Medicine through untinted glasses

The 1976 Harvey Cushing oration

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The 1976 Cushing orator takes a critical look at federal medical programs today, and at the health desires and needs of the public. He outlines the possible future roles of federal and state government and of the medical profession itself.

Mr. President, colleagues, ladies and gentlemen, I am deeply and warmly honored to have the opportunity to give the Harvey Cushing Oration.

I well remember Dr. Cushing’s aura. Perhaps it has grown with the years, perhaps it has changed, but when he was alive, whether you lived in the East, the South, the Middle West, or, I daresay, on the Coast, there was a broadly held and vibrant image. An aura first of a very great physician, of a man of dedication and singleness of purpose in advancing the field that he had opened up. If one hoped to work with him, one approached that end aware of the rigorous standards of accomplishment that would be expected. His increasing accolade from the medical authorities of the day enhanced that reputation of greatness, and his tender concern for youthful patients and for their distressed families warmed the hearts of those who loved. This was the nubbin of the aura we sensed. To me, on brief meeting, he was shy, polite, reserved, and his very bearing seemed to substantiate all of those qualities.

In 1930, I came East from Chicago with my roommate, Bronson Ray, who had applied for a residency under Dr. Cushing, and I, having a westward yen, contented myself with joining a spirited ward round under Henry Christian. Later, Bronson said, “My God, he didn’t ask me a question on medicine — he just asked me what I was interested in and what I had done,” and he apparently had given Bronson a chance, among other things, to enlarge on a pack trip we had taken in the Sierra Nevadas with 40 donkeys and 12 boys, as a means of helping to pay our way through medical school. Well, Bronson got the residency and I have often wondered which of his talents intrigued Harvey Cushing, or whether he even heard about that talent, which on cold mountain mornings we prized most highly. Bronson was our best and most successful fisherman, our most expert packer, who could throw a diamond hitch or a box hitch or invent a hitch. He could find a lost trail, bake high-rising 9-pound loaves of bread, and was always a boost to our spirits, but I wonder if Dr. Cushing was aware of one of his singular attributes. We would turn our donkeys loose while we camped for 2 or 3 days for trailmaking or surveying, and then on the day when we were to make our next
march, we would get up at 3 or 4 o’clock in the morning and start out in search of the donkeys. It is cold at an altitude of 10,000 feet at 4 a.m. A few of our jennies had bells, but there were bells in the sound of the creeks and trees also, even in our ears, when we listened hard. Tracks were helpful where the ground was soft enough, but the one thing that all the burros had, or had left behind them, was dung, and Bronson, better than anyone else in our outfit, could estimate the age of dung in days or hours or even less, so we could quickly tell whether our trail was growing hot or cold or whether we were going upstream or down. Yes, Bronson Ray was, and may still be, the best judge of the age of donkey dung — certainly the best one Dr. Cushing ever had.

In following the title “Medicine Through Untinted Glasses,” I shall try to throw away the rose-colored ones that I favor and the dark-blue doomsayers’ glasses, and look objectively, albeit with a certain amount of prejudice, at medicine and where I think it might be heading in the relatively near future — the next 10 years or so.

**Medicine Before 1976**

It is foolish to look ahead without a good look over one’s shoulder at the past, as well as at the present scene, so that one may project from the relatively known. I don’t think we need to go back to the age of Hippocrates when the prestige of medicine was so warmly enhanced by the Greek gods, on whose temple steps medicine was practiced. It has certainly had its ups and downs of gradual and violent nature since that time. As one example, the status and the demands for the surgeon at the time of the Battle of Agincourt in 1415 were such that the shoemaker, the laundryman, and several others ranked above him. It is more pertinent to view the relatively recent picture: the low estate of medicine during the period of and after the Civil War, certainly one reason for the birth of all the other avenues to health made by sincere, searching people, and not necessarily by charlatans, but before the mantle of science came alive on our shoulders. Among other efforts and cults during that period were Grahamism and naturalism — one searching a more primitive diet, the other a more primitive way of life. There was electromagnetism and homeopathy. It was then that Christian Science was born and osteopathy, later Fletcherism, had its vogue.

