent health care, but is free to add to this by supplemental payments of his own funds for greater frequency of examinations, less waiting time, a single room, or other things that he wants, even though they are not medically essential.

I am convinced that a national health policy and a national health program can be designed that will improve the care of the average surgical patient. Eventually such a program must be very broad in scope because health is not solely a matter of medical and hospital care. A truly national health program must assure ade-

quate amounts of good food, good water and good air for everyone, not simply when we are sick, but from birth. It must include effective public safety measures and better measures to prevent crime, since homicide is an increasingly significant cause of death in the United States. If we are to have mental health as well as physical survival, we must insist on those other freedoms for which this country was brought into being; namely, the right to liberty and the right to pursue happiness.

Advances in medical science and technology have made possible the concentration or focusing of many expensive resources for the benefit of the very ill person. This has made virtually all of us medically indigent for certain types of illnesses. We need universal insurance against medical catastrophe, and we need to have the ordinary types of medical and hospital care underwritten for those who cannot afford them. It is not clear that we will be able to reduce the cost of medical care without lowering its quality; it is clear that we must strive to increase its value.

The most promising avenues to this end appear to be prevention, an area in which surgery has a much larger role to play than is commonly realized. We must focus on early diagnosis and prompt elimination of early neoplasms and other hazardous conditions. A broad range of facilities for different intensities in medical care must be brought into being and equitably financed. These must range from the intensive care unit, with one or more highly trained physicians available 24 hours a day, to the very simple office facility. Financing must be so organized that there is no incentive to put a patient in a more expensive facility than his condition requires, and no incentive to keep him out of an expensive facility when he requires it for treatment or safety.

All of us in the medical profession are, in the last analysis, patients, not doctors. What we would want for ourselves is a good measure of the quality of medical care we must strive to make available to all.

Let us face the future with confidence that the care of the surgical patient can be improved much further. We have already pledged ourselves to serve this end. Let us also urge our government to adopt a national health policy which will serve this same purpose with fidelity.