In the 1890’s and just after the turn of the century, as sanitation and inoculations were beginning to prevent so much illness and to save so many lives, we, the allopaths, were represented by the horse and buggy doctor, who, with relatively few tools, gave time, patience, comfort, and love to his patients and their families, and charged amazingly little for it. This is the man that the public now would like to see returned and, of course, they want him to have all the scientific and technical attributes of the best-trained doctors of the present time.

It has been estimated by thoughtful people that 1917 is somewhat of a landmark in medicine. Of 1000 patients going to their separate physicians for their varied ailments before that year, more would have died, more would have become chronically ill or crippled, and their illnesses would have lasted longer than if they had stayed home. This was the beginning of a great era of therapeutics when useful and useless herbs were prepared in complex prescriptions; surgery was limited in scope by infections and otherwise, and hormones and antibiotics were hardly dreamed of for medicine. We had mercury and bismuth for syphilis. Salvarsan was just becoming available. We had digitalis for the failing heart but also used it along with wide open windows for lobar pneumonia. We had opium and its derivatives, we had quinine, and still needed it, and on a lesser level we had belladonna, bromides, phenobarbital, strychnine, and aspirin. But in the beginning of the century people were still starved for colds or fever, purged, leeched, dunked in hot water and then in ice water, and numerous other things that more than counterbalanced the slender therapeutic armamentarium.

Between 1940 and 1945 there is another period to remember. It was between those years, possibly in 1943, that one could say medicine has advanced more since that time than in all the history of mankind up until that time. I need not dwell on the advances in surgery, medicine, and psychiatry; you are certainly aware of them.

I would like to emphasize one more date: 1960. It was in 1960 at a White House Conference on Aging called by President Eisenhower that four or five thousand
thoughtful people decided that good health care was the right of every American, along with the right to food and shelter. They may not have had any more authority than their good names and the background of the White House, but following this, in the 1960's, Congress passed over 50 laws having to do with medicine. Of these, Medicare and care for mothers and infants were among the best, Medicaid among the less carefully thought out, and a host of others, often depending on the illnesses in congressional families or among their friends, or ideas brought to them by health pressure groups then in their infancy. It was through this period that the National Institutes of Health grew so amazingly. It was before this period, in 1953, that Health, Education, and Welfare was started and really began its growth, and now, in 1976, what do we have?

Present Problems of Medicine

We would seem to be in midstream on our way to an uncertain goal. There is publicly-paid-for medical care available to those over 65. Care is available for most of the poor, for mothers and infants in many areas, for crippled children, for Indians and Eskimos, for those with emotional problems or with psychoses and for narrow categories of illness chosen by chance, by whim, or for myopic reasons.

For the middle class we have doubled or tripled the cost of medical care and there has sprung up private health insurance, which eases the pain of cost. We have saved lives or postponed death for many, we have lessened suffering and disability for millions but statistically it is difficult to show increased longevity.

We have yet to organize on a broad scale the delivery of medical care in our worst slums, and rural health care rightly or wrongly makes everyone shudder. Also, we are stealing a large number of doctors from countries that need them much more than we and who could ill-afford to educate them.

We have reached this midstream point at a cost to the federal government of 100 billion dollars in the past few years alone and of raising the health share of the gross national product to 8%. We have bought a very expensive potpourri of medical care, and there is a question in a rapidly increasing number of minds: is it worth it, is it what we had hoped for or aimed for, and if it is, can we do it more equitably and with less waste?

Are we aiming at something that cannot be realized? Is our aim realistic or appropriate or is it even good? We can ill-assess the present unless we look at ourselves and our "druthers": that balance between our wishes and hopes and more pragmatic aims, and what we are willing to give up to realize them.

If we are interested particularly in saving lives or in maintaining usefulness for large numbers of people, there are well over 100,000 people killed in accidents each year; on the highways, in homes, and elsewhere. Millions are injured and many hundreds of thousands maimed. We could concentrate on reducing those numbers. There are the tens of thousands who die from the effects of tobacco smoke each year and many more who are made cardiac or pulmonary cripples. We should be able to make an impact on that problem. If we would prevent or cure important illness, could we not find a better escape drug than alcohol and put it to use? Could we not reduce blindness, use vaccines to their fullest, and finally and very importantly, could we not reduce starvation between the ages of 10 and 20 years? Such thrusts at saving lives, reducing crippledom, and preventing pain and suffering is not our "kettle of fish," not yet at least. It is not what our people have in mind when they pay for the overall cost of health care. It does not catch their imagination or to any great degree get their cooperation.

Federal and State Medical Programs

On the more broadly positive side, this is what our people have received from the federal government in health care in the past 10 or 15 years:

First, the older people have been able to get health care virtually free. There are, of course, deductions and coinsurances, but if they are too poor, those on Medicare can turn to Medicaid for coverage. This feeling that they can get health care from somebody of their own choosing has been of great reassurance to them and to their families. It may even have extended the lives of some of them while at the same time it did give them the feeling, a reassuring feeling, that somebody with expert knowledge had passed
judgment on their condition and was doing what could be done for them. The poor have, to a degree, been helped through Medicaid, but this law, which had as one of its main purposes the exploration with the states of better systems of health delivery, turned federal money disappointingly into the old channels of distribution. Mothers with infants and small children have had help, particularly in keeping their children well. Children considered crippled have had doors to diagnosis and therapy opened up to them that were never open before. Efforts have been made to educate people about their diseases or about keeping well. Great advances have been made in our thinking about mental disease and emotional disease and in the availability of psychiatric care for those who need it. Through concerted effort, both private and public, much more is known about the rheumatic diseases, their cause, to a degree, their prevention, and the treatment, so that one has moved away from the old posture of referring a rheumatic patient to one's competitor across the hall. Many others with less well known diseases have been helped. The government has certainly supported medical, biological research, basic and otherwise, handsomely at the NIH and in every medical school in the country, as well as research institutes. This support alone has amounted to well over 10 billion dollars in the past decade.

Not only our Congress but states, counties, and cities have often added more than their bit, or have continued services that the federal government had ignored or taken for granted. The plethora of overlapping laws passed by Congress was so ill-coordinated, often hastily planned, and selfishly motivated, that the Department of Health, Education, and Welfare had an almost impossible task in implementing them. In 1972, Elliot Richardson, then Secretary of Health, Education, and Welfare, had an almost impossible task in implementing them. In 1972, Elliot Richardson, then Secretary of Health, Education, and Welfare, asked his comptroller to estimate what the cost would be should the Department do everything the laws specified and do it for all who were eligible. It turned out that if the Department followed the laws and did so for all those eligible, it would cost 5 or 6 billion dollars more than the total federal budget; or about two and one-half times the then budget of HEW. For this, and overlapping reasons, the Department found it necessary to oppose most health bills in spite of their wordy promise. Even with urging from the Secretary, Congress was reluctant to repeal a single redundant or overlapping law. With this multitude of laws with broad and with specific aims, overlapping and under-financed and obviously not fully implemented, the spokesmen for our people are still unhappy.

It would appear that we want relief from minor ills and from minor pain. We want solace, reassurance, a degree of love, and the best of specialists available to care for us should we need them. We think medicine has more answers than it really has and we tend, through our belief in the media, to expect a good outcome, except in cancer, and if we do not get it and we do not know our physician well, or if he has been preoccupied in saving an organ vital to our life, we may take him to court. Prevention of illness and maintenance of health leaves us cold, as it were. We want the right to drive, drink, smoke, and be careless, as we will. Should you by chance think that I believe that we should order everybody not to smoke, that we should have a return of prohibition, or that we should forbid people to take risks, you misjudge me. I am just trying to point up the larger us and our ill-focused aims or hopes.

In summary, too many cooks have pretty well spoiled a soup of dubious recipes prepared for the wrong palate.

One can assume that while the states will grow in influence and impact on the health care system, the federal government will continue to furnish a large and more slowly increasing amount of the money to support it. With possible setbacks, the government will give the states increasing latitude in how to spend the money allocated to them. This move has been called federalization and decentralization in the past and more recently it is called block grants. The states still license physicians and hospitals, but some powerful senators and some important committees in Congress are eager to use malpractice as an excuse to license doctors federally and to relicense them every 5 years or so and at the same time to harness them more closely to people's needs through compulsory acceptance of assignments and through reporting to federal agencies mishaps and malpractice. However, unless the cost of malpractice insurance premiums and defensive medicine increases,
and quickly, the federal government will not pass legislation on that score. I doubt that the total cost of malpractice premiums will go down much in the next 3 or 4 years, and then perhaps slowly over the next few, but the distribution of the premium costs will be changed by broadening the base for payment to all patients or the government, by changes in classification, and more likely in separating real malpractice from expected percentage of poor results and unreasonable expectations and pure resentment and dislikes.

The states will give the medical profession the opportunity, and a number already have, to discipline those doctors who need it. At least 5% would seem to deserve disciplining. If we don’t do it, if we are unwilling or unable to discipline ourselves, we lose an important part of the definition of profession and surely the federal government or the states will step in and do it for us under conditions more like policing.

The Forward Plan for Health

The Forward Plan for Health created under the imaginative and purposeful leadership of our Assistant Secretary, Dr. Theodore Cooper, will play a large part in pointing the future of health care. It is the work of the health planning group in the Assistant Secretary’s office. It has had input from many sources and input is continuously sought and acted upon. A large printing has already been exhausted. Congress is interested as are professional groups and organizations. It is the beginning of the arriving at a consensus on what we want in health and how we are going to attain it.

Basic to it will be efforts to control ballooning health care costs. There will be a change from open-ended budgets to specific budgets that health care providers will have to meet. There will be great and increasing efforts to maintain and to improve that elusive aim — the quality and the effectiveness of health care.

Access to health care, point of entry to a loose system, will be accomplished either directly to doctors or through nurses or paraprofessionals to doctors with a line through clinics, and if necessary, to hospitals.

There will be increasing stress and enlightenment on the broader problems affecting health that are really not in the realm of medical care: environment, housing, nutrition, education, and training of an increasing number of people in how to keep well.

Pursuit of and support of research with more emphasis on aim will occur. If the aims are dictated by the Office of Management and Budget or by Congress it would, in all probability, be based on superficial and political decisions or on short-term financial considerations.

Health service areas will continue to be delineated and brought into being with health systems agencies and state agencies in preparation for a national form of health insurance should it come.

As the cost is borne in more and more on the people, the steam is going out of the drive for national health insurance. Something will be created, but not comprehensive national health insurance.

In giving so much credence to the Assistant Secretary’s future plan for health, I do so because I think it expresses well what the people of this country really want, and at the same time through informing them will bring them a little further along the road in their needs.

So, in looking forward to the next 5 years or the next 10, for that is the way things go in the government, this is done with a fairly sensitive realization of what that vast middle group who pay the bill really think.

The Future of Health Care

On the whole, Americans are kind and generous, but they hate to be taken, and they are beginning to think that somehow they have been. They still want care for the aged, for the crippled, for some special groups, and for the poor, and possibly even national insurance to cover themselves, but they don’t want to pay through the nose, and they are. They think there is some simpler way of accomplishing these aims for the people. Had Congress been more sensitive or more unified, I think it would have been aware of this feeling and its growing strength a year or so ago.

I am sure you would like some more specific insight into problems that loom for you now. The government, both Congress and the Administration, feel that the health professions have been insensitive to the demands, hopes, and needs of the people and
they will increasingly regiment us during the next 5 or 6 years, and very likely far beyond that. They will assume that many of us are ill-motivated and will, therefore, need policing in areas where they cannot possibly do so effectively. We in HEW are fighting these pressures and demands right now. Congress believes that it can figure out a way to police the level of medical practice, to police the efficiency of practice, to police the cost of care, to determine the kinds of physicians who should practice, and to determine how they should be distributed. There will be increasing efforts in all of these areas within the next decade, or even year.

For the carrying out of laws, regulations are created, probably with undue zeal, for they are written by young lawyers in the tradition of Supreme Court Justice Felix Frankfurter, the tradition being: "let there be no possible misunderstanding." One can see how with that aim pursued for a number of overlapping and sometimes vague laws, one could end up with a veritable forest of dos and don'ts so discouraging to honest people trying to do a job, but always with loopholes for those interested primarily in money.

Secretary Mathews of HEW believes strongly that in pursuing our mission to serve the people, there is much need for clarifying and simplifying the mechanism through which this is done. He is perturbed and distressed about this stultifying cause for rigidity and frustration and has instituted a broad program to review all our regulations for the purpose of simplifying and coordinating them. This one accomplishment could begin the streamlining of the work of those who deal with the government and certainly lessen tensions and improve communications.

Should we have national health insurance or catastrophic insurance, there will be a need for organization under government auspices on geographical and professional bases. There will be continued planning, at least broadly, along the lines described in Public Law 93-641, which was the National Health Planning and Resources Development Act of 1974. Toward this end, as you know, areas have already been designated. There may be some changes as their need becomes obvious, but the planning and the need will continue.

There will be increasing use of nurses with broader responsibility and authority earned and conferred, and of allied professionals and paraprofessionals as entry points into the health care system and in the continuum through diagnosis and treatment.

Professional Service Review Organizations, or their equivalent by some other name, will continue and probably be expanded. We have been too slow in doing this job ourselves and one can only hope that we will have the wisdom to earn our way back into it.

In reaching for efficiency and for higher levels of professional care the government is already aware of the difficulties of accomplishing this in dealing with individual physicians. It will continue to foster health maintenance organizations and when it wakes up will demand that an increasing amount of clinical teaching be carried out within such organizations. By the same token, it will encourage hospitals to be responsible for the actions of physicians so that units to be evaluated will include large numbers of health professionals.

As the cost of health care continues to rise, the federal government will first try to cut it down by paying less and less on the dollar, driving out the more responsible people, and inviting in those who have figured out how they can make money and meet the requirements, even though only paid 50 cents on the dollar. I need hardly remind you that such work is not only apt to be worthless, but ends up in a lot of unnecessary treatment of undiagnosed diseases. After several more years of this, Congress and the Office of Management and Budget will be forced to search and support a more intelligent professionally oriented effort.

I have purposely left the most sensitive question for the last. What will the medical profession do in the next 10 years to try to meet important desires and the needs of our population for health care? I have left it for the end because I do not have much hope that as a profession we will accomplish anything broadly positive and constructive. We are on the defensive and our attitudes and efforts will probably best be described by "for God's sake, leave us alone," or actions akin to strikes, and strikes are rarely pro bonum publicum.

If one sees doctors and some of our largest organizations headed more and more toward unionization as a mechanism for self-protection against the many who attack us as an establishment, I believe the specialist
organizations can and will view the problem more from the patient's — the public's — point of view, and will take action to protect the patient from inferior medical or surgical care, will maintain realistic fees, be aware of hospital and laboratory expenses, and will see that care is available where it is needed and can be appropriately carried out. Even though they often see their patients only four or five times, they will become increasingly aware of and will respond to the patient's poignant desire to be related to as a person as well as with keen interest in his disease.

The probability of success through such close-knit groups with common backgrounds and the possibility that they can lessen government interference is strong.

One might tackle the changing and confusing field of ethics with respect to health, but ethics will certainly be changed against the background of society, and very likely by society, without the help of medicine, as it was at the White House Conference on Aging when there was proclaimed, in fact, a new ethic with respect to health.

Dr. Cushing had a great faith in democracy and the reactions of the average man, and in the average man's impact on brilliant leaders and other outstanding men.

Perhaps this was best expressed in part of a letter he wrote to President Charles Eliot of Harvard, and which John Fulton quotes in his biography. Eliot had disagreed with him on this subject saying, in effect, that it was the elite of the nation that determined its present status and its place in history. Cushing said, "without the Jean Josephs, which constitute France to my thinking, the Louis Pasteurs would not be possible, nor would they be appreciated. So the patriot leaders of the American Revolution were made possible by the character of the people behind them — so, too, the leaders in the Civil War."

I hold with this premise and it is pretty much the basis for this small glimpse into the future.

The public is confused: it has been razzle-dazzled by exaggerated claims of what is available and by statements of the vast amounts of money spent toward that end. With or without help, it will come to realize what important services it wants and also what it should logically want, and will more clearly express those desires. The people will dissect the problem of health and will come to the premise that it is not all the doctors' responsibility and certainly not that of the various governments, but a combination of themselves as individuals or in unison, of the medical profession, and of government.

"Come and get it" medicine has certainly not been the answer, but an aura of nostalgia still exists in the minds of many for it. The next decade will see their thinking well on the way to a more objective and logical and complete *modus operandi* for health care.

We shall hear increasingly during the next decade in our professional literature and in general literature, the call of thoughtful doctors pointing up our strengths and our shortcomings and sharpening our goals so that society can reappraise us, increasingly believe us, and help us in our next step.

The twelfth Cushing Oration was delivered at the Annual Meeting of the American Association of Neurological Surgeons, San Francisco, California, on April 6, 1976.